QUARTERLY CHILD REVIEW RCW 74.13.640 JULY – SEPTEMBER 2024

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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Executive Summary

This is the Quarterly Child Fatality Report for July through September 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 Three Report

This report summarizes information from completed reviews of three child fatalities and six near-fatalities [1] completed in the third 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	0
Region 2	1
Region 3	2
Region 4	4
Region 5	1
Region 6	1
Total Fatalities and Near-Fatalities Reviewed During 3rd Quarter 2024	**9**

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.

[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 Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2024	13	8	5

Child Near-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	24	11	13

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 Third Quarter Findings

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

- Six of the 9 cases referenced in this report were closed at the time of the child's death or near-fatal injury.
- Six of the 9 cases this quarter were either open or recently closed Child Protective Services (CPS) / Family Assessment Response (FAR) cases. Two of the seven cases were recently closed Child Family Welfare Cases (CFWS) cases.
- Seven of the 9 critical incidents involved children ingesting fentanyl or other oipoids. One of the 9 incidents involved an infant dying from accidental asphyxiation. An infant died from inflcited fatal injuries. Fentanyl/opioid ingestion is the leading cause of near-fatal injury in cases reviewed by DCYF.
- One child referenced in this report identified as White. Two children identified within this report are Hispanic, two children identified as Native American and four children were identified as Black/African American.
- Substance abuse was a significant risk factor in 8 of the 9 critical incident cases this quarter.
- Substance abuse was a significant risk factor in all of the 7 fentanyl/opioid related cases.
- Domestic violence was a risk factor in 5 cases.
- Mental health issues were a risk factor in 4 of the 9 critical incident 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 3 of the cases, DCYF intake received between 1 to 6intake reports prior to the fatality or near fatality. DCYF intake received between 10 to 19 prior reports on families in 3 cases documented in this report. Three cases had between 20 and 45 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 two 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 third quarter of 2023:

O.S.

R.W.

M.J.T.