WASHINGTON STATE

OFFICE OF THE FAMILY AND CHILDREN'S OMBUDS

CHILD FATALITIES AND NEAR FATALITIES IN WASHINGTON STATE

JUNE 2025

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EXECUTIVE SUMMARY

The Office of the Family and Children's Ombuds (OFCO) was established to ensure that government agencies respond appropriately to concerns related to children in need of state protection, children residing in state care, and children and families under state supervision due to allegations or findings of child abuse or neglect. As part of its oversight of the state child welfare system, OFCO examines critical incidents, such as child fatalities and near fatalities. OFCO also participates in executive child fatality and near fatality reviews, and reports on the implementation status of recommendations produced from these executive reviews. Through these processes, OFCO identifies issues related to critical incidents and facilitates systemic improvements.

The Department of Children, Youth and Families (DCYF) notifies OFCO when a critical incident occurs.[1] OFCO then conducts an independent preliminary review of the circumstances surrounding the incident and the Department's involvement. Critical incidents include:

- **Child Fatalities:** When the family was involved in the child welfare system within the preceding 12 months of the child's death, including "information only" referrals, or, when the fatality occurred in a DCYF licensed, certified, or state operated facility.[2]

- **Child Near Fatalities:**[3] When the family was involved in the child welfare system within the preceding 12 months, including "information only" referrals, or the near fatality occurred in a DCYF licensed, certified, or state-operated facility. A near fatality is defined as an act that, as certified by a physician, places the child in serious or critical condition.[4]

- **Other Critical Incidents:** The Department notifies OFCO of other critical incidents including child abuse allegations in licensed foster homes or residential facilities, incidents involving DCYF clients (such as dangerous behavior by foster youth), incidents affecting DCYF staff safety, or high-profile circumstances that may generate significant media interest. OFCO briefly reviews each of these cases to assess whether there is any unaddressed safety issue, and, if so, may conduct a more thorough review.

Section I of this report describes OFCO's critical incident review activities from January 1, 2024, to December 31, 2024. The critical incidents discussed in this report include child fatalities and child near fatalities. It is important to note that OFCO is not notified of all child fatalities or near fatalities, only those that are recorded in the DCYF reporting system.

From January 1, 2024, to December 31, 2024, OFCO conducted 78 administrative examinations of child fatalities involving both child abuse or neglect cases and fatality cases unrelated to child maltreatment, and 62 examinations of child near fatalities. Of these, OFCO considered 38 child fatalities and 44 child near fatalities to be related to child maltreatment.

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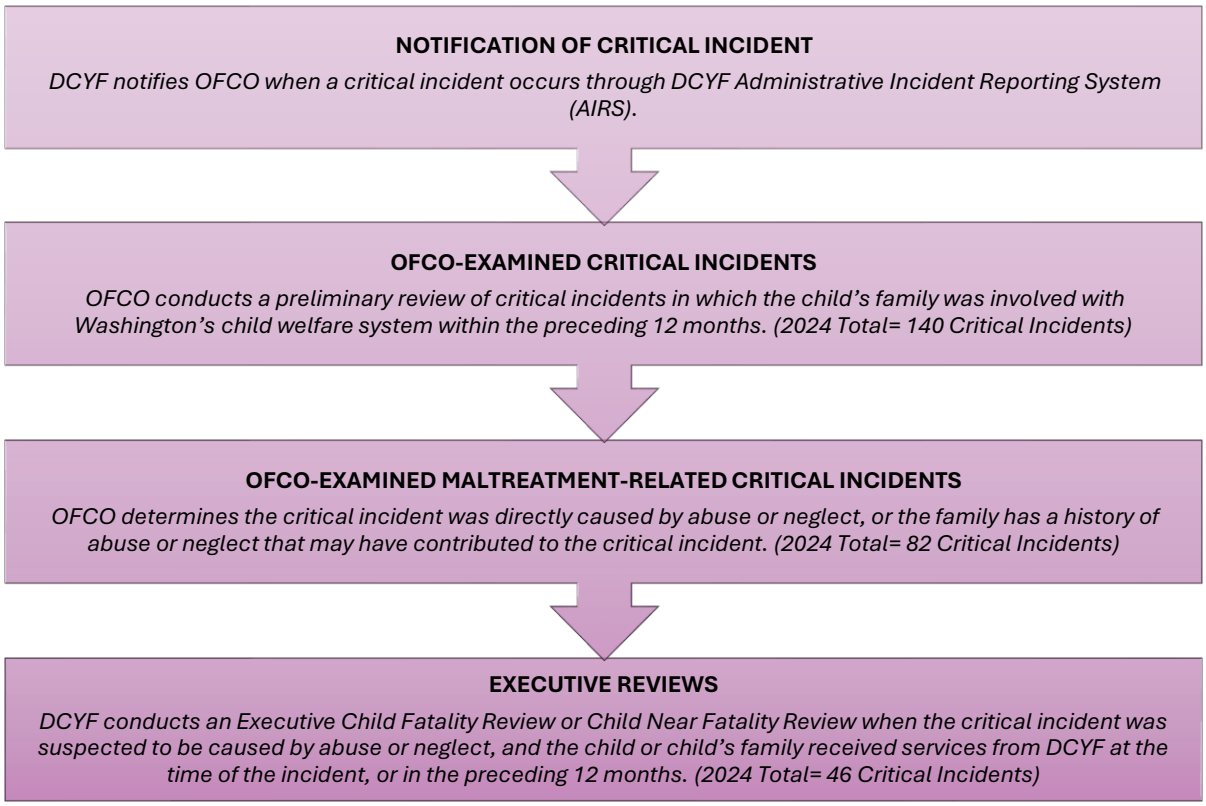
[1] OFCO receives notice through DCYF's Administrative Incident Reporting System (AIRS).
[2] When a report does not meet the legal definition of child abuse or neglect, intake staff documents this information as an "Information Only" intake in the DCYF database.
[3] RCW 74.13.640(2) requires the Department to promptly notify the Ombuds in the event of a near fatality of a child who is in the care of or receiving services from the Department or a supervising agency or who has been in the care of or received services from the Department or a supervising agency within one year preceding the near fatality. The Department may conduct a review of the near fatality at its discretion or at the Ombuds' request.
[4] RCW 74.13.640(2)(c).

Substance use and the fentanyl crisis continues to impact child fatalities and child near fatalities. In 2024, accidental ingestions and overdoses accounted for over 25% of the fatalities (20 fatalities) and 66% of the near fatalities (41 fatalities) OFCO reviewed. Seventy-eight percent of the critical incidents from accidental ingestion of drugs or drug overdoses involved fentanyl. Young children are particularly at risk for accidental ingestion of drugs. Of the 61 incidents involving accidental ingestions, 38 incidents involved accidental ingestion by children ages 0 to 3 years of age.

For the first quarter of 2025, OFCO examined 47 critical incidents. Twenty of these cases involved accidental ingestions and overdoses, and of these, 14 consisted of children three years of age or younger accidentally ingesting fentanyl.

DCYF conducts an Executive Child Fatality Review when the death of a child was suspected to be caused by abuse or neglect, and the child or child's family was receiving services from DCYF at the time of death, or in the preceding 12 months.[5] The review committee consists of individuals with no prior involvement with the case, and typically includes DCYF staff, OFCO staff, and community professionals with expertise relevant to the case, such as law enforcement officials, chemical dependency treatment providers, domestic violence treatment providers, mental health treatment providers, child health providers, or social work practice specialists. The purpose of reviewing child fatalities and near fatalities is to increase understanding of the circumstances around the child's injury or death, evaluate practice and programs, make recommendations to prevent future child fatalities or near fatalities, and improve the health and safety of children. OFCO is required to issue an annual report on the implementation of recommendations issued by fatality review committees.

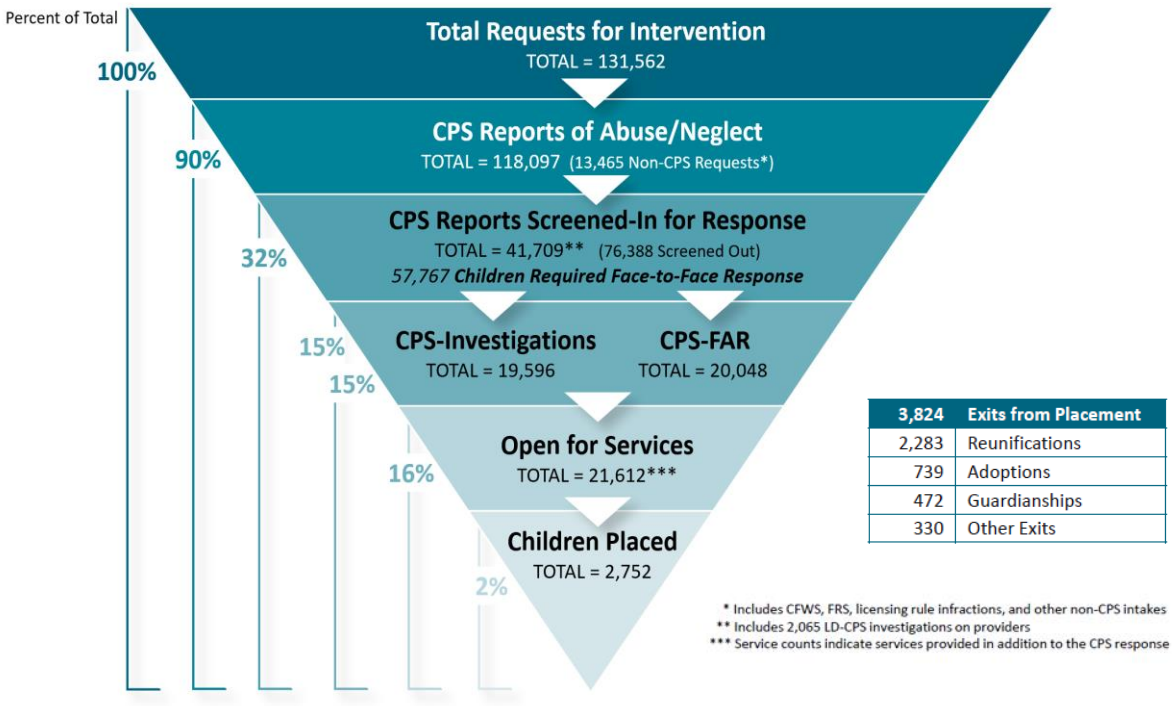
Figure 1: **OFCO Critical Incident Review Process**



[5] RCW 74.13.640.

It is important to consider critical incidents within the context of the number of families who receive DCYF services each year. In 2024, CPS received 118,097 reports of alleged child abuse or neglect and screened in for either CPS investigations or Family Assessment Response 41,709 reports of child maltreatment. In these cases, 57,767 children required an initial face-to-face response.

Figure 2: **DCYF Child Welfare Overview, 2024**[6]



Section II of this report describes the implementation status of recommendations made in child fatality and near fatality reviews conducted between January 1, 2024, and December 31, 2024. During this period, DCYF conducted 16 child fatality reviews and 30 near fatality reviews.

Additionally, OFCO reviewed each of the child fatality and near fatality reports to identify common themes arising in these reviews and to craft recommendations. OFCO noted that in several critical incident reviews, committees discussed: an apparent confusion over the legal standard for establishing court oversight through a dependency; the prevalence of critical incidents following a mother and/or infant testing positive for substances at birth; and the need to effectively engage fathers. Section II also discusses the following recommendations:

- **<u>Develop Guidelines on the Use of In-Home Dependencies</u>**

  DCYF should engage judicial officers, court administrators, and child welfare professionals to develop practice guidelines and training focused on the use of in-home dependencies as an option to provide ongoing services, support, and protective supervision in situations where a child is not at risk of imminent physical harm, but circumstances pose a danger of substantial damage to the child's psychological or physical development. Additionally, the

[6] DCYF Office of Innovation, Alignment, and Accountability. January 2025. https://dcyf.wa.gov/practice/oiaa/reports.

guidelines should describe how to incorporate prior involvement with child welfare services when assessing child safety and risk and the need for court supervision.

- **Increase Treatment Resources for Pregnant and Parenting Women**

  Policymakers and legislators should ensure there are adequate inpatient and outpatient SUD treatment facilities for pregnant and parenting women as these services are essential to reducing accidental ingestion of drugs and overdoses by infants and toddlers.

- **Increase Efforts to Engage Fathers and Paternal Relatives**

  DCYF should make further efforts to identify data metrics to understand how fathers experience the child welfare system and how the system responds to fathers. Metrics could include child reunification with fathers, participation in parent-child visits, and fathers' and paternal relatives' participation in case planning events. Additionally, DCYF should provide training to address bias and stigma fathers may experience.

SECTION I: OFCO-EXAMINED CRITICAL INCIDENTS

CHILD FATALITIES EXAMINED BY OFCO

OFCO conducts a preliminary review of all fatalities in which the child's family was involved with Washington's child welfare system within 12 months of the fatality, regardless of whether the subject child received services from the Department, and regardless of whether the child's death was suspected to be caused by child abuse or neglect.

OFCO examines these fatalities to:

- identify current safety issues for any children remaining in the home;
- determine whether the fatality appears to have resulted from abuse or neglect, thus requiring DCYF to conduct an executive child fatality review, or whether ongoing child maltreatment concerns in the child's family may have contributed to the fatality;
- identify any problematic casework practice or decisions made by DCYF, to ensure more effective protection of any other children in the family, or to improve agency services and case management in similar cases in the future; and
- assist policymakers in developing stronger policies to protect children.

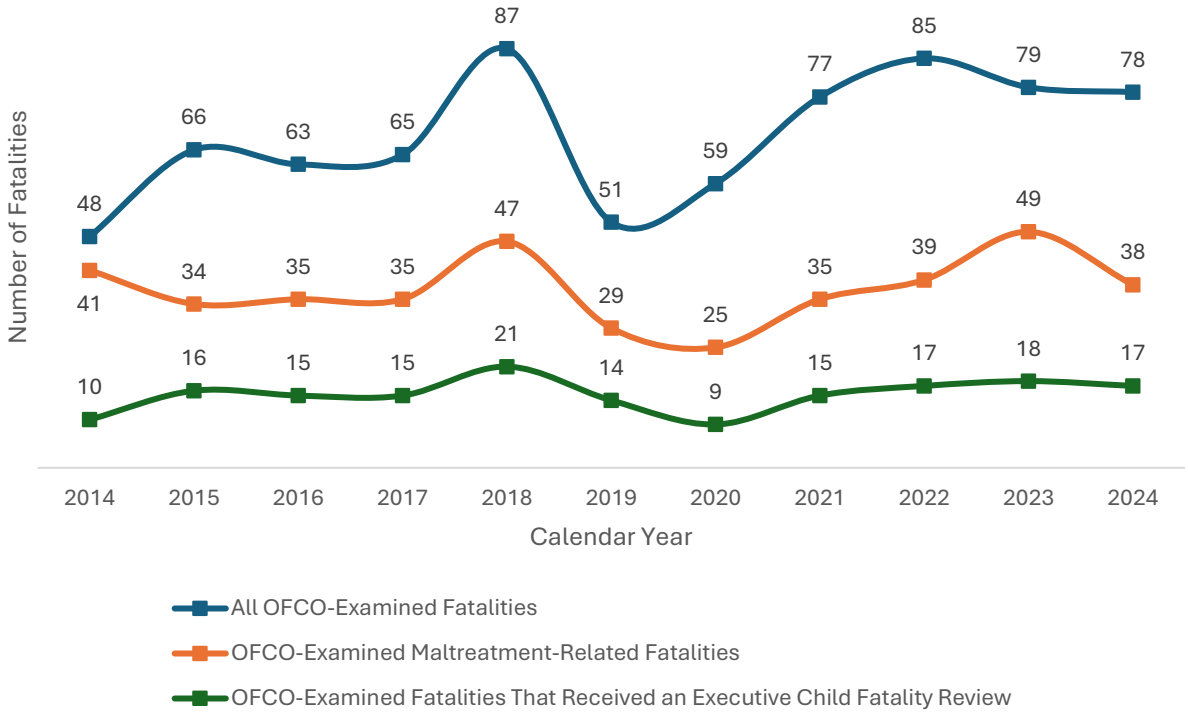
OFCO examined 78 child fatalities between January 1, 2024, and December 31, 2024. Not all of these fatalities were related to maltreatment. For example, OFCO may receive notice of an expected medical death of a child when the family had contact with the Department in the past 12 months.

OFCO defines maltreatment-related fatalities to be those in which:

- the child's death was directly caused by abuse or neglect; or
- the child's death was not a direct result of maltreatment, but the family has a history of child maltreatment concerns or other risk factors were present that may have contributed to the child's death.

Of the 78 child fatalities examined between January 1, 2024, and December 31, 2024, OFCO considered 38 to be related to child maltreatment. The following data describes the profile of these 38 maltreatment-related child fatalities.

Figure 3: **OFCO-Examined Child Fatalities by Year**



OFCO CHILD MALTREATMENT DEFINITIONS

Clear Physical Abuse

A CPS investigation concluded that physical abuse by a caretaker caused the child's death. Law enforcement reports, medical records, and/or an autopsy report may also have concluded that intentionally inflicted physical injuries caused the child's death.

Clear Neglect

A CPS investigation concluded that neglect by a caregiver (e.g. an infant or toddler left unattended) caused the child's death. Law enforcement reports, medical records, and/or an autopsy report may also have concluded that negligent treatment/maltreatment caused the child's death.

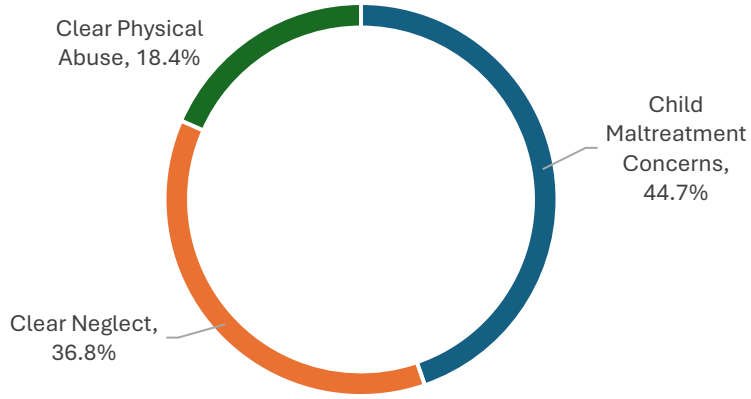
Child Maltreatment Concerns

Factors associated with child abuse or neglect were present in the family's history and, while not a direct cause, may have contributed to the child's death. These factors could include substance abuse; domestic violence in the presence of children; mental health issues that impair a parent's ability to appropriately care for a child; and prior substantiated abuse or neglect of the deceased child, or of other children in the family.

MALTREATMENT-RELATED CHILD FATALITIES

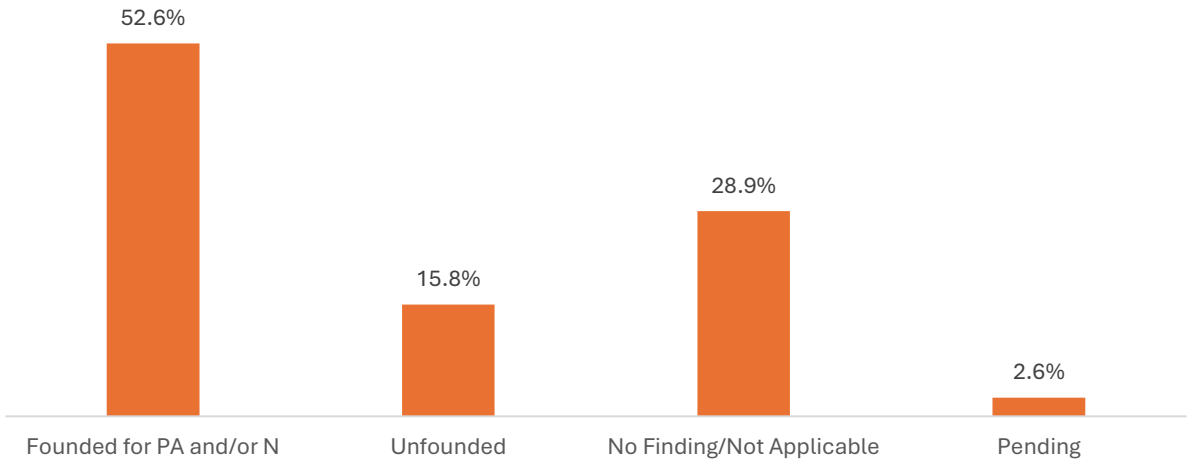
Of the 38 child fatalities related to child maltreatment, 7 children died due to physical abuse and 14 as a direct result of neglect. OFCO found maltreatment concerns in 17 additional cases.

Figure 4: **Type of Maltreatment in Child Fatalities, 2024**



CPS investigations into 20 of the 38 fatalities resulted in a "founded" finding of neglect and/or physical abuse. Investigations into six deaths were "unfounded." No findings were made in 11 deaths.[7] At the time of this report, one investigation remains pending.

Figure 5: **Findings in Maltreatment-Related Child Fatalities, 2024**



[7] Findings may not have been made for many reasons, including no report made to CPS Intake regarding the death, the intake screened in for a risk only investigation, or the intake screened out.

MANNER OF DEATH

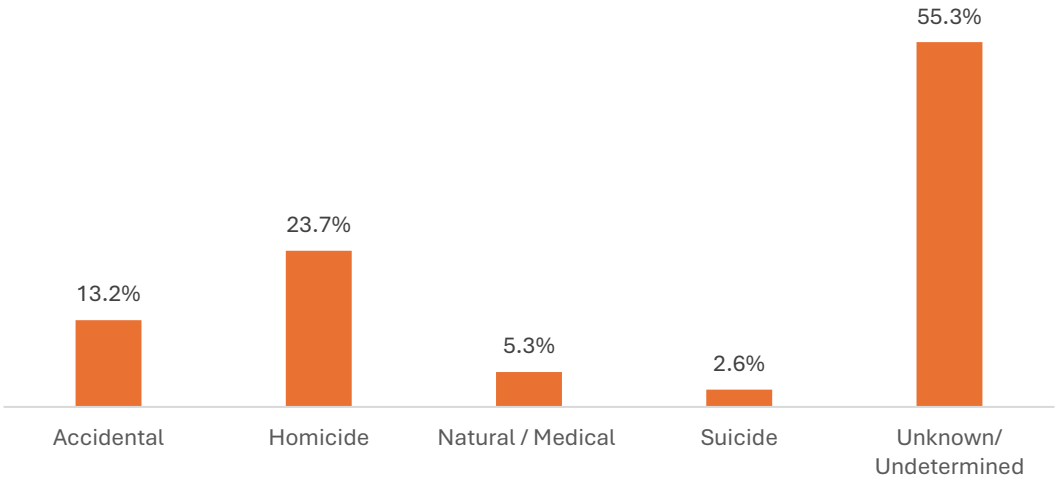
The manner and cause of death is determined by a medical examiner or coroner. The manner of death describes the context or circumstances of the death and is assigned to one of five categories:

1. natural or medical;
2. accidental;
3. homicide;
4. suicide; or
5. unknown or undetermined.

The cause of death details how the death occurred. For example, the manner of death is determined as natural or medical when the cause of death is pneumonia, or the manner of death is determined as accidental when the cause of death is a motor vehicle accident. SIDS is generally considered a subset of natural or medical death, however, if significant risk factors were present during the scene investigation, such as an unsafe sleep environment or inappropriate bedding, the manner of death may be classified as unknown or undetermined. The manner of death may also be classified as unknown or undetermined for drug overdoses as there may not be enough information to establish whether the overdose was accidental or intentional.

Of the 38 maltreatment-related fatalities, the manner of death for 21 fatalities were unknown or undetermined, nine were homicide, and five were accidental.[8] Two fatalities were ruled as natural or medical and one as suicide.

Figure 6: **Manner of Death, 2024**

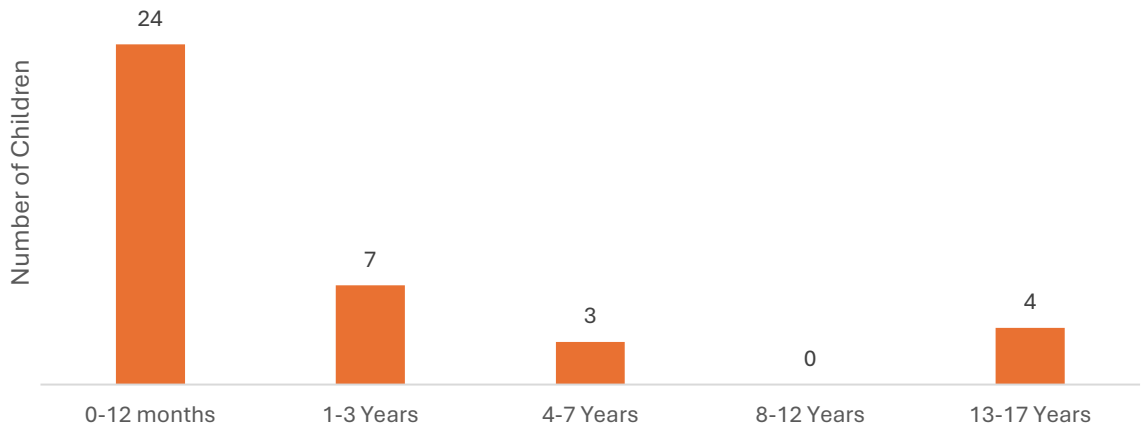


[8] Unknown/Undetermined category includes fatalities with limited case information and where the manner of death was not reported.

CHILD AGE AT TIME OF DEATH

The majority of the maltreatment-related fatalities involved infants (birth to 12 months); they accounted for over 63% of the fatalities (24 fatalities). Twelve infant fatalities were sleep-related, a decrease from last year.[9]

Figure 7: **Child Age at Time of Death, 2024**

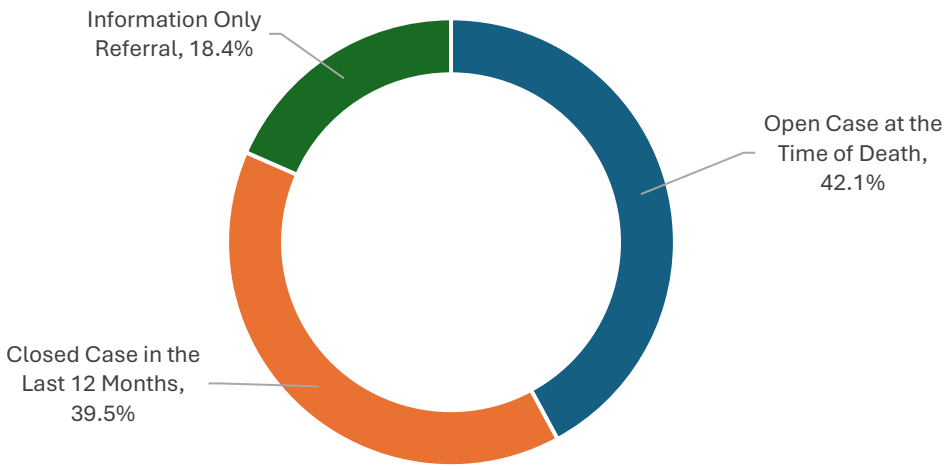


FAMILY CONTACT WITH THE DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES

Of the 38 maltreatment-related fatalities examined by OFCO between January 1, 2024, and December 31, 2024, 16 families had an open case with DCYF. Of these 16 cases, the majority of fatalities (14) occurred while the children were in the parents' care, one of which occurred during an overnight visit of a dependent child with the parents. Two children passed away in the hospital due to birth complications related to prenatal substance exposure. Fifteen families had a Child Protective Services (CPS), Family Assessment Response (FAR), and/or Family Voluntary Services (FVS) case closed within the previous year.

[9] Nearly one-third of child fatalities reviewed in 2023 were sleep-related infant deaths (26 fatalities).

Figure 8: **DCYF Case Status Within 12 Months, 2024**



Of the 16 families with an open case at the time of death, nine were open for a CPS investigation, four had an open CFWS case, two were participating in FVS, and one had an open case with the FAR program.

Table 1: **Program Type for DCYF Open Cases at Time of Death, 2024**

Program Type	Number of Fatalities
Child Protective Services (CPS) Investigation Pathway *Investigates screened in reports of child maltreatment.*	9 fatalities
Child and Family Welfare Services (CFWS) *Case management and permanency planning for children and youth in out-of-home placement.*	4 fatalities
Family Voluntary Services (FVS) *Cases transfer to FVS after a CPS investigation AND the parent agrees to services OR the family was determined to be at moderately high or high risk for abuse or neglect. Participation is voluntary.*	2 fatalities
Family Assessment Response (FAR) *A CPS alternative pathway to investigate low to moderate risk screened in reports of child maltreatment and offer any needed services.*	1 fatality

FATALITIES OCCURRING AFTER FAMILY REUNIFICATION

The safe reunification of families is the primary goal of a dependency proceeding. The Department is required to offer or provide services to address concerns that led to a child's removal from the home.[10]

Of the 38 maltreatment-related fatalities, two fatalities occurred after family reunification; one child passed away from methadone ingestion during an overnight visit with the parent, and another passed away from physical abuse by a relative three years after reunification.

Four families had open or prior dependencies that did not involve the child that died.

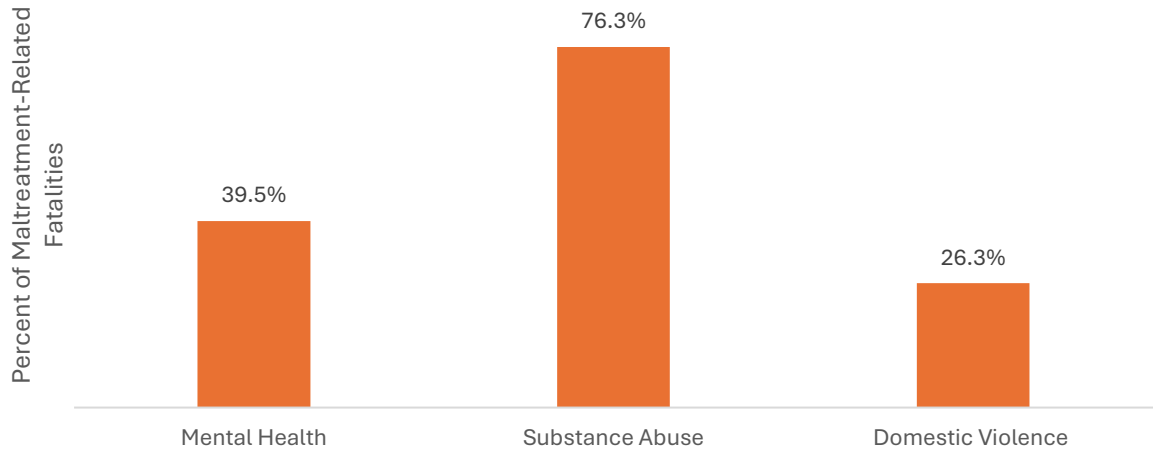
RISK FACTORS FOR CHILD FATALITIES: SUBSTANCE ABUSE, DOMESTIC VIOLENCE, AND MENTAL HEALTH

Parental substance abuse is a major risk factor for child fatalities, maltreatment, and involvement with the child welfare system. Of the 38 maltreatment-related fatalities, over 76% involved families with a reported history of substance abuse (29 families). Of these 29 families with known substance abuse history, 22 families had a documented history of methamphetamine, fentanyl, and/or other opioid use.

Domestic violence and mental health disorders were also identified as significant risk factors in many of these fatalities.

At least one of three risk factors were present in over 86% of maltreatment-related fatalities.

Figure 9: **Family Risk Factors in Maltreatment-Related Fatalities, 2024**



[10] RCW 13.34.

CHILD NEAR FATALITIES EXAMINED BY OFCO

State law requires DCYF to notify OFCO of the near fatality[11] of any child who has been in the Department's custody, or receiving services, within the last 12 months.[12] OFCO conducts a preliminary review of these near fatalities, even if the subject child was not the recipient of Department services and including "information only" referrals.

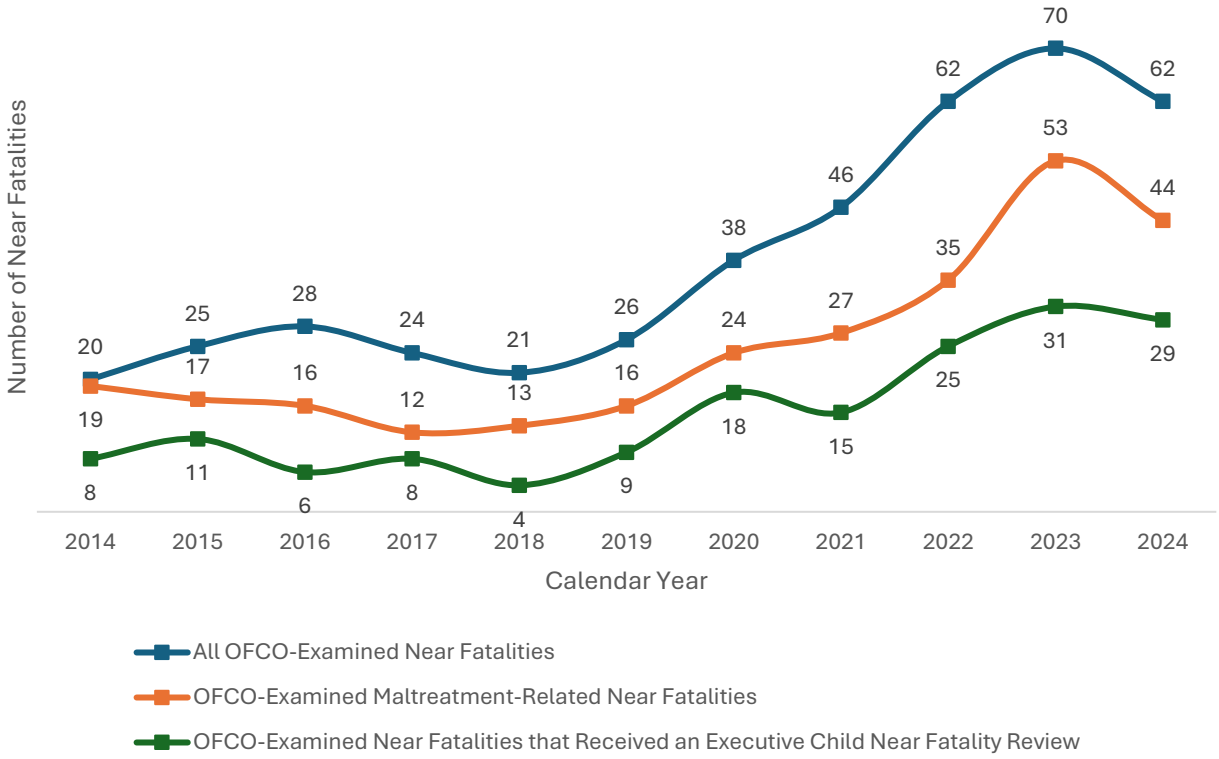
OFCO examined 62 near fatalities between January 1, 2024, and December 2024. OFCO considered 44 of the near fatalities to be related to child maltreatment.[13]

OFCO examines these cases to:

- identify any safety issues regarding the child and any other children remaining in the home;
- determine whether the near fatality appears to have resulted from abuse or neglect, thus requiring a DCYF near fatality review, or whether ongoing child maltreatment concerns in the family may have contributed to the near fatality;
- identify any problematic casework practice or decisions by the agency to ensure more effective protection of the children in the family, as well as improve agency services in similar cases in the future; and
- assist policymakers in developing strategies to avoid near fatalities.

[11] RCW 74.13.500 defines "near fatality" as "an act that, as certified by a physician, places the child in serious or critical condition."
[12] RCW 74.13.640(2).
[13] OFCO defines maltreatment-related near fatalities to be those in which a CPS investigation concluded that physical abuse and/or neglect by a caretaker caused the near fatality, or factors associated with child abuse or neglect were present in the family's history and, while not a direct cause, may have contributed to the near fatality.

Figure 10: **OFCO-Examined Child Near Fatalities by Year**



MALTREATMENT-RELATED NEAR FATALITIES

OFCO identifies child near fatalities that were directly caused by child abuse or neglect, as well as those in which abuse or neglect concerns may have contributed to the incident, and the family had DCYF history in the preceding 12 months. Of the 62 near fatalities examined by OFCO between January 1, 2024, and December 31, 2024, 44 were determined to be caused by abuse or neglect, or abuse or neglect concerns were present. Of the maltreatment-related near fatalities 70.5% were caused by neglect (31 near fatalities). Most of the incidents involved children three years of age and under.

Figure 11: **Type of Maltreatment in Near Fatalities, 2024**

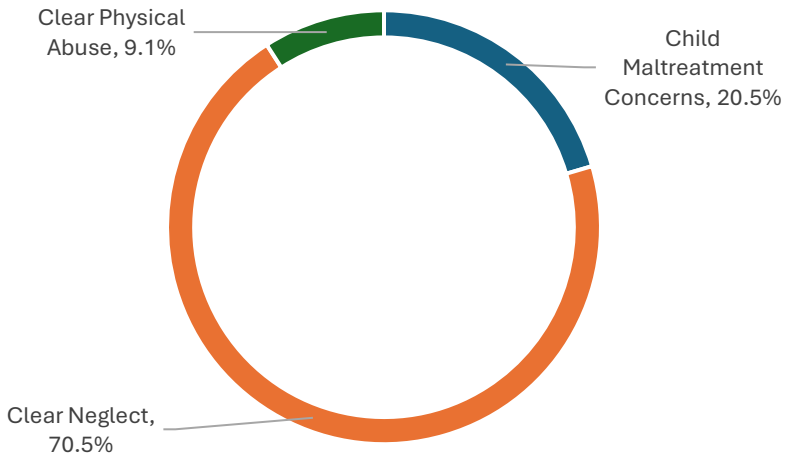
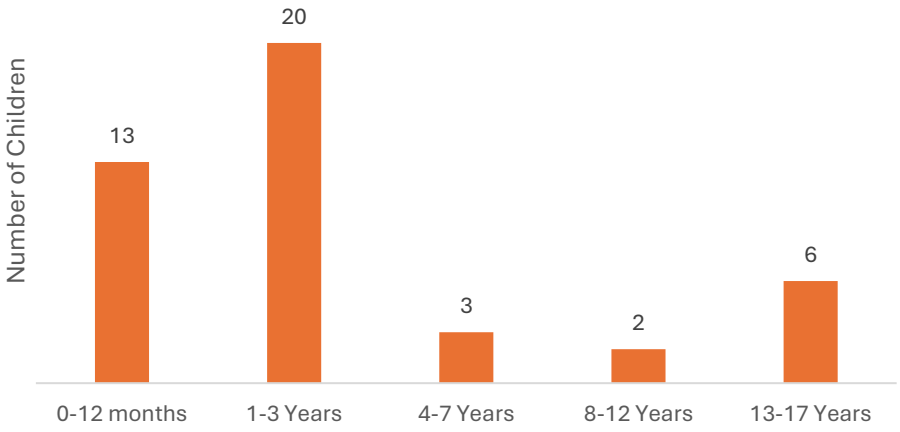


Figure 12: **Child Age at Time of Near Fatality, 2024**

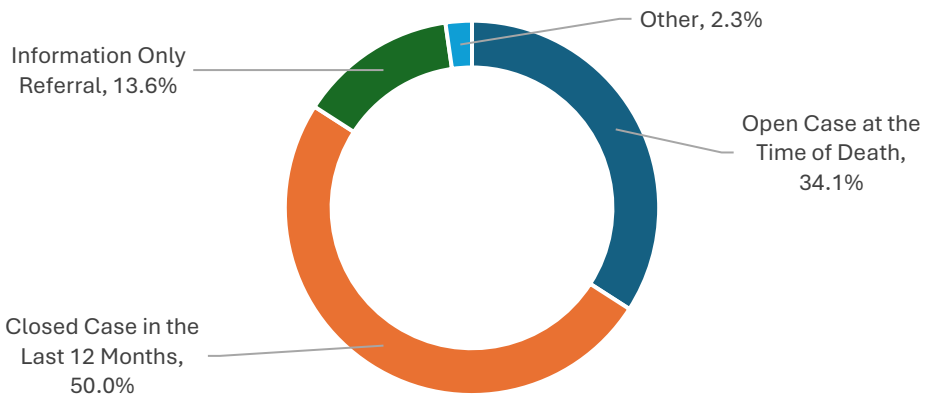


FAMILY CONTACT WITH THE DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES

Of the 44 maltreatment-related near fatalities examined by OFCO between January 1, 2024, and December 31, 2024, 15 families had an open case with DCYF. Of these open cases, 13 incidents occurred while the child was in the parents' care, one of which occurred during a supervised visit of a dependent child with the parents. One child was in the care of a grandparent, and one was in the care of a legal guardian.

Twenty-two families had a Child Protective Services (CPS), Family Assessment Response (FAR), or Family Voluntary Services (FVS) case that had closed within the previous year.

Figure 13: **DCYF Case Status Within 12 Months of Near Fatality, 2024**



Of the 15 families with an open case at the time of the near fatality, five were open for a CPS investigation, four had an open CFWS case, five were open to the FAR program, and three were participating in FVS.[14]

Table 2: **Program Type for DCYF Open Cases at Time of Near Fatality, 2024**

Program Type	Number of Near Fatalities
Child Protective Services (CPS) Investigation Pathway *Investigates screened in reports of child maltreatment.*	5 near fatalities
Child and Family Welfare Services (CFWS) *Case management and permanency planning for children and youth in out-of-home placement.*	4 near fatalities
Family Assessment Response (FAR) *A CPS alternative pathway to investigate low to moderate risk screened in reports of child maltreatment and offer any needed services.*	5 near fatalities
Family Voluntary Services (FVS) *Cases transfer to FVS after a CPS investigation AND the parent agrees to services OR the family was determined to be at moderately high or high risk for abuse or neglect. Participation is voluntary.*	3 fatalities

[14] Two cases were open to two programs at the time of the near fatality: One case was open to CPS and FVS and one case was open to CFWS and CPS.

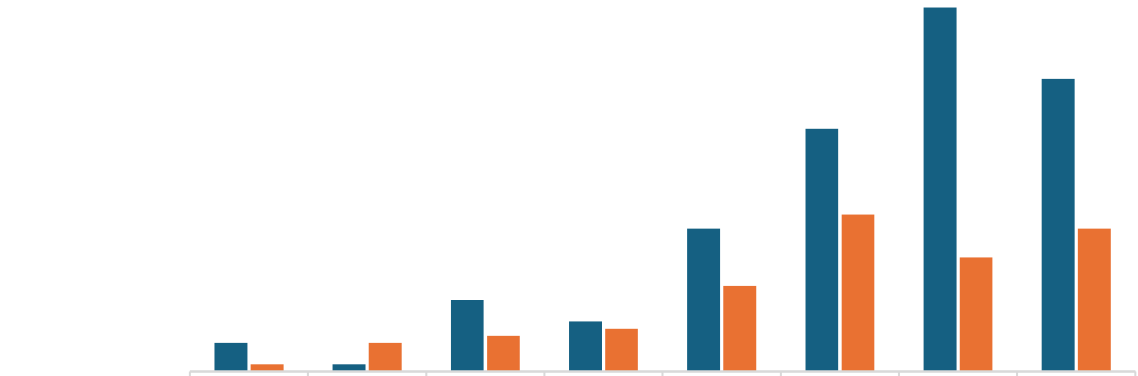
ACCIDENTAL INGESTION OF DRUGS AND DRUG OVERDOSES

In 2024, accidental ingestions and overdoses accounted for over 25% of the fatalities (20 fatalities) and over 66% of near fatalities (41 near fatalities) examined by OFCO between January 1, 2024, and December 31, 2024.

Of the 61 incidents involving accidental ingestions and overdoses by children examined by OFCO in 2024, 38 involved accidental ingestion by children under 11 years of age, 22 involved accidental overdoses by youth between 11 and 22 years of age while using substances, and one involved an intentional overdose by a 16-year-old.

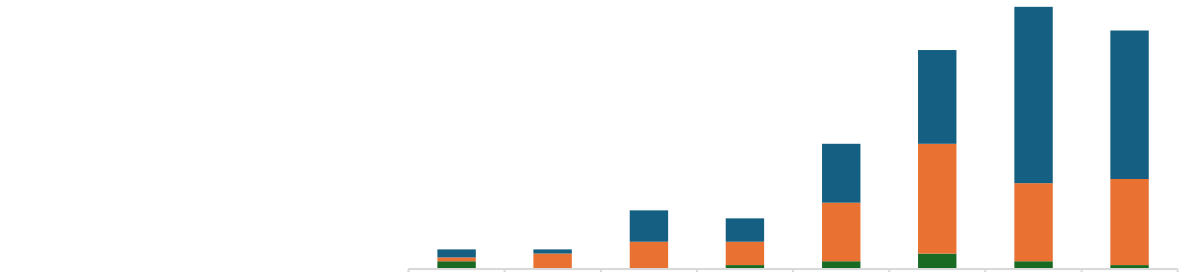
Over 78% of critical incidents from accidental ingestion of drugs or drug overdose involved fentanyl (48 incidents). Fentanyl accounted for 30 of the 38 accidental ingestions by children under 11 and 18 of the 22 accidental overdoses by youth between 11 and 22 years of age while using substances.

Figure 14: **Critical Incidents Involving Accidental Ingestion and Overdoses, 2017-2024**



	2017	2018	2019	2020	2021	2022	2023	2024
Near Fatalities	4	1	10	7	20	34	51	41
Fatalities	1	4	5	6	12	22	16	20

Figure 15: **Accidental Ingestion and Overdoses, 2017-2024**



	2017	2018	2019	2020	2021	2022	2023	2024
Accidental Ingestion, Ages 0 to 11	2	1	8	6	15	24	45	38
Accidental Overdose, Ages 11 to 22	1	4	7	6	15	28	20	22
Intentional Overdose, Ages 12 to 20	2	0	0	1	2	4	2	1

Figure 16: **Age of Children Involved in Accidental Ingestions and Overdoses, 2024**

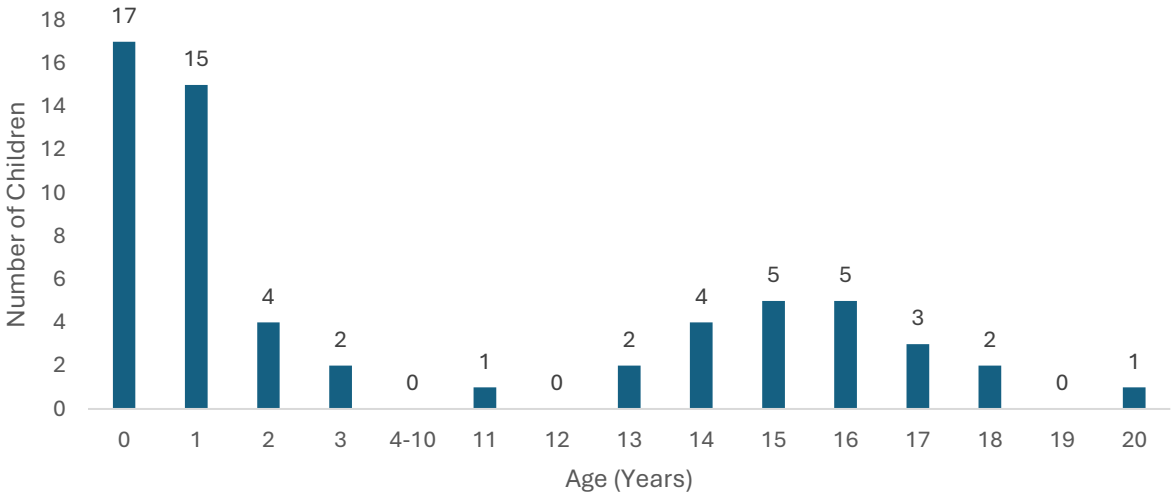


Figure 17: **Race and Ethnicity of Children Involved in Accidental Ingestion and Overdoses, 2024**

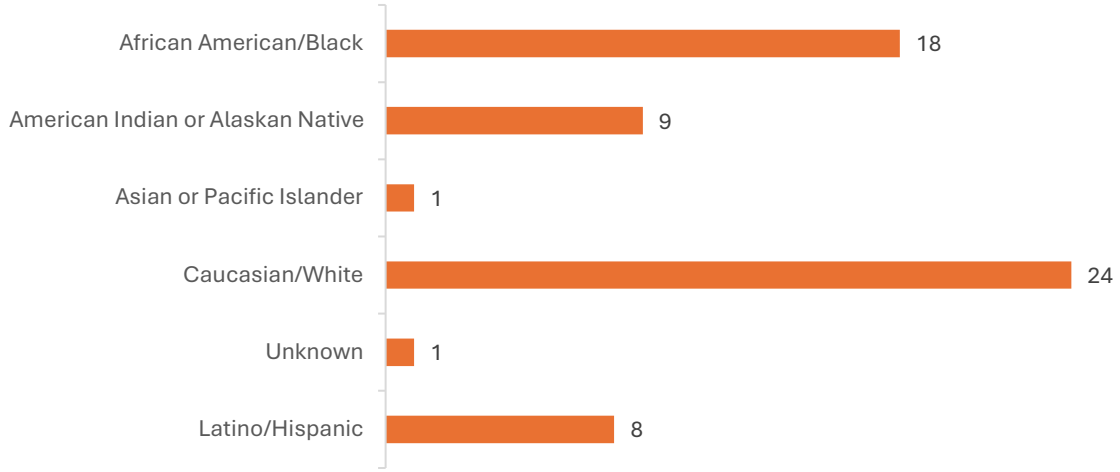
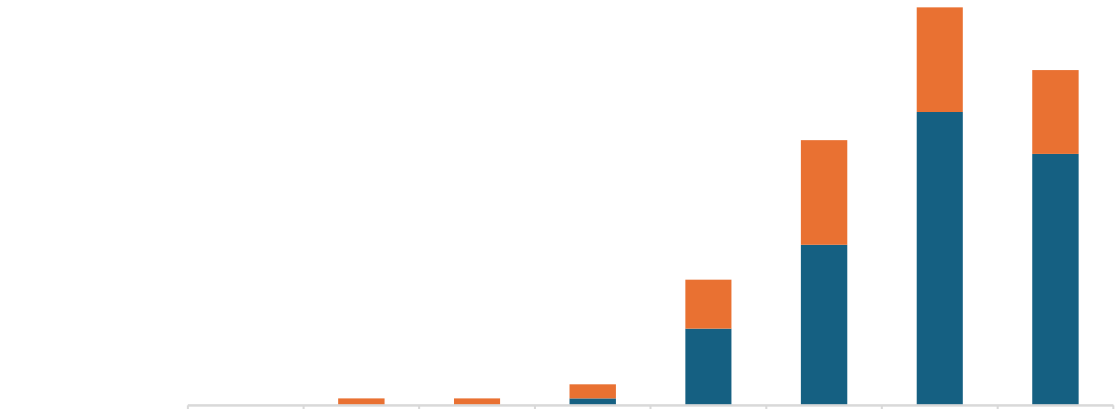
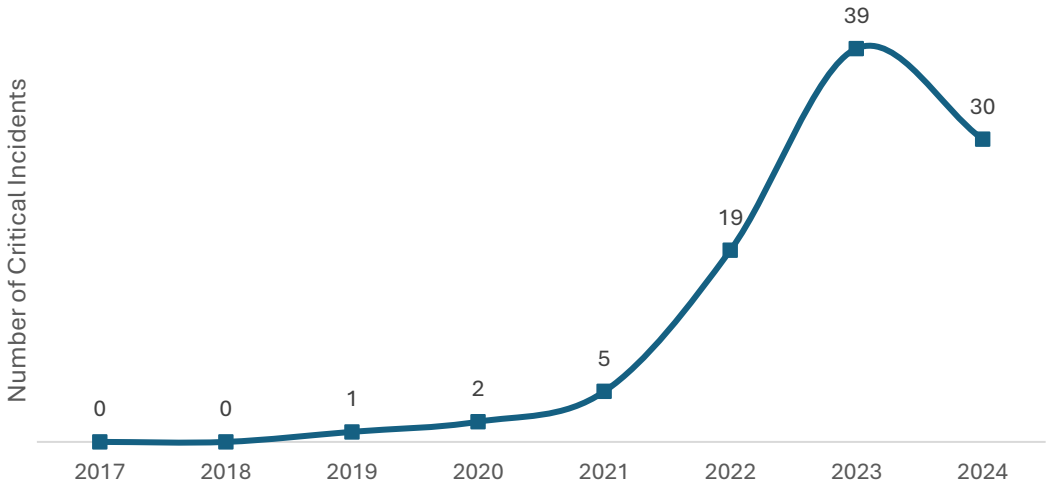


Figure 18: **Critical Incidents Involving Fentanyl, All Children and Youth, 2017-2024**



	2017	2018	2019	2020	2021	2022	2023	2024
Fatalities	0	1	1	2	7	15	15	12
Near Fatalities	0	0	0	1	11	23	42	36

Figure 19: **Critical Incidents Involving Accidental Ingestion of Fentanyl by Children Ages 0-11, 2017-2024**



While the number of critical incidents, and in particular the number of child fatalities and near fatalities involving the accidental ingestion and overdoses, declined in 2024 from 2023, critical incidents during the first quarter of 2025 have increased.[15]

[15] Appendix A, page 28.

SECTION II: EXECUTIVE REVIEWS

The Department of Children, Youth, and Families (DCYF) conducts a child fatality review when the death of a child was suspected to be caused by abuse or neglect, and the child was in the care of or receiving services from DCYF at the time of death, or in the preceding 12 months.[16] If it is not clear whether a child's death was the result of abuse or neglect, the Department must consult with OFCO to determine if a review should be conducted. The Department must also review any near fatality of a child[17] who was in the care of or receiving services from the Department at the time of the incident, or in the preceding 12 months.[18] Even if these criteria are not met, DCYF may conduct a review of any fatality or near fatality at its discretion, or at the request of OFCO.[19]

The purpose of reviewing child fatalities and near fatalities is to increase the agency's understanding of the circumstances around the child's injury or death and to evaluate practice, programs, and systems to improve the health and safety of children.[20] These reviews help identify areas for increased education and training, as well as potential policy or legislative changes.

The committee reviewing a child fatality or near fatality is made up of individuals with no prior involvement with the case, and typically includes DCYF staff, OFCO staff, and community professionals with expertise relevant to the case, such as law enforcement, chemical dependency, domestic violence, mental health, child health, or social work practice. The review committee has full access to all relevant records and files regarding the child and family that have been produced or retained by the supervising agency.[21]

DCYF must issue a report on child fatality review results within 180 days following the fatality, unless granted an extension by the Governor.[22] These reports are subject to public disclosure and must be posted on the Department's public website. The Department is required to redact confidential information contained in these reports to protect the child's privacy, as well as the privacy of siblings, and any other information protected by law (e.g., HIPPA protected information).[23]

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[16] See RCW 74.13.640. Prior to the passage of SHB 1105 in 2011, DCYF was required to review any unexpected deaths of children who were in the care of or receiving services from DCYF or had received care or services in the last year. As amended, DCYF must only review those deaths that are "suspected to be caused by child abuse or neglect." This eliminates fatality reviews of a child's accidental or natural death, even if the child had been receiving child welfare services in the year prior to the fatality.

[17] RCW 74.13.500 defines "near fatality" as "an act that, as certified by a physician, places the child in serious or critical condition."

[18] RCW 74.13.640(2). A review is also required if the child was receiving services from a supervising agency at the time of the incident or in the prior three months.

[19] Id. The Department also conducts internal fatality or near fatality reviews when a case does not meet the statutory requirements that mandate an executive review, but the Department and/or OFCO believe a review could aid in evaluating the agency's practice. Because these reviews do not meet the statutory requirements for public release, internal review reports remain confidential in order to protect the privacy of the child and family.

[20] See DCYF Practices and Procedures Guide Section 6301, Child Fatality/Near-Fatality Reviews.

[21] RCW 74.13.640(3).

[22] Id.

[23] Individual child fatality reports are available at: https://www.dcyf.wa.gov/practice/oiaa/reports/child-fatality.

Between January 1, 2024, and December 31, 2024, DCYF conducted 30 near fatality reviews and 16 fatality reviews. At the time of this report, OFCO received executive reports for 36 of the 46 reviews. Three reviews produced seven recommendations, of which five were implemented or are in the process of being implemented (see Appendix C).

DCYF's Updated Fatality and Near Fatality Review Process

In 2024, DCYF transitioned away from a critical incident review model that produced recommendations in individual reviews, as this practice resulted in a multitude of sometimes duplicative recommendations (for instance, in 2023, review teams generated 96 recommendations). DCYF now employs a systems mapping model to identify recurring themes and develop strategies to address systemic barriers and identified concerns. DCYF brings together DCYF staff, relevant field experts, and lived experience experts to engage in a systems mapping process to visualize gaps or change opportunities within and between systems and create opportunities to problem solve across disciplines and organizations. In 2024, DCYF conducted one system mapping event relating to communication and collaboration between DCYF's licensing division and child welfare division (see Appendix C for the results of that mapping event). DCYF intends to convene two mapping events yearly; one occurred in May 2025, and another is projected for November 2025.

CHILD FATALITY AND NEAR FATALITY REVIEWS: OFCO RECOMMENDATIONS

OFCO reviewed each of the 2024 child fatality and near fatality reports to identify common themes arising in these reviews and to craft recommendations. OFCO noted that in several critical incident reviews, committees discussed: an apparent confusion over the legal standard for establishing court oversight through a dependency; the prevalence of critical incidents following a mother and/or infant testing positive for substances at birth; and the need to effectively engage fathers.

- **Recommendation: Develop Guidelines on the Use of In-Home Dependencies**

  DCYF should engage judicial officers, court administrators, and child welfare professionals to develop practice guidelines and training focused on the use of in-home dependencies as an option to provide ongoing services, support, and protective supervision in situations where a child is not at risk of imminent physical harm, but circumstances pose a danger of substantial damage to the child's psychological or physical development. The guidelines should recognize the different legal standards for removing a child from a parent's care – "imminent physical harm,"[24] from the legal standard for dependency – "a danger of substantial damage to the child's psychological or physical development."[25] Additionally, the guidelines should describe how to incorporate prior involvement with child welfare services when assessing child safety and risk and the need for court supervision.

[24] RCW 13.34.050.
[25] RCW 13.34.030(6)(c).

Discussion

During both Child Fatality Reviews and Child Near Fatality Reviews, the Committees frequently identified confusion over circumstances that would meet the threshold for either removing a child from the home and/or filing a dependency petition to obtain court supervision. The Department appeared to apply the same standard for seeking removal of a child from the home to filing for a dependency, and did not seek court supervision through a dependency proceeding while also keeping the child in the home. The Committees also noted that a family's prior engagement with child welfare services was not fully considered. For example:

> ***M.K. Child Fatality Review***[26]
> *The Committee also discussed that it may be beneficial for DCYF to have further discussions statewide, including with their legal counsel, about utilizing in-home dependency action to assist with child safety.*
>
> ***O.S. Child Fatality Review***[27]
> *The Committee spoke at length about the impact of the Keeping Families Together Act (House Bill 1227) . . . One specific aspect discussed was the standard to request court oversight, with the child remaining in the parent's care. Some Committee members believed the standard for requesting court oversight, with the child remaining in the parent(s) care would be lower than requesting court oversight with out-of-home placement. The field office believed the standard is the same for both and emphasized the overall higher standard imposed by HB 1227.*
>
> ***R.W. Child Fatality Review***[28]
> *The Committee believed there were at least two different times during the case at issue here where an active safety threat was present and met the threshold for further intervention, such as offering a voluntary placement agreement or filing a dependency petition. The Committee acknowledged that the staff believed, based on their experiences in previous cases, that the court would have denied the dependency petition. However, the Committee believes that even if the dependency petition was denied, filing the petition would more than likely have been an appropriate response.*
>
> ***M.T.J. Child Fatality Review***[29]
> *The Committee was concerned that the history with DCYF was not fully appreciated during the 2023 case. Specifically, the mother's pattern of neglecting her children and concerns that were identified in the mother's psychological evaluation from the prior dependency case.*

In practice, the Department generally files for dependency only when a child is removed from the parents' care. State laws, however, allow for a court ordered dependency disposition that keeps children in their homes and in the custody of their parents while also providing court supervision and ongoing services through the Department of Children, Youth, and Families.

The filing of a dependency petition is not predicated on the removal of a child from the parents' care and a finding that the child is at imminent risk of physical harm. The legal standard for

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[26] mk-cfr-final-redacted.pdf.
[27] ecfr-os-24.pdf.
[28] ecfr-rw-2024.pdf.
[29] Child Fatality Review - M.T.J.

establishing dependency does not require a finding that the child is at imminent risk of physical harm. The definition of a dependent child includes: a child who has no parent, guardian, or custodian capable of adequately caring for the child, such that the child is in circumstances which constitute a danger of substantial damage to the child's psychological or physical development.[30]

Even when a child is removed from a parent's care, based on a finding of imminent risk of physical harm,[31] the court may return a child to the parent's care while the dependency proceeding moves forward.[32] At the initial shelter care hearing, the court must return the child to the parent's care unless there is reasonable cause to believe removal of the child is necessary to prevent imminent physical harm due to child abuse or neglect, or there is no parent or legal custodian to provide supervision and care for the child.[33] The court must also consider whether participation by the parents in any services would eliminate the need for removal and if the parents are willing to participate in such services. If the parent agrees to participate in the prevention services, the court shall place the child with the parent while adjudication of the dependency is pending.[34]

When determining if a child is dependent, the court may consider the history of past involvement of child protective services or law enforcement agencies with the family for the purpose of establishing a pattern of conduct, behavior, or inaction with regard to the health, safety, or welfare of the child.[35] If a child is found to be dependent, the court may order a disposition that maintains the child in their home, with services designed to alleviate the immediate danger to the child, address any damage the child has already suffered, and aid the parents so that the child will not be endangered in the future. State law directs the court to choose services to assist the parents in maintaining the child in the home, that least interfere with family autonomy and are adequate to protect the child.[36]

Dependency review hearings occur at least every six months to review progress and determine whether court supervision should continue. In cases where a dependent child remains in the parents' care, the in-home placement is contingent on: the parents' compliance with court orders related to the care and supervision of the child, including compliance with the department's case plan; and the parents continued participation in available substance abuse or mental health treatment if substance abuse or mental illness was a contributing factor to the removal of the child. The court may remove a child from the parents' care based on the parents' noncompliance with the case plan or failure to participate in available services or treatment for themselves or the child.[37]

The strategic use of in-home dependencies would expand options to engage families, provide needed services, and avoid the trauma of family separation. Particularly in cases involving parental substance use or mental health issues, an in-home dependency allows adequate time to provide services that otherwise do not fit the mandatory time limits of a CPS investigation or

[30] RCW 13.34.030(6)(c).
[31] RCW 13.34.050(1).
[32] RCW 13.34.065(4)(b).
[33] RCW 13.34.065(5)(a).
[34] RCW 13.34.065(5)(b)(i).
[35] RCW 13.34.110(2).
[36] RCW 13.34.130(1)(a).
[37] RCW 13.34.138(3)(a).

Family Assessment Response.[38] The dependency process also provides all parties with court supervision, accountability, and the forum to resolve any disagreements regarding the case plan.

- **Recommendation: Increase Treatment Resources for Pregnant and Parenting Women**

  Policymakers and legislators should ensure there are adequate inpatient and outpatient SUD treatment facilities for pregnant and parenting women as these services are essential to reducing accidental ingestion of drugs and overdoses by infants and toddlers.

  Discussion
  Accidental ingestions and overdoses accounted for over 25% of the fatalities (20 fatalities) and over 66% of near fatalities (41 near fatalities) examined by OFCO during the 2024 calendar year. Of these 61 critical incidents, 38 consisted of the accidental ingestion of drugs by a child under 4 years old. In reviewing the circumstances of these critical incidents, OFCO noted that DCYF was informed that either the child or the child's mother, or both, tested positive for substances at the time of the child's birth. In many cases, however, DCYF is not notified when an infant is born substance exposed. In 2023, DCYF, the Health Care Authority, the Department of Health, and the Washington State Hospital Association issued new guidelines to hospitals and mandated reporters stating that when there are no other safety concerns, substance exposed infants should receive voluntary wrap around services in their community without being reported to Child Protective Services[39]. These guidelines state:

  To improve the health outcomes of mothers/birth parents with substance use disorder, best practice is to provide obstetric care that addresses all medical and behavioral health needs at the time of birth. This includes inpatient withdrawal/stabilization care, providing naloxone kits before discharge, and coordination of outpatient dyadic substance use services. Urgent implementation of these best practices is needed to decrease overdose deaths and decrease maternal mortality/morbidity in Washington.[40]

  Washington State must ensure that both inpatient and outpatient substance use disorder (SUD) treatment resources are available for pregnant and parenting women. Residential SUD treatment can be provided for mothers and their children under the age of six, for up to six months. In addition to SUD treatment, mothers may receive services for childhood trauma, sexual abuse, mental health issues, employment skills and education, medical care, and legal advocacy. Currently, however, within Washington there are only five residential treatment facilities with a total capacity of 121 mothers.[41]

- **Recommendation: Increase Efforts to Engage Fathers and Paternal Relatives**

  DCYF should make further efforts to identify data metrics to understand how fathers experience the child welfare system, and how the system responds to fathers. Metrics could include child reunification with fathers, participation in parent-child visits, and fathers' and paternal relatives'

[38] A CPS investigation must be completed within 90 days. A CPS/FAR must be completed within 45 days but may be extended to 120 days with the parents' agreement. RCW 26.44.030(13)(a) and (14)(c)(i).
[39] DCYF, DOH, HCA and WSHA Guidelines (June 23, 2023), https://dcyf.wa.gov/sites/default/files/pdf/SignedCrossAgencyLetter.pdf.
[40] Id.
[41] Washington State HCA Pregnant and Parenting Women services fact sheet (2025).

participation in case planning events. Additionally, DCYF should provide training to address bias and stigma fathers may experience.

Discussion

In several reviews, the critical incident review committee identified that fathers, and by extension paternal relatives, were either not contacted at all or that attempts to engage and assess fathers and paternal family members were inadequate. Circumstances included instances where a father and/or his relatives may have been an under or unutilized safe resource but also included instances where a father and/or his relatives were inadequately assessed following a concern with the mother and placement with father or paternal relatives that resulted in a critical incident.

Father engagement issues discussed during critical incident reviews support key findings identified in the *2024 State of Fatherhood in Washington Study*,[42] including:

- Fathers and fatherhood figures experience stigmas and inequities.
- Data and monitoring systems that capture fathers are not fully developed, making it hard to assess and address inequities.
- Policies and approaches to fatherhood inclusion remain inconsistent.

DCYF recognizes that positive fatherhood involvement improves outcomes for children including school readiness, academic achievement, and social emotional development. To improve father engagement, DCYF partners with the Washington Fatherhood Council and established the Engaging Father's Project which provides information and resources for fathers.[43]

The State of Fatherhood Study identified a need for more data and an effective monitoring process to track and measure how fathers receive services and how systems respond to fathers. DCYF noted that there are opportunities to build more data metrics to track how fathers navigate and experience the child welfare system and that child reunification with fathers is an important metric to capture.[44] Other metrics could include fathers' and paternal relatives' participation in case planning events such as Family Team Decision Making meetings and parent-child visits provided to fathers. Additionally, DCYF staff should receive training to address bias, stigma, and inequities fathers may experience in the child welfare system.

[42] State of Fatherhood in Washington Study Report, 2024, Washington Fatherhood Council. Fatherhood Study Report9.20.24 final.pdf.
[43] Resources for Fathers | Washington State Department of Children, Youth, and Families.
[44] State of Fatherhood Study.

SECTION III: APPENDICES

APPENDIX A:
CHILD FATALITIES AND NEAR FATALITIES EXAMINED BY OFCO, QUARTERLY 2024-2025

APPENDIX B:
CHILD RACE AND ETHNICITY OF MALTREATMENT-RELATED CRITICAL INCIDENTS, 2024

APPENDIX C:
CHILD FATALITY AND NEAR FATALITY REVIEW RECOMMENDATIONS

APPENDIX A: CHILD FATALITIES AND NEAR FATALITIES EXAMINED BY OFCO, QUARTERLY 2024-2025

Table 3: **Child Fatalities and Near Fatalities Examined By OFCO, Quarterly 2024-2025**

	2024 Q1	2024 Q2	2024 Q3	2024 Q4	2025 Q1
OFCO-Examined Critical Incidents	36	42	34	28	47
Critical Incidents Involving Accidental Ingestions and Overdoses	17	25	12	7	20
Critical Incidents Involving Fentanyl/Opioid	13	22	11	6	18
Critical Incidents Involving Accidental Ingestion by Children Ages 0-3	7	18	8	5	14
Critical Incidents Involving Accidental Ingestion of Fentanyl/Opioid by Children Ages 0-3	5	17	7	4	14
Critical Incidents that Received an Executive Review	9	16	13	8	19

Of the 47 critical incidents that occurred during the first quarter of 2025, 19 received either a child fatality executive review or a child near fatality review as the critical incident was attributed to child maltreatment and the family was involved with DCYF in the preceding 12 months. 6 additional critical incidents are pending review.

APPENDIX B: CHILD RACE AND ETHNICITY OF MALTREATMENT-RELATED CRITICAL INCIDENTS, 2024

Table 4: **Child Race and Ethnicity of Maltreatment-Related Critical Incidents, 2024**[45]

Race/Ethnicity	Fatality	Near Fatality	Total	% of incidents	WA Children in Out-of-Home Care[46]	WA State Children[47]
American Indian/ Alaska Native	2	9	11	13.4%	17.0%	2.4%
Asian/ Pacific Islander	3	0	3	3.7%	3.0%	10.4%
Black/African American	9	12	21	25.6%	15.0%	5.0%
Hispanic	2	6	8	9.8%	17.0%	25.3%
White/Caucasian	18	17	35	42.7%	46.0%	62.2%
Unknown	4	0	4	4.9%		

[45] OFCO reports race and ethnicity according to DCYF's WSRDAC/M standard: American Indian/Alaska Native, Multiracial combined with American Indian/Alaska Native and Black/African American, Multiracial combined with Black/African American, and Asian/Pacific Islander, Multiracial combined with Asian/Pacific Islander.

[46] Department of Children, Youth, and Families. Children in Care by Race/Ethnicity, Last Day of SFY 2016-2023. https://www.dcyf.wa.gov/practice/oiaa/agency-performance/cw?page=1.

[47] Office of Financial Management. Estimates of April 1 population by age, sex, race and Hispanic origin. 2024. https://ofm.wa.gov/washington-data-research/population-demographics/population-estimates/estimates-april-1-population-age-sex-race-and-hispanic-origin. (*WSRDAC/M reporting standard: no).

APPENDIX C: CHILD FATALITY AND NEAR FATALITY REVIEW RECOMMENDATIONS

The recommendations made by representatives from the community, OFCO, and DCYF participating in child fatality and near fatality reviews and identified and developed in systems mapping events are forwarded to a DCYF administrator or DCYF's Continuous Quality Improvement Committee for review and prioritization. At regular intervals, administrators are required to report on the progress of implementing a recommendation or provide a written response when a specific recommendation is not implemented.

Listed below by topic are the recommendations made in child fatality and near fatality reviews conducted from January 1, 2024, through December 31, 2024, and DCYF's decision status for each recommendation. As previously discussed, DCYF discontinued the process of generating recommendations from individual reviews during this period. As a result, the review committees generated only seven recommendations this year. To preserve their intent and meaning, the following recommendations are quoted directly from the executive reports:

TRAINING *Chemical Dependency*	
DCYF should develop a substance use disorder dashboard that would be accessible to internal DCYF staff as well as external partners, such as relative and foster caregivers, providers, etc. The page should include, but would not be limited to the following; links to trainings or information about how to obtain trainings regarding substance use; what to look for when doing a walk-through of a home; what to do if you encounter substances or paraphernalia and a reminder to use precautions; the opioid pamphlet (DCYF 0112); photos of paraphernalia and substances; and community-based resources for substance use disorder treatment and support.	Decision: Partial Implementation

CASEWORK PRACTICE *Operations and Administration*	
DCYF should create a headquarter after hours program manager position. The Committee identified that after hours is a very challenging section of child welfare's work that does not have a program manager overseeing the entire state. This section of work has been highlighted or discussed in the news media, Office of Family and Children's Ombuds reviews, and multiple child fatality and near fatality reviews.	Decision: Modified Implementation

DCYF should require that each region have a non-case carrying position such as a Social Service Specialist 4, who works a swing shift, and can provide in person assistance to after hours staff, similar to a Quality Practice Specialist. By having a swing shift, the role affords the ability to also check in regularly with the regions' area administrator (who often work during regular business hours) for continuity and communication.	Decision: Considered, Not Implemented

CASEWORK PRACTICE *Policy & Procedure*	
DCYF should create a policy that outlines a chain of custody for children/youth's medications that should include a requirement of lockable storage container (lock bag or locking box not a plastic resealable type bags) as well as mandatory medication logs to identify who medication is handed off to, when medication is given to a child, and what medications are prescribed to a child.	Decision: Modified Implementation
Each DCYF field office should have a plan in place for a centralized location that children/youth's prescription medications will be located when said child/youth is in a field office. The medication log should be with the medications at all times as well in a locked container.	Decision: Modified Implementation

CASEWORK PRACTICE *Other Casework Practice*	
To reduce resistance from families being provided with lockboxes or denying receipt of a lockbox DCYF should consider providing an informational sheet with all lockboxes that outlines other uses for the lockbox to include how having a harm reduction kit may help them provide support and help to another person in need in the future	Decision: Already Exists

TRAINING AND CASEWORK PRACTICE	
The Committee recommends the Area Administrator address the identified areas of improvement from this review by utilizing resources such as case consultations with Quality Practice Specialists and Regional Program Consultants; targeted trainings for identified areas of improvement; and policy reviews for staff as applicable.	Decision: Full Implementation

2024 SYSTEMS MAPPING EVENT

DCYF's report on the outcome of the 2024 Systems Mapping Event:

After the system mapping review on 10/22/2024, the Deputy Assistant Secretary of Child Welfare and Deputy Assistant Secretary of the Licensing Division reviewed our current communication processes between Child Welfare and Licensing Division. The Deputy Assistant Secretary of Child Welfare messaged out to regions that did not have dedicated coordination between Child Welfare and Licensing Division to begin scheduling and inviting Licensing Division. We both messaged out the importance of collaboration and professionalism during staffing and interactions. The Child Welfare Assistant Secretary, Licensing Division Assistant Secretary, Child Welfare Deputy Assistant Secretary, and Licensing Division Deputy Assistant Secretary also meet monthly to discuss on-going coordination or any issues that arise in the regions.

In addition to the communication expectations, some of the key insights from the mapping sessions were included in the Licensing Divisions final decision to restructure from a pre/post licensure process to a full Kinship/Foster Care model. Under the new model, one licensor will work with the family from point of initial license through the life of that license. A few of the benefits include:

- *Licensing Division primary worker will specialize either in Kinship licensing or Foster Care licensing*
- *One primary assigned worker in Licensing Division for Child Welfare to coordinate with*
- *Licensing Division caseloads will be reduced to better support all licensed caregivers*