

QUARTERLY CHILD REVIEW RCW
74.13.640 JULY–SEPTEMBER 2025



Washington State Department of
CHILDREN, YOUTH & FAMILIES

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Executive Summary

This is the Quarterly Child Fatality Report for July through September 2025, 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 agency 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 Three 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 Three years 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 July 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 agency 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 eight near-fatalities ¹ completed in the third quarter of 2025. All child fatality reviews can be found on the [Child Fatality & Serious Injury Reports](https://www.dcyf.wa.gov/practice/oiaa/reports/child-fatality) (<https://www.dcyf.wa.gov/practice/oiaa/reports/child-fatality>) 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).

Third Quarter Fatality and Near Fatality Reports

DCYF Region	Number of Reports
Region 1	2
Region 2	1
Region 3	0
Region 4	1
Region 5	3
Region 6	3
Total Fatalities and Near-Fatalities Reviewed During Third Quarter 2025	11

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 2025. 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 2025

Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2025	15	8	7

Child Near-Fatality Reports for Calendar Year 2025

Year	Total Near-Fatalities Reported to Date Requiring a Review	Completed Near-Fatality Reviews	Pending Near-Fatality Reviews
2025	30	22	8

The child fatality reviews referenced in this Quarterly Child Fatality Report are subject to public disclosure and are [posted on the DCYF website](https://www.dcyf.wa.gov/practice/oiaa/reports/child-fatality) (<https://www.dcyf.wa.gov/practice/oiaa/reports/child-fatality>).

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 eight near-fatalities reviewed during the third quarter of 2025, the following were notable findings:

- Ten of the 11 cases referenced in this report were closed at the time of the child’s death or near-fatal injury.
- Four of the 11 cases this quarter were recently closed Family Assessment Response (FAR) cases. Three cases were recently closed Child Protective Services (CPS) cases. Three cases were recently closed Child Family Welfare Services (CFWS) cases. One case was open CFWS at the time of the critical incident.
- There were five critical incidents this quarter where children ingested fentanyl or other opioids (High Potency Synthetic Opioids – HPSO).
 - None of the five children died because of the HPSO ingestion.
 - All five of these incidents involved children three years and under.
 - Fentanyl/opioid ingestion continues to be the leading cause of near fatal injury in cases reviewed by DCYF.
- There was one incident of children being harmed in a house fire.
 - These were siblings; one died from smoke inhalation; the other was a near fatality.
 - These two critical incidents occurred during the same incident.
- There was one fatality of an infant in unsafe sleep environment.
- Five of the cases had children in the family removed and returned to parental custody prior to the critical incident.
- Eight of the children identified in this report identified as White. One child identified as Native American. Two children identified as Black/African American.
- Substance use was a significant risk factor in eight of the 11 critical incident cases this quarter.
- Substance use was a significant risk factor in all four fentanyl/opioid related cases.
- Prenatal drug exposure was present in 4 of the 11 critical incident cases. Prenatal drug exposure occurred in three of the four fentanyl/opioid ingestion 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.
 - In five cases documented in this report, DCYF intake received between one and five intake reports prior to the fatality or near fatality.
 - In three cases documented in this report, DCYF intake received between 6 to 10 prior reports.
 - In two cases documented in this report, 11 reports were received prior to the near fatality.
 - In one case documented in this report, 30 reports were received prior to the near fatality.
 - The three cases with 11 or more prior reports were near fatal fentanyl ingestion incidents.
- 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 three child fatality reviews completed during this quarter. Child fatality reviews are subject to public disclosure and are [posted on the DCYF website](https://www.dcyf.wa.gov/practice/oiaa/reports/child-fatality) (<https://www.dcyf.wa.gov/practice/oiaa/reports/child-fatality>).

Exhibit A contains the following child fatality reviews from the third quarter of 2025:

A.F. (<https://dcyf.wa.gov/sites/default/files/pdf/reports/ecfr-af-2025.pdf>)

L.C. (<https://dcyf.wa.gov/sites/default/files/pdf/reports/ecfr-LC-2025.pdf>)

W.T. (<https://dcyf.wa.gov/sites/default/files/pdf/reports/ecfr-wt-2025.pdf>)