

CHILD FATALITY REVIEW



Washington State Department of
CHILDREN, YOUTH & FAMILIES



Washington State Department of
CHILDREN, YOUTH & FAMILIES

CONTENTS

Full Report..... 1
Executive Summary..... 2
Case Overview..... 2
Committee Discussion 4

The Department of Children, Youth, and Families (DCYF) does not discriminate and provides equal access to its programs and services for all persons without regard to race, color, gender, religion, creed, marital status, national origin, sexual orientation, age, veteran’s status, or the presence of any physical, sensory, or mental disability.

All DCYF publications and marketing materials will carry the required ADA statement:
If you would like copies of this document in an alternative format or language, please contact
DCYF Constituent Relations (1-800-723-7831 | 360-902-8060, ConstRelations@dcyf.wa.gov).

Full Report

Child

- B.L.

Date of Child's Birth

- July 2019

Date of Fatality

- March 2025

Child Fatality Review Date

- September 30, 2025

Committee Members

- Erin Summa, MPH, CPST, Injury Prevention Program Manager, Mary Bridge Children's Hospital
- Cristina Limpens, MSW, Senior Ombuds, Office of Family and Children's Ombuds
- Melanie Reichert, BS, SUDP, Substance Use Disorder Professional, Nisqually Generations Healing Center
- Jennifer Cooper, MSW, Administrator of Child Welfare Programs, Department of Children, Youth, and Families

Facilitator

- Libby Stewart, Critical Incident Review Specialist, Department of Children, Youth, and Families

Executive Summary

On September 30, 2025, the Department of Children, Youth, and Families (DCYF) conducted a Child Fatality Review (CFR)¹ to examine DCYF's practice and service delivery to B.L. and [REDACTED] family. B.L. will be referenced by [REDACTED] initials throughout this report.²

On March 14, 2025, DCYF received information from the Medical Examiner's office that five-year-old B.L. died the previous day. The mother reportedly fell asleep with her [REDACTED] in bed with her. When the father woke her at 4 a.m. the following morning they found B.L. was not breathing and [REDACTED] lips were purple. The mother reported she was using fentanyl multiple times a day and had used while pregnant with B.L. The criminal investigation found fentanyl and other substances throughout the home that would have been accessible to B.L. The father fled the scene before law enforcement arrived. The intake met the legal threshold for a Child Protective Services (CPS) investigation. Allegations of abuse or neglect that meet legal sufficiency result in a screened-in intake for either CPS investigation or Family Assessment Response (FAR). FAR intakes are an alternative response to CPS investigations. The allegations in FAR intakes are lower risk than those in CPS investigations.

Prior to B.L.'s death, DCYF received 15 intakes identified under B.L.'s mother's case number. Of the 15 intakes, four came in between May 2018 and April 2019 regarding B.L.'s older sibling.

A CFR Committee was assembled to review DCYF's involvement and service provision to this family. The Committee included members with relevant expertise selected from diverse disciplines within DCYF and community partners. Committee members had no prior direct involvement with B.L. or [REDACTED] family. Before the review, the Committee received relevant case history from DCYF. On the day of the review, the Committee had the opportunity to speak with staff who were assigned to this case in 2024.

Case Overview

The information documented in this section is not fully inclusive of all contacts and actions by DCYF staff.

Between May 2018 and B.L.'s birth in July 2019, DCYF received multiple intakes regarding parental substance use and neglect regarding B.L.'s older sibling. In July 2019, a hospital called to report that B.L. tested positive for opiates and methadone at [REDACTED] birth and that [REDACTED] mother stated she last used heroin the day before [REDACTED] was born. The information screened in for a CPS Risk Only. CPS Risk Only means an intake that alleges imminent risk of serious harm without allegations of child abuse or neglect.

B.L. and [REDACTED] mother moved in with B.L.'s paternal grandfather. B.L.'s father was also living in the same home. A second intake was called into DCYF and resulted in another CPS investigation. That caller alleged that both

¹ "A child fatality or near fatality review completed pursuant to [RCW 74.13.640] is subject to discovery in a civil or administrative proceeding but may not be admitted into evidence or otherwise used in a civil or administrative proceeding except pursuant to [RCW 74.13.640(4)]." RCW 74.13.640(4)(a). Given its limited purpose, a child fatality review (CFR) or a child near fatality review (CNFR) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death or near death of a child. The CFR Committee's review is generally limited to documents in the possession of or obtained by DCYF or its contracted service providers.

The Committee has no subpoena power or authority to compel attendance and generally hears only from Agency employees and service providers. It does not hear the points of view of the child's parents and relatives, or of other individuals associated with the child. A CFR/CNFR is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's fatal injury. Nor is it the function or purpose of a CFR/CNFR to recommend personnel action against DCYF employees or other individuals.

² B.L.'s name is not used in this report because [REDACTED] name is subject to privacy laws. See RCW 74.13.500.

parents were using heroin, B.L.'s father was dealing drugs, and that B.L.'s father previously beat the mother "beyond recognition." B.L.'s mother initially cooperated with voluntary in-home services. The father was in and out of jail during the investigation. The mother relapsed and DCYF filed a dependency petition.

B.L.'s father complied with services and they were reunified in March 2020. B.L.'s mother was living with the father and B.L. at the time of reunification. At the time of the case closing in September 2020, B.L. and [REDACTED] parents lived with the paternal great grandfather and B.L.'s uncle who was also newly sober. B.L.'s mother did not comply with substance use treatment but did successfully complete Family Preservation Services, an in-home service provided to preserve B.L.'s placement with [REDACTED] parents. The provider did not believe that the mother needed a parenting assessment. The mother did not comply with working with Parent-Child Assistance Program (PCAP).³ B.L.'s father completed a parenting assessment which recommended his continuation with medication assisted substance use treatment and sober support programs. His urinalyses were negative. The Guardian Ad-Litem assigned to B.L.'s dependency case was supportive of the return home and of case dismissal.

In January 2021, a new CPS investigation opened after someone called DCYF and reported that B.L.'s parents were using heroin and the drugs and paraphernalia were accessible to their child. Both parents denied the allegations and provided negative urine tests. The case closed after the investigation was closed with an unfounded finding.

In May 2022, two intakes screened out alleging neglect of B.L. by [REDACTED] parents who were using drugs. An intake was received and screened out in the months of January, June, September, and October of 2023. All allegations were of parental substance use and neglect.

In April 2024, DCYF received a call reporting B.L.'s mother was using methamphetamines and fentanyl as well as selling substances. The caller reported that the father was also addicted to substances and in and out of jail. The caller reported that when the mother is using only methamphetamines, she provides fairly good care but not when she is using fentanyl. The caller reported that the substances and paraphernalia were accessible to B.L. This resulted in a CPS investigation.

The assigned CPS caseworker went to the family's home the next day. B.L.'s mother said, while expressing her embarrassment over her [REDACTED] spitting on her, that her child had been diagnosed with [REDACTED]. The caseworker did not observe any immediate threats to B.L.'s safety. The caseworker asked about B.L.'s older [REDACTED] and learned that [REDACTED] lived in [REDACTED] with [REDACTED] father. B.L.'s mother denied using drugs. She stated that she asked a roommate to move out of the home and believes that person called DCYF in retaliation.

The caseworker spoke with B.L.'s [REDACTED] father and confirmed that [REDACTED] was living in [REDACTED]. The child's father said that the few times that his [REDACTED] visited Washington state, [REDACTED] was not allowed to go to the mother's home. The caseworker spoke with the maternal and paternal grandmothers who both denied the allegations and said they did not have any concerns for their [REDACTED] safety. B.L.'s mother initially stated she would comply with substance use testing but thereafter refused to engage with the caseworker and did not provide any urine tests or oral swabs regarding substance use. The caseworker made repeated attempts to engage the

³ Parent-Child Assistance Program is an evidence-based, voluntary program that supports pregnant and parenting mothers who have experienced substance use. For more information, see: <https://pcap.psychiatry.uw.edu/>.

parents but did not cooperate. DCYF did not have information to substantiate the allegations. The case closed in July 2024 with an unfounded finding.

On March 14, 2025, DCYF was notified that B.L. died while in the care of [REDACTED] parents. The cause of death was identified as acute fentanyl toxicity. The investigation resulted in a founded finding of neglect and/or maltreatment for both B.L.'s mother and father. A founded finding means that evidence gathered during an investigation shows it is more likely than not that the allegation is true.

Committee Discussion

The following section reflects the discussion and perspectives of the Committee. These discussions explore systemic challenges, suggested areas for improvement, and aspects of the case handled well by DCYF staff, as identified by the Committee.

While these insights inform broader learning and potential systemic improvements, they do not represent formal findings or policy positions of DCYF. Any identified improvement opportunities are not intended to suggest a direct correlation with the fatality in this case. Improvement opportunities are defined as the gap between what the family needed and what they received from the child welfare system. Improvement opportunities may also identify systemic barriers.

The Committee had the opportunity to speak with DCYF staff who were involved in supporting the family. This discussion provided a chance for the Committee to learn about case specific details, typical office practice and resources, and system challenges. The Committee identified positive aspects of the casework practice and discussed opportunities for improvement.

The Committee discussed the prior dependency matter, the screened-out intakes in 2023, and the timeframe of events. The Committee raised concerns about the screening and intake process and believed it could be beneficial to review the criteria. The Committee identified that this case had significant chronicity that may have not been fully addressed during interventions prior to the fatality. The Committee discussed the idea that if some of the intakes could have been screened in, the family could have accessed needed services at an earlier point in the case. The Committee also acknowledged that DCYF offered voluntary services to the parents' multiple times, and they did not accept the offers.

The Committee expressed concerns that the screened-out intakes in 2023 may have met the legal threshold for assignment and thus was a missed opportunity to assess child safety and offer supportive services. Because no intake worker was present to present information at the meeting, the facilitator corresponded with the Intake Area Administrator regarding those specific intakes after the meeting. The administrator supported the original screening decisions and disagreed that the intakes met the threshold. The Committee members were provided with the response from the administrator.

The Committee identified that this was a challenging case for DCYF in 2024. The DCYF staff discussed with the Committee changes related to high potency synthetic opioid (HPSO) cases and how DCYF now handles cases involving HPSOs. DCYF staff shared the HPSO training provided by DCYF child welfare program managers which included education and information on how to assess HPSO cases specifically and how to better articulate concerns around HPSO when considering legal intervention. The staff involved in this case did not receive the training until after B.L.'s case closed in July 2024.

The Committee also discussed HB 1227⁴ and SB 6109⁵. The staff shared that the challenges they were facing specific to HB 1227 have been aided by not only the HPSO training but also by SB 6109 which directs judicial officers to give “greater weight” to cases involving HPSOs. The DCYF staff shared that their local Office of the Attorney General recently had leadership changes which led to the creation of a team specifically for shelter care cases. The staff found this change to be beneficial.

The Committee also appreciated hearing about the challenges this office faced. There was a large number of vacancies as well as a change in the area administrator just prior to the case opening in 2024. A significant portion of the staff hired to fill those vacancies were new to DCYF and child welfare. The DCYF staff discussed how that dynamic was challenging due to the inability to regularly engage with seasoned staff to help with their learning. The Committee also discussed this from a statewide perspective. The Committee discussed their perspectives related to perceived practice changes for DCYF filing dependency petitions in the last 10-15 years. They discussed there was a period of time when chronicity was given greater weight when considering legal intervention due to the relationship between chronicity and future abuse or neglect. They identified that this case had chronicity indicators for repeated allegations of parental substance abuse and subsequent neglect to children.

There was a generalized discussion by Committee members that DCYF is not the only entity responsible for child safety and that more collaboration with community partners is necessary to support families and child safety.

The Committee discussed that B.L. may have benefited from attending child care. As part of reunification during the 2020 dependency, the parents were ordered to enroll the child in child care, but the child was never enrolled before the case closed. The mother repeatedly told DCYF and medical providers that her [redacted] was diagnosed with [redacted] although there were no medical records gathered to support that diagnosis. The Committee believed that child care may have assisted with any challenging behaviors B.L. exhibited regardless of whether they stemmed from [redacted] or other factors. The Committee acknowledged that the 2024 CPS caseworker discussed child care with the mother but since she refused the offer, nothing further could have been done.

Another aspect of concern for the Committee was the lack of engagement and completion of services in 2020 by B.L.’s mother. Yet, when B.L. was returned to [redacted] father’s care, B.L.’s mother was also living in the home. The Committee discussed concerns that B.L. came into care due to parental substance use concerns that impacted [redacted] safety and that [redacted] mother had not ameliorated that issue and was B.L.’s primary caregiver during the day while [redacted] father worked.

The DCYF staff shared specific examples of what they would find helpful and supportive related to working with families experiencing substance use disorders. They suggested several ideas including substance use specific symposiums with local treatment providers, having access to videos to share with parents, providers, and relatives about HPSO, and having substance use disorder professionals in the office for DCYF staff to consult and are available to go out to meet with families.

⁴ For information about HB 1227, see: <https://fjrp.org/hb-1227-keeping-families-together-act/>.

⁵ For information about SB 6109, see: <https://www.wacita.org/dependency-law-changes-and-public-health-guidance-for-courts-on-high-potency-synthetic-opioids/>.