

# CHILD FATALITY REVIEW



Washington State Department of  
**CHILDREN, YOUTH & FAMILIES**



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## Full Report

### Child

- J.B.

### Date of Child's Birth

- January 2024

### Date of Fatality

- July 1, 2025

### Child Fatality Review Date

- October 6, 2025

### Committee Members

- Elizabeth Bokan, JD, Deputy Director, Office of the Family and Children's Ombuds
- Qytrice Rouina, SUDP, Tacoma Pierce County Health Department
- Elizabeth Moldonado, MPH, BSN, RN, Public Health Nurse I, Nurse Family Partnership
- Selena Deer, MSW, Regional Program Manager, Department of Children, Youth, and Families
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### Facilitator

- Kari Jellison, MS, Critical Incident Review Specialist, Department of Children, Youth, and Families

Finalized Date: December 5, 2025

Partnership, Prevention, and Services Division | Paul Smith, Critical Incident Practice Consultant

## Executive Summary

On July 1, 2025, the Department of Children, Youth, and Families (DCYF) conducted a Child Fatality Review (CFR)<sup>1</sup> to examine DCYF's practice and service delivery to J.B. and the family. J.B. is referenced by [REDACTED] initials throughout this report.<sup>2</sup>

On July 1, 2025, a detective contacted DCYF to report that J.B. was found in [REDACTED] mother's vehicle, deceased and with clear signs of trauma. This report initiated an emergent Child Protective Services (CPS)<sup>3</sup> investigation. The DCYF investigation of the critical incident was completed. The allegations of physical abuse and negligent treatment of J.B. were founded. DCYF provided services to the family within the prior twelve months before J.B.'s fatal event.

The family had historical involvement with the Department between 2021 and 2024. During this time DCYF received twenty reports about the family's welfare. Ten of these reports met the guidelines for DCYF to initiate a response, per the Washington Administrative Code. There were eight CPS investigations and two CPS family assessment responses.<sup>4</sup> There were 10 reports that did not identify a specific allegation of abuse or neglect of a child, and they were screened out. Between March 2023 and October 2024, J.B.'s mother was offered services through Child and Family Welfare Services (CFWS)<sup>5</sup> as part of a dependency case in the juvenile court system. This CFWS intervention was for J.B.'s older half-sibling and was closed with reunification of J.B.'s half-sibling with [REDACTED] father.

A CFR Committee (Committee) was assembled to review DCYF's involvement and service provision to J.B. and [REDACTED] family. The Committee included members with relevant expertise selected from diverse disciplines within DCYF and the community. Committee members had no prior direct involvement with J.B. or the 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 DCYF field staff who were involved in supporting the family.

## Case Overview

Please note that the information documented in this section is not fully inclusive of all contacts and actions completed by DCYF regarding the efforts made to engage with this family and ensure child safety.

The family came to the attention of DCYF in July 2021, before the birth of J.B. Concerns were reported that the father of J.B.'s half-sibling had relapsed. It was reported that heroin and syringes were within reach of J.B.'s

<sup>1</sup>"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)]." Given its limited purpose, a CNFR should not be construed to be a final or comprehensive review of all circumstances surrounding the near death of a child. The CNFR 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 only hears from DCYF 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 CNFR is not intended to be a fact-finding or forensic inquiry to replace or supersede investigations by courts, law enforcement agencies, or other entities with legal responsibility to investigate or review some or all the circumstances of a child's fatal injury or near fatal injury. Nor is it the function or purpose of a CNFR to recommend personnel action against DCYF employees or other individuals. "The restrictions [described in this paragraph, and the paragraph immediately above,] do not apply in a licensing or disciplinary proceeding arising from an agency's effort to revoke or suspend the license of any licensed professional based in whole or in part upon allegations of wrongdoing in connection with a minor's death or near-fatality reviewed by a child fatality or near-fatality review team." See RCW 74.13.640(4)(d). See: <https://app.leg.wa.gov/RCW/default.aspx?cite=74.13.640>.

<sup>2</sup>J.B.'s name is not used in this report because [REDACTED] name is subject to privacy laws. See RCW 74.13.500.

<sup>3</sup> For information about DCYF Child Protective Services Investigation, see RCW 26.44.185

<sup>4</sup> For information about DCYF Family Assessment Response, see RCW 26.44.260

<sup>5</sup> For information about DCYF Child and Family Welfare Services, see RCW 13.34

half-sibling. The family was in Utah when the incident occurred, but the family had returned to Washington. This incident resulted in a risk-only assessment; these provide no findings for abuse or neglect of a child. On the same date for the risk-only report, DCYF received a second report that was screened in for Family Assessment Response (FAR). This identified additional concerns that the mother had observed J.B.'s sibling with a handful of used heroin syringes.

DCYF completed assessments for each of the reports as separate interventions. DCYF confirmed that the family resided in Washington with paternal grandparents. It was learned that J.B.'s half-sibling was primarily cared for by the paternal grandmother. The father reported that he had support and resources through the Department of Social and Health Services. Local law enforcement completed a welfare check at the father's residence and identified no immediate safety concerns. DCYF was unable to locate the mother during this time. The risk-only assessment and FAR were both closed. There were no known needs for the family and no active safety threat. The FAR case worker noted that the father and paternal grandparents were provided with community resources.

DCYF's next contact with the family occurred in the Fall of 2022. There were two reports received about the safety and wellbeing of J.B.'s half-sibling. The first report was received in October 2022. It was alleged that the parents had been in a physical fight in their vehicle. It noted the father had left J.B.'s half-sibling in the vehicle to chase the mother down to assault her. This information met criteria for DCYF to initiate a FAR intervention. The father engaged in the FAR. The second report was received in November 2022. This report met criteria for an investigation of possible negligent treatment of J.B.'s half-sibling. The allegations outlined concern that J.B.'s half-sibling had access to substances and paraphernalia in the father's bedroom. During the open case, DCYF provided the father with harm reduction information and a lock box. DCYF was able to locate the mother, who had accessed a housing resource in King County. It was determined that there was insufficient evidence for the allegations of negligent treatment. Both the investigation and FAR were closed in December 2022. Each noted that there were no additional known needs for the family and no active safety threat.

In March 2023, DCYF engaged with the family for an investigation of possible sexual abuse and sexual exploitation of J.B.'s half-sibling. It was reported that the mother had reached out to the mandated reporter for support as she had fled from the family home. The mother outlined concerns related to domestic violence dynamics, molestation and online sexual exploitation of J.B.'s half-sibling by the father. J.B.'s half-sibling was placed into protective custody and placed with paternal relatives. The allegations were not substantiated during the investigation. However, DCYF assessed that there was an active safety threat and an out-of-home plan was required to ensure child safety. DCYF determined the family needed services to address domestic violence, mental health, chemical dependency, and parenting skills. The parents did not agree to voluntary services or placement for J.B.'s half-sibling. DCYF sought a court intervention to ensure child safety and support the family with services. The case remained open for services through CFWS between March 2023 and October 2024.

In April 2023, DCYF received two reports about the welfare of the family. The information in the reports did not identify a specific allegation of child abuse or neglect and was screened out. In September 2023, DCYF learned that the mother relapsed. DCYF documentation outlined that the mother was able to re-engage in substance use disorder services and participated in random substance testing. On October 30, 2023, the court ordered a trial return home for J.B.'s half-sibling with the father. This permitted the father to reside at the

paternal grandparents' residence. DCYF continued efforts to engage both the mother and father in the court ordered services. The caseworker completed fourteen in-person contacts with J.B.'s half-sibling and no safety concerns were observed or reported during those contacts. The caseworker gathered collateral information from relatives, support people, and providers who had contact with the family.

On January 19, 2024, DCYF received a report that the mother had given birth to J.B. and had an open CFWS case. The report noted that the mother had stable housing, safe support network, and was compliant in substance use disorder services. This report was screened in for a risk-only assessment by DCYF. The risk-only assessment remained open through March 21, 2024. The caseworker learned that the medical providers did not observe any concerns for J.B. or the mother's ability to meet [REDACTED] care needs. The DCYF caseworker had in-person contact with J.B. and [REDACTED] mother at the hospital and at the family residence after J.B. was discharged. The caseworker noted no immediate safety concerns for J.B. at the time of the in-person contacts. The caseworker reviewed safe sleep<sup>6</sup> guidelines and Period of Purple Crying<sup>7</sup> information with all adults in the home. The mother did not identify J.B.'s biological father.

The caseworker gathered collateral information from the mother's in-home service provider, the family support center, her roommates, and medical providers. The caseworker completed a second home visit and noted that the mother had both J.B. and [REDACTED] older half-sibling at the home; no safety concerns were observed. In February 2024, the mother obtained her own residence in another county. The caseworker completed a home walkthrough at the family's new residence. The mother and J.B. were present for the home visit and no immediate safety concerns were recorded. The caseworker completed the Structured Decision-Making risk assessment (SDM-RA)<sup>8</sup>. The family scored high, which requires DCYF to offer services to the family. In March 2024, the caseworker completed the safety assessment and noted that J.B. was safe. The risk-only assessment was then approved for closure. The family remained in services through CFWS.

On March 26, 2024, [REDACTED] RCW 13.50.100(7)(c) contacted DCYF to report concerns of possible physical abuse and negligent treatment of J.B.'s half-sibling by [REDACTED] RCW 74 father and paternal grandparents. The report initiated a new CPS investigation. DCYF collaborated with local law enforcement. Face-to-face contact occurred for both J.B. and [REDACTED] RCW 74 half-sibling at the mother's residence. The caseworker noted that there were no observed marks or bruising on any of the children. J.B.'s half-sibling did not provide any disclosure of physical abuse when interviewed. DCYF completed interviews with the father and paternal relatives about the concerns outlined in the report. The father and paternal grandparents denied the allegations. They reported they do not use physical discipline. The caseworker had collateral contact with a visit supervisor, who reported no concerns were observed for J.B.'s half-sibling when picked up or dropped off for visitation. The caseworker completed a medical consultation, and there were no concerns identified.

The mother remained engaged in services through CFWS during both investigations. In May 2024, the caseworker completed the comprehensive family evaluation (CFE)<sup>9</sup> and safety assessment. The CFE noted that

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<sup>6</sup> For more information on safe sleep, see: <https://safetosleep.nichd.nih.gov/>. Last accessed 9/24/2025.

<sup>7</sup> For more information on period of PURPLE crying, see: <https://dontshake.org/purple-crying>. Last accessed 9/24/2025.

<sup>8</sup> For more information on the Structured Decision Making Risk Assessment, see: <https://dcyf.wa.gov/practice/practice-improvement/aog/child-welfare-assessments>. Last accessed 9/24/2025

<sup>9</sup> For more information on the Comprehensive Family Evaluation, see: <https://dcyf.wa.gov/policies-and-procedures/1140-family-assessment>. Last accessed 9/24/2025.

J.B.'s half-sibling remained in primary custody of [REDACTED] father. The CFE outlined that the mother had overnight visitation with J.B.'s half-sibling three to four days per week. The caseworker identified no safety concerns were reported during the overnight visits. The CFE identified that the mother continued to be compliant with her court ordered services. The report noted the mother demonstrated the skills to keep J.B.'s older half-sibling safe.

In May 2024, both the SDM-RA and safety assessment were completed. The assessments documented that J.B.'s sibling was safe, and the family presented with moderate high risk. The allegations of physical abuse and negligent treatment were not substantiated as to the father and paternal grandparents of J.B.'s half-sibling. The investigation was approved for closure. The family remained involved in services through CFWS. DCYF did not receive any reports about the welfare of the family between April 2024 and July 2024.

On August 15, 2024, [REDACTED] RCW 13.50.100(7)(c) contacted DCYF to report concerns that J.B. and [REDACTED] older half-sibling did not have safe supervision when in the care of the mother. It outlined that J.B.'s half-sibling disclosed having to change J.B.'s diaper and that [REDACTED] was scared when the mother was not home. This information resulted in a new CPS investigation into allegations of negligent treatment of both children by the mother. The DCYF caseworker completed initial face-to-face contact with J.B. at [REDACTED] child care. Initial face-to-face contact with J.B.'s half-sibling occurred at the father's residence. The caseworker documented that the half-sibling reported there is an adult male in the mother's home, and the children are never left home alone.

The caseworker contacted the mother and J.B.'s alleged father by phone to discuss the new report and gather information about their current needs. The mother denied the allegations. She reported that she and the children were the only ones residing in her home. J.B.'s alleged father reported that he had periodic visitation. He reported he was familiar with the mother's substance use history. He expressed concern about the mother's sobriety status, and who she chooses to have around the children. He reported that the last time he had observed a concern for the mother's presentation was in the past couple of months. He stated that he remained at her home until after J.B. was put to bed. J.B.'s alleged father expressed concern that he was unable to trust the mother's self-report.

The caseworker completed collateral contacts with the CFWS caseworker, child care providers, relatives, and a mother's friend from church. The collateral information reflected mostly strengths for the mother, fathers, and children. The information described the parents as attentive to the needs of the children. It also confirmed that the children were developmentally on track. The collateral from the child care provider outlined concerns related to inconsistent attendance and difficulty with reaching the mother when she is late picking J.B. up from the center. The child care provider noted concern about the inconsistent presentation of the mother's behavior. They were unable to attribute the observed behaviors to substance abuse. An updated safety assessment was completed, which identified the children were safe.

On October 16, 2024, a report was made to DCYF about the welfare of the family. The information did not identify a specific allegation of child abuse or neglect and was screened out. On October 22, 2024, a report was made to DCYF about the possible sexual abuse of J.B.'s half-sibling by that child's father. This information resulted in a new CPS investigation. The caseworker completed the initial face-to-face contact with J.B.'s sibling at the school. Contact with J.B. and the mother occurred at the mother's residence. There was no disclosure made during the interview with J.B.'s half-sibling. The caseworker noted no immediate safety

concerns observed or reported during the contacts with J.B. or [REDACTED] half-sibling. The caseworker gathered information for the investigation from the mother and the half-sibling's relatives. Efforts were made to engage the half-sibling's father; he denied the allegations and did not participate any further in the investigation.

In October 2024, the caseworker completed the SDM-RA and the family presented with moderate high risk. The CPS investigation into the allegations reported in August 2024 was approved for closure; the allegations of negligent treatment were unfounded. The dependency case, for the half-sibling that began in March 2023, was dismissed and the CFWS intervention was in the process of case closure for the family. On November 14, 2024, a report was made about the welfare of the family. Some of the information reported was previously reported in October 2024. The new information did not identify a specific allegation of child abuse or neglect and was screened out.

On December 16, 2024, the CPS caseworker completed an updated safety assessment and determined J.B.'s half-sibling was safe. The CPS investigation for the allegations reported in October 2024 was closed. It outlined that there was insufficient evidence to keep the case open for DCYF services. Between December 2024 through March 2025 DCYF did not receive any reports about the family.

On April 21, 2025, a report was made to DCYF about concerns for possible negligent treatment and physical abuse of J.B.'s half-sibling by the sibling's father. This information resulted in a new CPS investigation with the family. The caseworker completed initial face-to-face contact with J.B.'s half-sibling at the mother's residence and face-to-face contact with J.B. at [REDACTED] child care. It was noted that the mother was present at the home during the initial contact and interview with J.B.'s half-sibling. The caseworker described that the family residence was cluttered with age-appropriate toys and some food observed on the stove. No immediate safety concerns were documented at the time of the home visit. The caseworker completed an interview with J.B.'s sibling and there was no disclosure of physical abuse made.

In April, May, and June 2025, the supervisor engaged in case consultation with the caseworker. The notes reflected updated case information. It also outlined that the caseworker would continue efforts to gather information, complete documentation of contacts, and complete assessments. DCYF's next contact with the family occurred in July 2025. The investigation initiated on April 21, 2025, was open at the time the critical incident report was received on July 1, 2025, and the assessments for safety and risk were pending.

## Committee Discussion

The following section reflects 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 highlighted several key strengths that reflected a commitment to comprehensive, family-centered engagement and timely assessment. Foremost among these was strong inter-program communication, which facilitated seamless coordination between team members for both CPS and CFWS. This ensured consistent messaging and support for the family. The caseworkers employed a sound harm reduction approach, effectively meeting the family where they were and engaging them in practical, non-judgmental conversations around safety. Documentation clearly reflected this engagement and included verification that the family possessed both a lock box and Narcan in their home - critical tools in mitigating risk. Individual practice strengths were also evident. The Committee identified that during the first investigation the caseworker demonstrated a thorough and well-grounded response to the reported concerns. The Committee called attention to how another caseworker contributed to preventative care through the provision of infant education on PURPLE crying<sup>10</sup> and safe sleep practices<sup>11</sup>. It was also recognized that this caseworker did not delay initial contact to assess present danger for both the victim and non-victim child and gathered relevant collateral information that same day, exemplifying diligence and a proactive stance in assessing overall family safety and wellbeing.

In consideration of improvement opportunities, the Committee identified gaps related to the assessment of family needs, collaboration with external partners, and support for professional development.

**The Committee conferred on the need for continued efforts to implement holistic, investigative, and family-informed approaches to assessments and interventions for families involved across systems.** Opportunities were missed to connect the parents to dual diagnosis services. These services may have concurrently addressed their mental health and substance use disorder needs and provided them with more comprehensive and sustained support. The Committee identified that the mother seemed to be systems savvy and was observed to minimize disclosures she had made to others. There was concern that this may have influenced the depth of assessments related to her underlying mental health needs and overall stability. It was suggested that DCYF could have increased its understanding of the mother's patterns of behavior by obtaining information specific to her follow-through with medication management, progress in mental health treatment, and direct observations of her capacity to manage the needs of herself and her children. The Committee further discussed that the role and potential impact on child safety were not fully explored for each father in the family constellation. It was identified that one of the fathers may have benefited from accommodation for his mental health diagnosis to support his engagement with things he was asked to address for both dependency and family court processes. The Committee also spoke about the missed opportunities to increase understanding about each parent's support system and household dynamics. The Committee wondered about the assessment of adults identified to either be residing in the home or utilized in a caregiving role for J.B.'s mother and father; regarding their capacity for caregiving and ensuring child safety.

**The Committee discussed that system partners (DCYF, courts, behavioral health providers) engaged with the parents were unable to fully address the complexity of the family's needs.** It was noted that increased efforts to gather, and share, information about engagement and progress in services may have provided a comprehensive understanding about each parent's ability to effectively mitigate the risks of harm to a child. The Committee identified that shared planning meetings may have reinforced collaboration between

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<sup>10</sup> For more information on safe sleep, see: <https://safetosleep.nichd.nih.gov/>. Last accessed 9/24/2025.

<sup>11</sup> For more information on period of PURPLE crying, see: <https://dontshake.org/purple-crying>. Last accessed 9/24/2025.

professionals, peer/natural support, and the parents; recognizing that each held some level of investment in successful outcomes for each parent and their children. The Committee suggested this may have guided the development of tailored approaches for each parent with their treatment, court service, and case plans. It was noted that this also may have increased the accuracy of on-going assessments utilized to determine the current skills and abilities each parent developed to manage risks impacting a parent's ability to ensure the safety and wellbeing of a child (ren). The Committee noted that families involved in both dependency and family court processes may benefit from the identification of processes that ensure the family court system is aware of, and understands how, decisions were made in the dependency court system. This may further enhance consistent judicial decision-making and sustain accountability for each parent to mitigate risks of harm to the children within their respective households.

There was dedicated focus by the Committee on professional development opportunities aimed at strengthening the practices of systems that serve families with complex needs. A key theme that emerged was the need for consistent practices across regions to ensure equitable and effective service delivery, regardless of geographic location. **The Committee emphasized the importance of enhancing both caseworkers' and system partners' understanding of how to assess meaningful behavior change.** It was identified that professionals and families would benefit from increased knowledge about how to develop and monitor effective relapse prevention plans, particularly in cases involving substance use. Additionally, there was recognition of the need to build capacity for accurate assessment of mental health stability, ensuring that case decisions are informed by a comprehensive understanding of a caregiver's functioning over time.

The Committee identified that this family experienced engagement with multiple caseworkers when involved with CPS investigations or risk only assessments. The Committee recognized that some of this was due to changes in where the family resided or the previously assigned caseworker moving on to other professional opportunities. However, the teams shared with the Committee that there are times when there have been intentional decisions made to assign a new caseworker. **The Committee identified the need for clear guidance around case assignment and transfer processes.** This included strengthening critical thinking skills for supervisors when making decisions around case assignments. To support supervisors with considering multiple factors at the time of case assignment that include caseworker skills, workload, and impacts to case progress with each transition to a new caseworker. The Committee shared that increased understanding of transition impacts may further support supervisors to provide increased guidance to caseworkers that ensure continuity and depth in case planning. It was discussed that this may also reduce the risk for loss of important information or stagnation towards case closure, and it may increase support for successful outcomes for families and children during times of case assignment or transition to a new caseworker.