

CHILD FATALITY REVIEW



Washington State Department of
CHILDREN, YOUTH & FAMILIES



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Full Report

Child

- L.C.

Date of Child's Birth

- May 2022

Date of Fatality

- July 9, 2025

Child Fatality Review Date

- October 27, 2025

Committee Members

- Deborah Lurie, JD, Senior Ombuds, Office of the Family and Children's Ombuds
- Laura Healy, BA, SUPD, Substance Use Disorder Provider, Semi-retired
- Tracie Hoppis, Manager of Family Support Services, Children's Village and MultiCare
- Lyndsay Craig, MSW, Quality Practice Specialist, Department of Children, Youth, and Families
- Sandy McCool, MSW, Intake & CPS Program Manager, Department of Children, Youth, and Families

Facilitator

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

Executive Summary

On October 27, 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 L.C. and family. L.C. is referenced by initials throughout this report.²

On July 10, 2025, a medical professional contacted DCYF to report L.C. drowned in a pool raising concern for allegations of child maltreatment. This report initiated an emergent Child Protective Services (CPS)³ investigation. At the time of the review, the DCYF investigation of the critical incident was completed and founded for the allegations of negligent treatment of L.C. The CPS investigation initially found the parents did not use adequate safety precautions to prevent a small child from accessing the pool. DCYF provided services to the family within the prior twelve months before L.C.'s fatal event, through CPS investigation and Family Assessment Response (FAR).⁴

A CFR Committee (Committee) was assembled to review DCYF's involvement and service provision to L.C. and family. The Committee included members with relevant expertise selected from diverse disciplines within DCYF and community partnerships. Committee members had no prior direct involvement with L.C. 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 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 staff regarding the efforts made to engage with this family and ensure child safety.

L.C.'s parents both presented with history of involvement with the child welfare system as minor alleged victims of negligent treatment and/or abuse. L.C.'s father first became involved with DCYF as a parent in 2018 and was offered Family Voluntary Services⁵ including substance use treatment and Project Safe Care⁶. Between 2018 and 2021, DCYF initiated two FAR assessments and one CPS investigation based on subsequent intakes. L.C.'s mother became a household member and stepparent in 2021. L.C. has two half-siblings.

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)]." 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>.

²L.C.'s name is not used in this report because juveniles' names are subject to privacy laws. See RCW 74.13.500.

³ For information about DCYF Child Protective Services Investigation, see RCW 26.44.185

⁴ For information about DCYF Family Assessment Response, see RCW 26.44.260

⁵ For information about DCYF Family Voluntary Services, see RCW.26.44.195

⁶ For information about Project Safe Care, see [PPS_0066 SafeCare](#). Last accessed 12.1.2025

In 2021, L.C.'s parents were engaged in a CPS investigation into concerns about the negligent treatment of L.C.'s half-sibling. These allegations were not substantiated, and the case was closed in June 2021. Between June 2021 and May 2025 DCYF did not receive any reports about the welfare of the family.

The family's next involvement with DCYF occurred in April 2025, when [REDACTED] ^{RCW 13.50.100(7)(c)} contacted DCYF to report that L.C.'s mother and a grandparent were heard slapping L.C.'s half-sibling. This report met criteria for DCYF to initiate FAR. The FAR was open for approximately a month. While the FAR was open, DCYF received three reports about the welfare of the family that were screened out for response due to the allegations being previously reported. The caseworker completed a home walkthrough and initial face to face contact with all three children in the household. The caseworker completed interviews with L.C.'s mother and collateral contacts with L.C.'s relatives, and a designated crisis responder (DCR)⁷. The caseworker learned from the parents about the challenges they were managing for both L.C. and [REDACTED] ^{RCW 7} teen half-sibling and the services they had sought out. These included being on the wait list for an [REDACTED] ^{RCW 74.13.520} assessment for L.C. and [REDACTED] ^{RCW 7} teen half-sibling's involvement with a wrap-around community mental health program. The family agreed to participate in FAR to address the conflict between the mother and the half-sibling. Services were offered, but the family had accessed a community resource for the half-sibling to reside outside of the home. The FAR was closed as successfully completed. DCYF provided the family with information on how to access Family Voluntary Services if the family plan changed and they wanted additional support from DCYF.

In June 2025, a mental health professional contacted DCYF to report concerns that the mother had left substances and paraphernalia accessible to her children and that there were strange men who frequented the residence [REDACTED] **RCW 74.13.515** [REDACTED]. This information met criteria for DCYF to initiate a CPS investigation into the negligent treatment of L.C. and the half-sibling in the home. This investigation was still pending at the time DCYF received the report about the critical incident.

Prior to the critical incident in July, the caseworker completed in-person contacts with L.C., the half-sibling, and the parents. These contacts occurred in the home and at other locations in the community. It was noted that during in-person contact at the family's home the caseworker did not observe any substances or paraphernalia. The caseworker completed interviews with the parents, and they denied the allegations and offered to participate in a substance test. The caseworker documented that the parents provided information about the development and resources they have accessed for their children. The in-person contact with L.C. occurred at child care, and L.C. was asleep at the time. The caseworker documented observation of L.C. and noted no concern for [REDACTED] ^{RCW 7} physical appearance. The caseworker completed in-person contact and an interview of L.C.'s remaining half-sibling at the DCYF office, and there was no disclosure of any concerns related to safety at home.

The caseworker was able to gather collateral information from non-household members including L.C.'s child care provider, grandparent, and other half-sibling. L.C.'s half-sibling was confirmed to no longer reside in the home due to personal needs and that there was no concern for the safety of the younger siblings. The information gathered identified no concerns about current substance abuse, and that both parents met the safety and care needs of the children. The collateral information clarified that the father is the primary

⁷ For more information about designated crisis responder, see: <https://www.hca.wa.gov/billers-providers-partners/program-information-providers/designated-crisis-responders-dcr>. Last accessed 9/24/2025.

caregiver for the children since the mother worked outside of the home and he was unable to work due to disability.

On July 10, 2025, a medical professional contacted DCYF to report L.C. drowned in a pool raising concern for allegations of child maltreatment. This report initiated an emergent Child Protective Services (CPS)⁸ investigation.

Committee Discussion

The following section reflects the discussion and perspectives of the Fatality Review 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 included how well the DCYF team knew their case and some of the challenges they experienced while collaborating with the family. They commended how the family was connected to relevant services for the oldest youth that honored their autonomy but also preserved value in the role of the mother, who had been taking protective, supportive measures to address her child's behavioral health needs. It was further articulated that their assessment of the family roles and youth's needs was accurate. The Committee acknowledged that DCYF ensured they tailored a family driven approach and were able to articulate how they utilized the information obtained during the FAR to determine their next steps.

In consideration of the information shared with the Committee, it was recognized that the family presented with multiple needs. This was due to the age range of their children from toddler to school age and teen, blended family dynamics, and both current and historical challenges they experienced. These diverse array of needs for the family led to the identification of improvement opportunities related to support for the development of protective capacities within the family, collaboration, and professional development for child welfare caseworkers.

The Committee considered presenting the needs for each of the children in the household. **It was noted that L.C. may have benefited from increased assessment of [REDACTED] development and access to developmental resources.** The Committee held a robust discussion about L.C.'s development and potential resources or collateral contacts (i.e. medical providers, professionals for early support for infants and toddlers, school districts, etc.) that could assist parents and caseworkers in understanding what L.C. needed to support [REDACTED] development. It was identified that **caseworkers may benefit from increased access to resources or consultation opportunities that enhance their understanding about child development, a specific child's**

⁸ For information about DCYF Child Protective Services Investigation, see RCW 26.44.185

developmental needs, and skills to ensure the family has followed up a child's identified needs. Central to this discussion was the parents self-report that L.C. presented with developmental delays and was on a waitlist for further assessment for [RCW 74.13.520]. While the caseworker did connect the family to a funding resource to access child care for L.C., the Committee wondered if the family may have benefited from a warm hand-off to an agency that could complete an initial developmental screen, verification that L.C. was on a waitlist for an assessment, or advocacy to help support the family access needed services sooner. This may have further connected L.C. and [RCW 74.13.520] parents to in-home support for strengthening [RCW 74.13.520] development and accessing other relevant parenting resources while on the waitlist for the [RCW 74.13.520] assessment.

The Committee discussed that the family may have benefited from increased assessment of each parent specific to their roles, parenting knowledge and skills, and the mental health and substance use disorder factors. Each parent in L.C.'s household had historical challenges related to unmet mental health and substance use disorder that impacted their parenting. The Committee discussed that recent reports had been made to DCYF that identified possible concern for substance use occurring in the home and for substances and paraphernalia to be accessible to the children. It was noted that the mother and father denied the allegations that involved concerns about substance use in the home, did not disclose any historical challenges they experienced, and reported their primary needs to be family conflict with the teenage youth in the home, a change in their household finances when the father became disabled and unable to work, and the father's expressed desire to work. The Committee engaged in conversations about the high level of stress the parents experienced and how that can negatively impact both mental health symptoms and individuals who were in recovery.

The Committee contemplated interrelated improvement opportunities within the domains of professional development and teaming. **The Committee suggested that caseworkers may benefit from support to recognize when focusing effect⁹ is present and possibly impacting decisions related to the identification of what collateral information to gather and how to integrate historical information to create a balanced assessment and plan for the family.** It was identified that most of the assessment information relied on self-report of the two parents, L.C.'s teenage half-sibling, and one relative who was a primary support for the family. The Committee acknowledged that while the caseworkers completed physical observations of the family home, these observations were influenced significantly by the reported concerns in the referrals of potential access to unsafe substances inside the home environment.

The Committee discussed that caseworkers and families served by DCYF would benefit from manageable workloads, that would reduce production pressures experienced during times when DCYF offices may have caseworkers out on extended leave, new caseworkers onboarding, and/or higher influxes of screened-in reports. The Committee recognized that this could permit increased time for caseworkers to spend with a family for their assessment and access resources that would support a caseworker's increased knowledge about child development, skills to effectively integrate historical and current information into an assessment, and strategies to reduce focusing effect.

⁹ For more information about focusing effect, please see:

<https://www.sciencedirect.com/science/article/abs/pii/S0001691802001555#preview-section-references>. Last accessed 11/13/2025.

The Committee also reflected on systemic barriers that can result in re-referral of families into the child-welfare system. The Committee discussed that system partners may benefit from increased opportunities for collaboration with DCYF. This collaboration could identify barriers and develop effective strategies that support prevention efforts and target effective use of limited resources. The Committee appreciated the insights from the DCYF team about how the system and families are impacted by responses to historical allegations. Insights shared with the Committee included discussion about mandated reporters not fully understanding what is legally necessary to report; thus, prompting some to provide information that isn't current. Further, intake workers lack time to review the case file for history, so are unable to determine if a report contains outdated information. Consequently, intakes containing historical allegations are screened in, which unnecessarily impacts workload.