

CHILD FATALITY AND NEAR FATALITY REVIEW



Washington State Department of
CHILDREN, YOUTH & FAMILIES



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Full Report

Child

- L.C. and W.C

Date of Child's Birth

- February 2020 and November 2023

Date of Fatality/Near Fatality

- March 9, 2025

Child Fatality Review Date

- May 27, 2025

Committee Members

- Erin Summa, PMH, CPST, Program Manager Injury Prevention, Mary Bridge Children's Hospital
- Ebony Morgan, Dependency Supervisor, Pierce County Juvenile Court
- Myranda Dixon, MSW, Child Welfare Legal Liaison, Department of Children, Youth, and Families
- Michelle Hetzel, MSW, Child Welfare CFWS Program Manager, Department of Children, Youth, and Families
- Patrick Dowd, JD, Director, Office of Family and Children's Ombuds

Facilitator

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

Executive Summary

On May 27, 2025, the Department of Children, Youth, and Families (DCYF) conducted a Child Fatality Review (CFR) and Child Near Fatality Review (CNFR)¹ to examine DCYF's practice and service delivery to L.C. and W.C. and their family. The children, L.C. and W.C., will be referenced by their initials throughout this report.²

On March 18, 2025, DCYF received a telephone call from a relative of L.C. and W.C. The relative reported that five-year-old L.C. died and 16-month-old W.C. was in intensive care at a hospital after a house fire. The house fire occurred on March 9, 2025. The [RCW 74.13.5] were at home with their father. Their mother and other sibling were not present. The father left the two [RCW 74.13.5] in the family's home and walked to another location on the property. The [RCW 74.13.5] father was speaking with his brother when the uncle noticed smoke coming from the family's home. By the time the men reached the home there were considerable flames. The [RCW 74.13.5] father ran into the home and was able to bring W.C. out. He could not find L.C. This information resulted in a Child Protective Services (CPS) investigation. Allegations of abuse or neglect that meet the legal sufficiency result in a screened-in intake to either CPS 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.

At the time of the incident the family did not have an open DCYF case. DCYF did not receive any calls from responding law enforcement, emergency services including the fire department, and not from anyone at Harborview Hospital where W.C. was life-flighted to and receiving medical care.

Prior to DCYF learning of the fatality and near fatal event, DCYF received seven intakes regarding the family. Of the seven intakes three met sufficiency for a CPS investigation or FAR assessment. L.C. and W.C. had another [RCW 74.13.5] and the [RCW 74.13.5] had a [RCW 74.13.5]. The children all share the same father.

A CFR/CNFR 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 L.C., W.C. or their 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 2023 and 2024.

Case Overview

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

Between October 6, 2017, and October 16, 2017, DCYF received three intakes regarding the [RCW 74.13.5] older [RCW 74.13.5]. The allegations were mainly surrounding neglect of the child by [RCW 74.13.5] mother. On July 11, 2021, DCYF received

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 L.C. and W.C.'s name are not used in this report because their names are subject to privacy laws. See RCW 74.13.500.

information that L.C. (then 16-months-old), [REDACTED] mother and father and L.C.'s [REDACTED] (then six-years-old) were living together. The parents regularly lock the [REDACTED] out of the home. [REDACTED] will go to neighbors to ask for food and water. [REDACTED] often would wear the same clothes for days at a time and [REDACTED] hair was always messy. The temperature during the most recent event was between 90 and 100 degrees. This resulted in a FAR assignment. The assessment documented that the parents denied the allegations, they also stated that the [REDACTED] "struggles to listen to females" and that the step-mother has to call the father at work to get his [REDACTED] to listen. The father also said that his [REDACTED] lies. The parents stated they have a lock on their refrigerator because the maternal grandmother told them that the child needed to be on a diet. The child's biological mother was contacted and she confirmed that she did not want to provide for her [REDACTED]. She also said that her [REDACTED] has anger issues. The caseworker referred the child for mental health services and closed the case.

In April 2023, a FAR assessment was assigned due to allegations that the [REDACTED] older [REDACTED] was made to watch [REDACTED] while the parents were out of the home and smoking cannabis. The referent also stated that they observed the child drop things on [REDACTED] heads. The referent also alleged the father yells obscenities at the kids and is concerned that the children may not be fed regularly.

The assigned caseworker went to the family's home the day after the report was made. He met with the children and father. The [REDACTED] mother was at work. The father denied the allegations stating that person who called in the allegations was a "drug addict" and they had a lot of problems with her. The caseworker documented that he did not observe any injuries on the children and they appeared "well."

On June 21, 2023, while the FAR case was still open, another intake was received. This intake alleged physical abuse to the [REDACTED] by the [REDACTED] mother. This was assigned for a FAR assessment as well. The investigation resulted in all of the children going to stay with a paternal uncle and aunt and both parents arrested related to the allegations. Law enforcement did not place the children in protective custody but allowed the father to make the decision to have the children stay with a relative. DCYF filed dependency petitions as to all three children.

RCW 74.13.515

The parents participated in all court ordered services (Incredible Years³ parenting and anger management) and engaged positively with DCYF throughout the dependency case. Due to housing issues for the paternal uncle and his wife, the children were returned to their parents in September. The mother was pregnant and gave birth to her third child, [REDACTED] in November 2023.

Throughout the dependency case there were concerns about cleanliness of the children and the home as well as some parenting issues (ex. leaving knives and cannabis within reach of the children). However, the parenting and anger management providers did not identify any concerns related to child safety. The parents were cooperative when the DCYF caseworker brought up any concerns. The family struggled financially and DCYF provided many concrete goods to help them. DCYF struggled with finding providers for the court ordered

³ Incredible Years is an evidenced based parenting program. For information about the program, see: <https://www.incredibleyears.com/early-intervention-programs/parents>.

services due to a lack of providers, contracted with DCYF and otherwise, in the area. There were also multiple attempts to enroll the [REDACTED] in child care but it never worked out due to the lack of child care openings.

All parties were in agreement with the dismissal of the dependency cases. The dependency case was dismissed on August 21, 2024, and the DCYF case closed the following month. DCYF never filed a dependency petition on the youngest child.

On March 18, 2025, DCYF was notified about the house fire. The information received was assigned for a CPS investigation. Law enforcement did not identify any criminal actions related to the incident. The DCYF investigation was unfounded as to any abuse or neglect related to the fire.

Committee Discussion

The Committee did not identify any unmet needs for the family that were within the control of the DCYF staff. They discussed systemic challenges related to availability of service providers as well as the challenges posed to families who are impoverished. The Committee members identified that casework by the CFWS caseworker was very well done and she showed great perseverance. They appreciated the staff's willingness to be reflective in their discussion of the case. Especially identifying that the office now has access to SafeCare⁴ and how beneficial that service would have been to the family to address the ongoing identified environmental safety issues.

The family lived in a very rural area of an already rural county. DCYF staff serve a significant number of impoverished families in this county and regularly struggle to find services to support the families they work with. Specifically for this case the family lived on a large property that included a couple other family members but did not have any other neighbors. The family struggled with transportation and the birth of the youngest child was medically challenging. The maternal grandmother faced serious medical issues and passed away during the dependency action. The family repeatedly faced incredibly difficult challenges yet they remained engaged and cooperative throughout the dependency process.

There was also discussion about safety plans and case plans. The subject matter expert on the Committee discussed that she did not identify any decisions made by DCYF staff that placed the children in an unsafe situation. However, she did identify that DCYF has struggled to provide formalized training and ongoing support to staff regarding creating safety plans and how safety plans differ from case plans. Specific to this case there were safety plan items that were actually service plan items. This was discussed as a statewide issue and not just specific to this case or region, rather an area that DCYF child welfare could improve upon.

The Committee appreciated hearing about the challenges faced by DCYF staff with the court system and early implementation of HB 1227⁵. There was discussion about the difference between assessing safety in a rural verses urban area and for a family that is living in a home that has a landlord as opposed to their own dwelling; the challenges posed when there isn't a landlord to make sure homes are safe (or for staff to put pressure on a landlord regarding safety concerns).

⁴ SafeCare is an in-home, contracted service with three modules: Health, parent and infant/child interaction, and home safety. The services lasts between 18 and 22 weeks.

⁵ HB 1227 Keeping Families Together Act changed the standard needed in order for the court to order out of home care for children. For more information see: <https://www.wacita.org/hb-1227-keeping-families-together-act/>.