

CHILD FATALITY REVIEW



Washington State Department of
CHILDREN, YOUTH & FAMILIES



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Full Report

Child

- J.D.

Date of Child's Birth

- December 2024

Date of Fatality

- May 26, 2025

Child Fatality Review Date

- September 4, 2025

Committee Members

- Derek P. Murphy, M-RAS, SUDP, CSC, Executive Director, Olalla Recovery Centers
- Vanessa Adams, MSW, LICSW, Program Coordinator, Kids Mental Health Pierce County, Pediatric Care Continuum at Mary Bridge Hospital
- Cristina Limpens, MSW, Senior Ombuds, Office of the Family and Children's Ombuds
- Candie Salatka, MSW, CPS Supervisor Region 3, Department of Children, Youth, and Families
- Alissa Copeland, MSW, MSW, AICSW, 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 4, 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 J.D. and [REDACTED] family. J.D. will be referenced by [REDACTED] initials throughout this report.²

On May 26, 2025, DCYF was notified that six-month-old J.D. died. The caller reported being told that J.D.'s parents were "high" on methamphetamines, slept in the same bed with J.D. and woke up to find [REDACTED] between the bed and the wall. DCYF intake called law enforcement and received confirmation of the death. This information resulted in a CPS investigation.

A CFR Committee (Committee) was assembled to review DCYF's involvement and service provision to the 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 J.D. 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 some of the DCYF field staff involved in the case in 2024 and 2025.

Case Overview

The information documented in this section is not fully inclusive of all contacts and actions by DCYF staff. Due to the significant amount of contact DCYF has had with the family this section contains an abbreviated accounting.

DCYF opened their first case involving J.D.'s mother in 2012. Between 2012 and J.D.'s death, DCYF received 85 intakes regarding the family. Allegations included parental substance use, neglect, physical abuse, sexual assault, domestic violence, unsafe living conditions, sex trafficking, and attempted suicide by a parent.

RCW 74.13.515

[REDACTED]. In 2023, DCYF received many intakes and conducted multiple CPS investigations regarding the family. All the investigations resulted in unfounded findings³ for abuse or neglect by J.D.'s parents. In December of 2024, J.D. was born.

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) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the 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 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 CFR 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 to recommend personnel action against DCYF employees or other individuals.

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

³ "Unfounded" means the determination following an investigation by the department that available information indicates that, more likely than not, child abuse or neglect did not occur, or that there is insufficient evidence for the department to determine whether the alleged child abuse did or did not occur." RCW 26.44.020(30).

At the time of J.D.'s birth, the mother and J.D.'s father lived with J.D.'s three ^{RCW 74.13.515} who were 12-years-old, 10-years-old, and almost two-years-old. In January 2025, DCYF received allegations that ^{RCW 74.13.515} was vaping and smoking cannabis and that the mother and mother's boyfriend provided ^{RCW 74.13.515} the substances. ^{RCW 74.13.515}

This resulted in a CPS investigation.

The CPS investigation was unfounded. While there were many risk factors identified, DCYF did not assess any of the children to be in imminent danger and the ^{RCW 74.13.515} child, mother, and boyfriend denied the allegations. ^{RCW 74.13.515}

Another CPS investigation began in February due to a law enforcement report. The report stated that the law enforcement officer observed the parents trying to switch spots in the vehicle while driving. The officer pulled the car over. J.D.'s father was arrested ^{RCW 74.13.515}

Due to the Structured Decision Making Risk Assessment[®] tool (SDM)⁴ rating as high, DCYF was required by policy to hold a Family Team Decision Making meeting (FTDM).⁵ During that meeting the family was offered service through a Family Voluntary Services (FVS) case. J.D.'s parent declined the offer. The case closed in early March 2025.

On March 19, 2025, DCYF received a telephone call ^{RCW 74.13.515} made allegations of parental substance use, stated J.D. had a rash on ^{RCW 74.13.515} neck going down ^{RCW 74.13.515} spine, claimed that J.D.'s mother is harboring a run away, and stated that J.D. was "super small." This resulted in a CPS investigation.

The CPS caseworker observed a red mark on the back of J.D.'s head near the base of ^{RCW 74.13.515} skull. The mother stated this was a birthmark. The caseworker photographed the mark and sent a request to the MedCon for evaluation. A DCYF MedCon is a physician with training specifically related to child abuse who is contracted with DCYF to provide evaluations and assessments of injuries to children. The MedCon provided their assessment that the red mark was consistent with a birthmark.

On April 17, 2025, three intakes were received by DCYF. One intake met the legal threshold for a CPS investigation and screened in. Allegations included past violence ^{RCW 74.13.515} ^{RCW 74.13.515} parental substance use, educational neglect of the two older children, lice and maggots in the home, and unsafe/unsanitary living conditions.

The CPS caseworker went to the home that same day. She did not observe any maggots in the home. The home was cluttered but not unsafe. The mother voiced her frustration, as she had during previous contacts, that she feels harassed by DCYF and that people are just trying to make her look bad by calling in the allegations. The caseworker observed all of the children and did not see any injuries. The next day the

⁴ The Structured Decision Risk Assessment[®] tool is completed by DCYF staff to assess for future risk. For more information about this tool, see: <https://dcyf.wa.gov/policies-and-procedures/2541-structured-decision-making-risk-assessment>.

⁵ For information about Family Team Decision Making meetings, see: <https://dcyf.wa.gov/policies-and-procedures/1720-family-team-decision-making-meetings>.

caseworker returned and interviewed all of the family members. The caseworker contacted J.D.'s pediatrician's office. The office did not have any concerns but did not have a record of a birthmark (the mark on the back of [REDACTED] head near the base of [REDACTED] skull).

On May 6, 2025, [REDACTED] RCW 74.13.515 called DCYF. [REDACTED] RCW 74.13.515 reported that [REDACTED] RCW 74.13.515 has been coming to school high every day. The child told the caller that [REDACTED] RCW 74.13.515 mother provides [REDACTED] RCW 74.13.515 with cannabis and alcohol. The caller reported [REDACTED] RCW 74.13.515 reported to the school that J.D.'s mother and her boyfriend use meth. [REDACTED] RCW 74.13.515 The two [REDACTED] RCW 74.13.515 called [REDACTED] RCW 74.13.515 and asked how to make a bottle for J.D. J.D.'s mother was not home and the caller was implying that this was neglectful. [REDACTED] RCW 74.13.515

[REDACTED] When the school calls the mother they report she sounds "loopy" and is dismissive of the concerns. This information resulted in a CPS investigation.

J.D.'s mother told the CPS caseworker that she knew who called in the intake and that [REDACTED] RCW 74.13.515 was angry with them because she kicked [REDACTED] RCW 74.13.515 out of their home for stealing. J.D.'s parents and [REDACTED] RCW 74.13.515 denied the allegations. [REDACTED] RCW 74.13.515

[REDACTED] RCW 74.13.515 stated they are going to refer WISE⁶ services, a community based wraparound service for families, for the family, and that J.D.'s mother agreed with the referral.

On May 26, 2025, DCYF was notified that J.D. died. The investigation of the death included an autopsy and toxicology report, which was negative. The parent's received founded findings of neglect. DCYF staff provided safe sleep education on several occasions to both parents.

Committee Discussion

The Committee discussed many systemic challenges faced by DCYF staff, areas of suggested improvement by DCYF, and positive aspects of this case. The Committee did not identify that any of the suggested improvements correlated to the fatality.

The Committee appreciated and shared the perspectives offered by DCYF staff that J.D.'s family was negatively perceived and treated by many community members throughout this case. There was a shared concern that bias impacted the sheer number of intakes the family received. The staff shared that the family clearly had struggles and there were multiple risk factors, but that they did not have evidence to support imminent physical harm to any of the children. The CPS caseworker and supervisor had planned to conduct a Safe Child Consultation (SCC),⁷ but J.D. passed away before this occurred. The Committee discussed their appreciation

⁶ For information about WISE, see: <https://www.hca.wa.gov/free-or-low-cost-health-care/i-need-behavioral-health-support/wraparound-intensive-services-wise>.

⁷ For information about Safe Child Consultations, see: <https://dcyf.wa.gov/practice/practice-improvement/HB-1227>.

for how the DCYF staff diligently engaged with the family and approached each contact with thoughtful and strength-based consideration.

The Committee and staff discussed that this family had significant chronicity and that their situation was complex. The Committee wondered what efforts, beyond SCCs, DCYF child welfare leadership has made to support staff who are assigned complex cases. They identified that experiencing high chronicity cases can easily lead to bias by the worker and supervisor, but that the staff who met with the Committee appeared to be aware of this challenge and were mindful to remain unbiased.

Initially Committee members were concerned about how staff assessed child safety and risk. They identified that the documentation did not help a reader understand how safety was assessed; however, after meeting with the staff this was no longer a concern. The staff provided additional verbal information to the Committee detailing their assessment of child safety and risk. The Committee discussed that when an office experiences significant turnover of staff and of an area administrator (this office had three area administrators within a few years' time) that workload, caseloads, and stress can lead to less documentation. It was mentioned by a Committee member that a new workload study would be helpful to assess what truly adequate caseload sizes for all case carrying staff should be.

The Committee discussed the family needed safe, affordable, and stable housing, and that this was an ongoing need throughout most of the family's engagement with DCYF. The Committee discussed that this is not a DCYF specific responsibility, but it is one that impacts a large portion of the families DCYF interacts with. They also appreciated hearing about the challenges faced by families and DCYF regarding a lack of readily available services for substance use treatment, clothing and food needs, and limited mental health treatment in this county.

DCYF staff and the Committee discussed bias related to the frequency of intakes and the community members calling in intakes. One Committee member, a professional in the county where this case occurred, agreed and supported the staff's statements about the judgement by the community and some providers regarding families that experience poverty or other challenges, like this family did. The Committee also discussed the stigma that is attached and rarely removed for families experiencing these challenges. The Committee agreed with DCYF staff who shared that there were other providers such as WISE or the family's pastor who worked closely with and frequently interacted with the family but never had reason to call in an intake.

One of the CPS supervisors eloquently discussed how DCYF has changed how the agency assesses child safety as it relates to living conditions and how that was impactful in this specific case. The supervisor was able to discuss how the mother's reluctance to trust DCYF staff stemmed from fear of her children being taken from her care based on prior interactions and how the standard for the previous legal intervention has changed. The Committee opined that the trauma the mother and children experienced during the previous dependency action impacted the family's willingness to readily cooperate and trust DCYF staff and that this made the DCYF staff's job even more difficult.