

CHILD FATALITY REVIEW



Washington State Department of
CHILDREN, YOUTH & FAMILIES



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Full Report

Child

- M.H.

Date of Child's Birth

- January 2025

Date of Fatality

- May 9, 2025

Child Fatality Review Date

- October 1, 2025

Committee Members

- Deborah Lurie, Senior Ombuds, Office of the Family and Children's Ombuds
- Marie Preftes-Arenz, MA, LMHC, SUDP, Service Array Program Manager, Department of Children, Youth, and Families
- Clay W. Eakin, MS, MAC, SUDP, Evergreen Recovery Centers
- Shelby Yada, MPA, Child Welfare Early Learning Navigator, Department of Children, Youth and Families

Facilitator

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Finalized Date: October 30, 2025

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

Executive Summary

On October 1, 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 M.H. and [REDACTED] family. M. H. will be referenced by [REDACTED] initials throughout this report.²

On May 9, 2025, DCYF received a call from Snohomish County Sheriff reporting the death of three-month-old M.H. Emergency Medical Services (EMS) were dispatched to the location of the three-month-old infant. Upon arrival, EMS reported to have observed that the mother had been co-sleeping with the infant on the couch in the residence. EMS performed CPR on M.H. and then called-in a "code black" to indicate that M.H. had died. This information resulted in a Child Protective Services (CPS) investigation. Allegations of abuse or neglect that meet legal sufficiency result in a screened-in intake to either CPS Investigations or CPS Family Assessment Response (FAR).³ At the time of this fatal event, there was an open DCYF case with the family.

The family had historical involvement with DCYF. M.H.'s parents experienced involvement with the child welfare system [REDACTED] RCW 74.13.515 [REDACTED] as adults beginning in August 2016. During this time DCYF received twenty-four reports about the family's welfare. Thirteen of these reports met the guidelines for DCYF to initiate a response, per the Washington Administrative Code. As a result, there were twelve CPS investigations and one CPS FAR. There were eleven reports that did not identify a specific allegation of abuse or neglect and were screened out.

A Child Fatality Review 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 partners. Committee members had no prior direct involvement with M.H. 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 staff assigned to this case in 2024 and 2025.

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 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 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 The names of the parents are not used in this report because neither parent has been charged with a crime in connection with the fatality. M.H.'s name is not used in this report because his/her name is subject to privacy laws. See RCW 74.13.500.

³ For information about DCYF intakes, see: <https://www.dcyf.wa.gov/policies-and-procedures/2200-intake-process-and-response>.

Case Overview

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

The family first came to the attention of DCYF in August 2016, after concerns had been reported that M.H.'s mother had just given birth to her first child. The mother was eighteen years old at the time. The report outlined the mother's history of challenges with managing mental health and substance use disorder. Housing instability was of concern, and the mother was observed to be impatient with the infant's crying. DCYF assessed that the family would benefit from on-going services to address identified needs related to parenting education, mental health and substance use disorder. From September 2016 through June 2018, ^{RCW 74.13.515}

RCW 74.13.515 DCYF made efforts to engage the mother in visitation, parenting classes, mental health and substance use disorder treatment services. The mother was unable to demonstrate the skills to manage her behavioral health considerations and the infant's basic needs. **RCW 74.13.515**

RCW 74.13.515

In October 2018, the mother gave birth to a second child, and this led to her involvement with DCYF through both Child Protective Services (CPS) investigations and Child and Family Welfare Services (CFWS). DCYF confirmed that the mother had stable housing and that she was not actively using illicit substances. The mother refused voluntary services through DCYF, and the case was closed with no active safety threat.

In November 2019, the mother experienced a CPS investigation into the negligent treatment of her second child. This investigation was initiated when law enforcement placed her child into protective custody because the mother was reported to have smoked an illicit substance in the vehicle with the child present. DCYF learned that both parents were present in the vehicle at the time that law enforcement became involved with the family. DCYF assessed that the child needed continued out of home placement to ensure her safety and to provide the family with on-going services through the dependency process to strengthen their protective capacities.

DCYF made efforts to engage both parents in visitation, parenting classes, mental health services, and substance use disorder services. The mother was engaged in the dependency process between November 2019 and March 2023. In December 2021, the mother gave birth to a third child. She was participating with inpatient treatment services at that time.

The mother was able to demonstrate progress and began trial return home with her second child in September 2022 and achieved full reunification in March 2023. At the time of case closure, DCYF had confirmation that the mother had stable housing, completed parenting classes, completed substance use disorder treatment, and demonstrated skills for managing the basic care needs of both her children. It was also noted that the mother had support from the Parent Child Assistance Program (PCAP⁴) and the children's great grandparents.

In June 2023, the Department opened a CPS investigation into the possible physical abuse of the older child by the mother. It was reported that the child disclosed being thrown through a window by ^{RCW 74} mother when she was angry. The mother denied the allegations. The father of the younger child was also interviewed. He

⁴ PCAP – For information about Parent-Child Assistance Program (PCAP), see: <https://pcap.psychiatry.uw.edu/>.

reported no concerns for the mother. These allegations were not substantiated, and the mother reported that she was not in need of any services or support during the investigation. DCYF determined that there was no active safety threat, and the case was closed.

In October 2023, DCYF made efforts to engage the parents during an investigation regarding allegations of negligent treatment of their children. DCYF documentation reflected that the parents did not engage with the caseworker to complete full parent interviews and observation of the home environment. It was noted that the mother provided text message communication confirming the negative substance test results from November 2023 and that child locks were installed on doors. DCYF determined there were no active safety threats and the case was closed.

A CPS investigation opened in December 2023 due to concerns related to unsafe sleep practices. The allegations were not substantiated and the investigation closed. The mother continued her involvement in services through the dependency of her older child.

Between February 6, 2024, and April 1, 2024, DCYF received three reports about the welfare of the family. These reports did not meet criteria for DCYF to initiate an investigation or family assessment response as they were allegations already reported or failed to identify a specific allegation of abuse or neglect. ^{RCW 74.13.515}

RCW 74.13.515

In October 2024, an intake screened into the Department as a CPS Risk-Only. It was reported that the mother went to Dawson's Place ⁵ to get services due to ^{RCW 74.13.515} touching ^{RCW 74.13.515} and she wanted to know how she could be protective. The Department conducted initial interviews with both children. Due in part to the mother's protective capacity, the Department did not conclude the children faced imminent physical harm. The mother refused to engage with the Department and the case was closed.

M.H. was born in January 2025. On January 31, 2025, DCYF received an intake reporting concerns of negligent treatment of her 3-year-old child. This referral was screened in as a CPS investigation. A day later, DCYF received a Risk-Only intake with concerns that the mother used methamphetamines eleven days prior to giving birth to M.H. During this investigation, the Department was able to engage with the mother more than in the years since her dependency case closed. The father of M.H. was unable to be fully assessed, but he was open to receiving brochures, resources, and speaking about the intake. The family was provided with concrete goods to include a cell phone and minutes for the father, a medical lock box with Narcan, a food voucher, a pack-and-play, and a car seat. The family was offered Family Voluntary Services⁶, Infant Early Childhood Mental Health⁷, PIC⁸, PCAP, SUD assessment and referrals, Oral Swab Testing, Birth to Three⁹, and Family

⁵ For information on Dawson's Place, see [Safety, Justice, Healing for Child Abuse Victims - Dawson Place](#)

⁶ FVS – For information on Family Voluntary Services (FVS), see: <https://www.dcyf.wa.gov/policies-and-procedures/3000-family-voluntary-services-fvs>.

⁷ For information on Infant Early Childhood Mental Health Services (IECHMS) see [Infant-early childhood mental health services | Washington State Health Care Authority](#)

⁸ For information about Pediatric Interim Care Center, see: [Pediatric Interim Care Center, the Newborn Nursery](#)

⁹ For information on Birth to Three Program see [Early Support for Infants & Toddlers | Washington State Department of Children, Youth, and Families](#)

Preservation Services¹⁰. The children were attending daycare regularly and the infant was up to date on medical care. There were concerns noted about the parents' methamphetamine use, however there had been no evidence to support that their use was directly impacting their ability to safely parent the children and meet their needs. The family refused services, and the case was closed as unfounded in March 2025.

Between May 1, 2025, and May 6, 2025, the Department received three intakes. On May 1, 2025, DCYF received an intake reporting concerns of negligence and maltreatment of the three children by both parents. It was alleged that the parents were arrested for burglary and false reporting, respectively, leaving no parent available to care for the children. On May 5, 2025, the Department received an intake reporting concerns of negligence and maltreatment of all three children by both parents. The intake alleged that law enforcement was inside the home and noted the conditions to be cluttered. A "bulbous glass pipe with burnt residue inside" was found on a dresser within access to the children. On May 6, 2025, DCYF received an intake reporting concerns for negligent and maltreatment of all three children by the mother after the oldest child disclosed that [REDACTED] had observed M.H. attempt to place a "small baggie filled with white powder" into [REDACTED] mouth. The Department offered a voluntary placement agreement, but both parents declined. The Department left information about Safe Sleep and FTDM information along with a note on the door during an unannounced visit on May 8, 2025.

On May 9, 2025, Snohomish County Sheriffs reported the death of 3-month-old M.H. EMS reported that the mother was co-sleeping with M.H. on a couch at a relative's home.

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 positive aspects of the casework, 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. Importantly, 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 did not identify any unmet needs for the family that were within the control of the DCYF staff. They discussed systemic challenges faced by DCYF staff when working with the hospital staff as well as challenges when working with the court system. The Committee identified that the casework reflected strong teamwork and shared decision making. The Committee also noted that the DCYF case worker was diligent at making continuous efforts to engage the family in services. The Committee appreciated the staff's willingness to be reflective in the discussion of the case.

¹⁰ Family Preservation Services are short-term, family-focused services designed to assist families in crisis by improving parenting and family functioning while keeping children safe.

The Committee was curious to understand the barriers that caused delays in the Department's decision to file a dependency petition. The DCYF staff provided insight into the amount of detail and work that goes into filing a dependency petition. The case worker provided ongoing efforts to engage the family through the duration of the process. For safety and oversight, multiple unannounced health and safety visits occurred. Two Family Team Decision Making meetings were scheduled. A safe child consultation was conducted. It was identified by DCYF that additional efforts were needed to engage the father in services. Efforts to engage the father in services included meeting with him in jail to discuss utilizing a voluntary placement agreement, although the father ultimately declined a voluntary placement agreement. A team of case workers drafted the petition while the assigned case worker continued to work with the family. The hospital did not test the baby or the mother for fentanyl at the hospital, and there was no concrete collateral information to provide to the court as evidence that fentanyl was a contributing factor to risk of harm. Despite the chronic history that the family had with DCYF, staff identified it was challenging to provide sufficient evidence for the court to recognize an imminent¹¹ risk of physical harm that would support court intervention.

During the week of the fatal event, staffing levels in the office were affected by several vacant positions and team members on leave. This office regularly manages high volume of high-risk cases. It is common for case workers to receive (3) new referrals each week. Due to the nearby hospital, this office often receives requests from other offices to provide courtesy supervision and assistance.

The Committee spoke about the services offered to the family between the time of M.H's birth, leading up to the critical incident. The family had access to services and support. Despite the Department's consistent efforts to engage with the mother, she refused services. It was noted that the case worker made consistent efforts to meet with the father and offer services to him while he was in jail.

The Committee discussed safe sleep practices and how it had been of concern in this case. The Department provided the safe sleep¹² information and The Period of Purple Crying^{®13} materials to the mother and spoke to her about the importance of maintaining a safe sleeping environment. The mother was not receptive to this information and stated that she was well aware of DCYF's safe sleep information. The Committee talked about how the intersection of infant safe sleep practices and parental substance use presents a complex and unique challenge for DCYF Staff. Understanding the risks associated with parental impairment and the need for comprehensive support in this area highlighted an educational opportunity that DCYF could develop.

The Committee spoke about DCYF's work with the hospital and drug testing newborns. The hospital did not test the infant for fentanyl at the time of birth, and it did not send the samples for further screening. The mother declined to be tested for substances. Drug test results are helpful for assessing child health and safety and case planning. The Department works with hospitals when a child is placed on a hospital hold or placed in protective custody. The Committee felt that having a designated hospital/law enforcement liaison in the region could help to improve communication and decision making around safety and DCYF practices. The

¹¹ **Imminent** - ¹¹DCYF can only seek court-ordered removal, and the court can only order a child removed, when there is imminent risk of physical harm. See RCW 13.34.050 (2023)

¹² For information about safe sleep, see: <https://dcyf.wa.gov/1100-child-safety/1135-infant-safety-education-and-intervention>.

¹³ For information about Period of Purple Crying[®], see: <https://dontshake.org/purple-crying>.

Department also works with hospitals when making a referral to Early Support for Infants and Toddlers (ESIT)¹⁴. To provide awareness of the impact on DCYF's ability to assess safety and support families, it is important to share information with the hospital about the Department's operational needs and challenges. It is believed that enhanced communication and training with the hospital in this area will allow for informed decision-making and consistent practices.