

CHILD FATALITY REVIEW



Washington State Department of
CHILDREN, YOUTH & FAMILIES



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Full Report

Child

- P.L.

Date of Child's Birth

- January 2025

Date of Fatality

- June 12, 2025

Child Fatality Review Date

- August 19, 2025

Committee Members

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- Esther Patrick, Executive Director, The Patrick Group
- Lindsey Barcklay, LICSW, MSW, SUDP, Domestic Violence Program Manager, Department of Children, Youth, and Families
- Anthony Proctor, Region 1 Quality Practice Specialist, Department of Children, Youth, and Families
- Cristina Limpens, MSW, Senior Ombuds, Office of Family and Children's Ombuds
- Nicole Kaley, SUDP, Substance Use Disorder Professional, Tacoma-Pierce County Health Department

Facilitator

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

Executive Summary

On August 19, 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 P.L. and [REDACTED] family. P.L. will be referenced by [REDACTED] initials throughout this report.²

On June 12, 2025, DCFY received three intakes regarding four-month-old P.L.'s death. One intake did not meet the legal threshold for a Child Protective Services (CPS) assignment and was screened out. The other two intakes screened in for CPS investigations. Allegations of abuse or neglect that meet the legal sufficiency threshold are screened-in either for a CPS Investigation 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.

The information reported to DCYF was that law enforcement was investigating the death and that it appeared to be related to unsafe sleep. Law enforcement conducted a search of the family home and located a white powder believed to be cocaine in the bathroom.

Prior to the fatality, DCYF received 15 intakes regarding the family. Of the 15 intakes four met sufficiency for a CPS investigation or FAR assessment.

A CFR 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 P.L. 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 staff who were assigned to this case in 2025.

Case Overview

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

Between 2020 and 2025, DCYF received 10 intakes regarding P.L.'s mother and P.L.'s siblings. The allegations included neglect, unsanitary living conditions, maternal substance use, lack of school attendance for school aged children, a relative having a handgun while on school property, and information that one of the children had a juvenile parole officer. [REDACTED] **RCW 74.13.515** [REDACTED]

In 2020, P.L.'s father experienced the death of his 10-year-old [REDACTED] due to methadone ingestion. P.L.'s father and the deceased child's mother did not cooperate with the law enforcement or DCYF. The source of the

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

methadone was unknown.

RCW 74.13.515

In January 2025, DCYF assigned a CPS investigation after receiving information that P.L. was born prematurely and that both newborn and mother tested positive for cocaine and methadone. P.L.'s mother used fentanyl during the pregnancy but reported she stopped in July 2024 when she started a methadone treatment program. P.L.'s mother did not obtain prenatal care. P.L.'s mother and father lived with nine children, not including P.L. P.L. is the only child in common. P.L.'s father had two children living in this home and a third child who did not live in the family's home.

On January 31, 2025, a courtesy CPS caseworker made the initial contact with P.L.'s mother. A courtesy worker made contact because the hospital where P.L. was born was far from the family's home and outside the area served by the assigned DCYF office. During their discussion, P.L.'s mother shared that she was engaged in substance use treatment related to a pain medication addiction, she was prescribed medication related to mental health needs, and only recently found housing. P.L.'s mother shared that she struggled with caring for nine children and being pregnant and that her ^{RCW 74.13.520} medication was not working, which resulted in her substance relapse, and that all of her supportive family members lived in Ohio. P.L.'s mother said that her fiancé, P.L.'s father, did not use substances and was a strong support for her.

On February 10, 2025, the regularly assigned CPS caseworker reached out to the mother. P.L.'s mother was still in the hospital. They scheduled an appointment for the following day to discuss the case further. On February 12, 2025, the CPS caseworker called the mother again and they discussed the mother's substance use, the children, parenting, supports, employment, mental and physical well-being, criminal history, and unmet needs for the family. P.L.'s mother identified that the family needed assistance with beds for the children. The caseworker arranged for a walk through of the family's home that same day with P.L.'s father. The caseworker discussed all the same topics she had discussed with the mother earlier in the day. The caseworker also met with the children who were home during the visit.

On February 13, 2025, both parents provided urine tests. Both tests were negative for any tested substances. On February 15, 2025, the family was referred to Intensive Family Preservation Services/Homebuilders to help the family with their needs. P.L.'s mother ended the service five days later stating she was overwhelmed.

Early in March 2025, the CPS caseworker met with all the children in the family and conducted interviews with those who were verbal. On March 7, 2025, the caseworker contacted P.L.'s pediatrician. The physician's office shared the family brought P.L. in for three appointments and ^{RCW} had a medical procedure on March 5, 2025. The pediatrician's office did not have any concerns.

On March 13, 2025, the CPS investigative assessment was approved and the case was closed. Because the January 2025 intake was assigned as a CPS Risk Only investigation there were no findings related to the allegations.

On May 22, 2025, DCYF received an intake that screened out.

RCW 74.13.515

RCW 74.13.515

On June 3, 2025, another intake was received and screened out. Allegations were similar to the ones reported on May 22.

On June 4, 2025, a psychologist called DCYF

RCW 70.02.020

This intake screened out.

On June 4, 2025, a second intake report was received. The caller, RCW 74.13.515 reported allegations of neglect. She said that on June 3, 2025, during a video call with the children, the 13-year-old RCW 74.13.515 was in significant abdominal pain. P.L.'s mother was not home during this call. RCW 74.13.515 called the children's mother about the issue but the mother was not responding. P.L.'s 17-year-old sibling was so concerned that RCW 74.13.515 called emergency services. When the children's mother learned emergency services was called, she returned to the family's home. The mother told medics she would have RCW 74.13.515 follow up with medical care, however RCW 74.13.515 learned that the mother did not follow through. This intake screened in for a CPS investigation.

On June 5, 2025, the CPS caseworker called P.L.'s mother to discuss the new intakes. The mother denied the allegations and said RCW 74.13.515 called DCYF to complain. The mother said she was grocery shopping when emergency services were called. The caseworker then called a collateral contact provided by the mother. The person reported concerns about the children and that the mother often leaves the children for extended periods of time while her fiancé is working at night. RCW 74.13.515

RCW 74.13.515

She also disclosed medical and dental neglect of the children, not enough food for the children, and inadequate sleeping arrangements. Another collateral contact said the children want to live with their maternal grandmother in RCW 74.13.515 but feel guilty about wanting to leave their mother. The contact believed it would be best if they moved to RCW 74.13.515

That same day the caseworker went to see three of the children at school. Two of the children disclosed some corroborating information but one, another child of P.L.'s father, did not.

On June 12, 2025, DCYF was notified that P.L. died.

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 was impressed with the staff's willingness to be vulnerable and reflect on how their work has changed and also their ability to clearly articulate the challenges they faced during the period under review.

The Committee agreed with the staff's identification of a need for improvement on assessing how domestic violence impacted the family and child safety. When discussing domestic violence, the CPS supervisor and caseworker not only pointed out that more assessment and curiosity, including asking for records such as protection orders, was missing but also that DCYF does not have resources in place for children impacted by domestic violence. The information and services offered by DCYF are geared towards adults.

The DCYF domestic violence program manager was on this Committee. She shared with the other Committee members that Washington now utilizes HOPE cards. These small cards allow the carrier to have vital information regarding protection orders easily available and replace the need to carry the multiple pages of a printed protection order. She also expressed thoughts on how beneficial it would be to child welfare if there was a nationwide system, similar to the national crime information center, where child welfare could access protection orders. Currently a child welfare worker either requests a copy of the order from the protected person or will need to know the county where the order was issued and request a copy. Even when a child welfare worker knows the county, there are multiple other barriers that impact the ability of staff to obtain orders.

The Committee also agreed that the inability of DCYF to obtain the mother's substance use treatment records and information beyond acknowledging she was a patient at the clinic, was a barrier to understanding and assessing the children's safety. The Committee agreed that more curiosity by staff could have led to a better assessment regarding the mother's unmet mental health needs. Another area where curiosity could have been stronger was regarding P.L.'s father's history. The father had another child who passed away from ingesting methadone, a substance that P.L.'s mother was receiving as well. The caseworker and supervisor acknowledged that they were aware of the history and that it would possibly have been helpful to take a deeper dive into understanding that history and how it may have played a role or influenced P.L.'s situation.

The Committee discussed how difficult DCYF staff's work is generally and how that challenge is increased with budget crises which have led to a hiring freeze, a lack of qualified candidates, and challenges regarding the hiring process. The staff shared that of the office's 25 full time CPS caseworker positions, 11 were vacant in January 2025 when this case reopened and have remained vacant. The area administrator also shared challenges regarding applicants not meeting requirements or repeated issues with going through the selection process up to the point of making a job offer only to be told that human resources had erred, and the candidate did not have the requirements necessary for the job.

The CPS supervisor shared that in January the office had an abundance of overdue cases and she was supervising nine caseworkers instead of the usual five caseworkers because the office was down a supervisor for family voluntary services. The office has recently requested and received assistance from DCYF headquarters and regional quality practice specialists pertaining specifically to clinical supervision³. The supervisor identified that as part of the recommendations made by headquarters and regional quality practice specialists her supervision case notes now reflect what decisions were made and how they were made on cases.

The CPS caseworker shared that during the time period she was assigned this case she had about 15 cases assigned and she was sometimes assigned multiple intakes in one day. She also shared that during the time she was assigned this case she had another family with a newborn involving HPSOs. That case became court involved and required a lot of her time. Those examples coupled with the identified challenges specific to this case led the Committee to agree that DCYF did what it could do for and with this family prior to the critical incident while juggling overwhelming caseloads and an inadequate amount of staff.

Another challenge faced by DCYF staff relates to HB 1227⁴ and how the changes interacted with cases where a parent or caregiver was using high-potency synthetic opioids (HPSO) such as fentanyl. The Committee heard that this challenge has decreased some due to SB 6109⁵ which emphasized that “great weight” should be given to cases involving HPSO. The Committee also discussed that DCYF needs to provide more support to staff in understanding how those changes impact assessment of imminent danger to children and how to effectively express when children are no longer safe in their parent or guardian’s care. It was also stated by a Committee member that there needs to be more shared accountability for HPSO cases involving children as other entities and community partners play a role in supporting a person’s journey to sobriety and the responsibility of protecting children when necessary. Another Committee member suggested that it would be most beneficial if the legislature shared in such changes as well.

The Committee also asked about whether DCYF staff discuss safe sleep with youth who are providing care for their siblings. Specific to this case, DCYF became aware that the older children often provided care for their younger siblings and the Committee discussed if DCYF extends the same education and discussion to older sibling caregivers as it does to parents and adult caregivers. The staff shared that they had not had that conversation with the older siblings but that it was a helpful question that will inform their future practice.

The Committee inquired about the length of time between referring the family for Homebuilders and when the service began. The question was asked to get a better understanding of whether there is a service array challenge that leads to service delays. The staff shared that there was a week between the two, which is average based on their experiences, but that there is often difficulties or waitlists for services which adds to the time between referral and service initiation. The DCYF staff shared that this has recently been shared with multiple groups within DCYF and child welfare to hopefully ameliorate this issue.

³ For information about clinical supervision, see: <https://dcyf.wa.gov/policies-and-procedures/46100-monthly-clinical-supervision-case-reviews>.

⁴ For more information about HB 1227, see: <https://fyjp.org/hb-1227-keeping-families-together-act/>.

⁵ For information about SB 6109, see: <https://www.wacita.org/dependency-law-changes-and-public-health-guidance-for-courts-on-high-potency-synthetic-opioids/>.

One Committee member asked the DCYF staff about their perceptions on the community's training and support surrounding reporting allegations of abuse or neglect to DCYF and whether DCYF should be doing something differently. The supervisor shared that the office has two lead workers who recently met with all public schools to discuss this issue. The office also recently met with the Region 4 (King County) intake area administrator in an effort to help the staff better understand the intake process and how or why certain intakes and situation meet the legal threshold for assigned or do not and are screened out.