

CHILD FATALITY REVIEW



Washington State Department of
CHILDREN, YOUTH & FAMILIES



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Full Report

Child

- S.J.H.

Date of Child's Birth

- November 2019

Date of Fatality

- May 29, 2025

Child Fatality Review Date

- August 27, 2025

Committee Members

- Deborah Lurie, Senior Ombuds, Office of the Family and Children's Ombuds
- FaLeisha Wright, Supervisor, Department of Children, Youth, and Families
- Lindsey Barcklay, MSW, LICSW, CMHS, SUDP, CCTP, DV Program Manager, Department of Children, Youth, and Families
- Meg Hatlen, APNS, Parent Child Health, King County Public Health
- Lori Vanderburg, MS, LMFT, Executive Director, Dawson Place Child Advocacy Center
- Leslie Stewart, SUDP, Youth Development Director, Asian Counseling & Referral Service
- Charlotte Pfeiffer, MSW, LSWAIC, Pilimakua Home Visitor, Hummingbird Indigenous Family Services

Facilitator

- Leah Mattos, MSW, Critical Incident Review Specialist, Department of Children, Youth, and Families

Finalized Date: November 12, 2025

Approved for distribution by Paul Smith, Critical Incident Practice Consultant

Executive Summary

On August 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 S.J.H. and [RCW 74] family. S.J.H. is referenced by [RCW 74] initials throughout this report.²

On May 29, 2025, a DCYF supervisor was contacted by a detective, who reported that five-year-old S.J.H. had died. The detective said law enforcement was called by emergency medical services who had responded to the family’s home due to a reported medical emergency. The first responders reported that S.J.H. had “significant injuries presumed to be from physical abuse”. S.J.H.’s father was arrested. The DCYF supervisor reported this information to the child abuse hotline. Later that day, law enforcement contacted DCYF again to report they were placing the three minor children of the father’s partner, who also resided in the home, into protective custody.

DCYF had prior involvement with the family, with the most recent Child Protective Services (CPS) case closing approximately one month prior to S.J.H.’s death. A new CPS case was assigned to investigate the circumstances of S.J.H.’s death. During the CPS investigation the father’s partner was arrested. To DCYF’s knowledge the father and his partner have pending criminal charges. [RCW 74.13.515]

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 the 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 with supporting the family.

Case Overview

The case history for S.J.H. includes two separate cases files within the child welfare reporting system. The first case file is connected to S.J.H.’s mother with case involvement from 2020 to 2022. The second case file is connected to the partner of S.J.H.’s father, and her three children, with case involvement in 2022, 2023, and

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 CFR should not be construed to be a final or comprehensive review of all 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 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 CFR 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 CFR 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>.

²S.J.H.’s name is not used in this report because [RCW] name is subject to privacy laws. See RCW 74.13.500.

2025. This summary is intended to provide an overview of DCYF's case involvement and may not include every case detail or agency action.

This is a summary of case involvement with S.J.H.'s mother. From 2020 to 2022, the agency received a total of seven reports regarding the welfare of the family. While not all reports required agency response, two reports resulted in two CPS investigations following S.J.H.'s mother's death. A summary of reported concerns and allegations included S.J.H.'s mother's health decline and her passing (2020), family conflict, intimate partner violence, substance use by the father, and unmet medical needs for S.J.H. S.J.H. was diagnosed with **RCW 74.13.520** and meant that S.J.H. had complex medical and developmental needs. S.J.H. was reported to be at risk for **RCW 74.13.520** requiring specialty medical and developmental appointments that were not followed up on after **RCW 74.** mother's death.

In 2020, the family came to the attention of the agency when reports were received from a relative and Adult Protective Services (APS) regarding S.J.H.'s mother's declining health and family conflict. No concerns were reported regarding child abuse or neglect related to S.J.H., so agency response was not required.

Later in 2020, the first CPS investigation was assigned following the passing of S.J.H.'s mother when a medical provider reported concerns about S.J.H. not receiving necessary medical follow-up. During the investigation the caseworker spoke with the father, relatives, medical professionals, and law enforcement. The father said the mother had previously taken care of S.J.H.'s medical care needs. The father accessed medical care for S.J.H. which was confirmed by the caseworker. S.J.H. was assessed as safe in the care of **RCW 74.** father and the case closed as unfounded⁴ with no ongoing DCYF services.

In 2021, a second CPS investigation was assigned when a medical professional reported concerns about S.J.H. not receiving recommended specialty medical care. It was reported that S.J.H. had not been seen by the doctor since spring. The father had been at the clinic on the date of the report in fall but left before seeing the doctor and did not respond to follow-up phone contacts from the clinic. During the investigation, efforts were made to locate S.J.H. and the father unsuccessfully. The father had contact by phone with the caseworker, and he agreed to an appointment with the caseworker at the office but then did not attend. The caseworker made additional attempts to contact the father and other relatives and speak with medical professionals. The CPS investigation closed approximately 30 days after the case was assigned as unable to complete due to being unable to locate the family.

In 2022, S.J.H.'s medical clinic called the agency again expressing concerns for **RCW 74.1** wellbeing due to not being seen by the doctor since spring of 2021 and the father had not been responsive to the clinic's efforts to contact him following the time he left the appointment in the fall. This report did not screen-in for response as it was coded as duplicative information from the 2021 report and CPS investigation. There were no additional case contacts connected to S.J.H.'s mother's case file.

³For information on **RCW 74.13.520**; see: <https://my.clevelandclinic.org/health/diseases/22808-goldenhar-syndrome>. Last accessed on September 25, 2025.

⁴RCW 26.44.020 (29) defines "Unfounded" as follows: 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. <https://app.leg.wa.gov/rcw/default.aspx?cite=26.44.020>.

This is a summary of case involvement with the partner of S.J.H.'s father, who is the mother of three children. From 2022 to 2025, prior to S.J.H.'s death, the agency received a total of seven reports regarding the welfare of the family, which included the father, his partner, her three children, and S.J.H. Three CPS-Family Assessment Response (CPS-FAR)⁵ cases, an alternate pathway in CPS, were assigned in 2022, 2023, and 2025. Reported concerns were related to suspected physical abuse by S.J.H.'s father of his partner's children. The most recent open case closed in April 2025, approximately one month prior to S.J.H.'s death. A summary is provided of the case involvement in 2022 and 2023, with additional case specific details provided related to the most recent case in 2025. This summary does not include every case detail or agency response.

In 2022, a CPS-FAR case was assigned when the agency received a call from an educator who reported concerns about physical abuse of the mother's two (school-aged) children by her partner, S.J.H.'s father. The oldest child was observed to have a bruise on their arm and expressed fear of their mother's partner, stating the children are hit by S.J.H.'s father with a bamboo stick when they get in trouble. During the CPS-FAR case, the caseworker interviewed S.J.H.'s father, the father's partner, the two school-age children, spoke with law enforcement, educational contacts, and medical professionals. S.J.H. was observed but was not interviewed due to [REDACTED] age. An attempt was made to contact the children's father, who was reportedly incarcerated out-of-state. The father's partner was identified as protective, and it was documented she would no longer allow S.J.H.'s father to discipline her children. The children were assessed as safe in the care of the mother with moderate risk. The case was submitted for closure with no recommendations for ongoing DCYF services.

In 2023, a CPS-FAR case was assigned when the agency received a report [RCW 74.13.515] concerning possible physical abuse of the mother's two oldest children by her partner, S.J.H.'s father. During the open case, an additional report was received by law enforcement detailing a welfare check conducted with the family. The caseworker went to the family's home, and the door was opened by the oldest child. The caseworker asked if their mother was home and the child said their grandmother was there but sleeping. The caseworker briefly observed the two oldest children and S.J.H. before the child closed the door. Two additional contacts were made to the mother without her response. The CPS-FAR case closed approximately 60 days after the case was assigned and documented as unable to complete due to being unable to locate the family.

In 2024, DCYF had no contact with the family.

In January 2025, a third CPS-FAR case was assigned when DCYF received a report from the school regarding allegations of physical abuse of the mother's school-aged children by the father of S.J.H. In summary, the mother's youngest child was observed to have two linear bruises on their arm, stating their father hit them, the oldest child reported being hit by S.J.H.'s father when they got in trouble, and the middle child disclosed feeling afraid at home but told the referrer they could not talk about it. Below is an overview of the case involvement, which does not include every case detail or agency response.

On January 30, 2025, the assigned CPS caseworker collaborated with law enforcement and the children's school and received permission from the mother to interview the children and interviewed the mother's two

⁵For information on CPS Family Assessment Response (CPS-FAR), see: <https://www.dcyf.wa.gov/policies-and-procedures/2332-child-protective-services-family-assessment-response>.

youngest children. The youngest child disclosed being “whacked” by S.J.H.’s father. The caseworker provided an update to law enforcement who gave permission to interview the family. The caseworker met with S.J.H.’s father and his partner, the mother of the three school-aged children, at their home. The family identified experiencing financial stressors. The father shared about S.J.H. and [REDACTED] needs, detailing that [REDACTED] was not toilet trained and could speak very few words. He told the caseworker he was interested in having [REDACTED] evaluated for school but that [REDACTED] was not enrolled in any school programming. The caseworker discussed the allegation with the father and his partner. The father was documented as expressing frustration with the mother’s inability to set limits with the children. The father agreed to allow his partner to discipline the children. The caseworker scheduled a time to complete interviews with the father and his partner.

On January 31, 2025, the caseworker spoke with law enforcement who reported a domestic violence incident in April 2024 between the father and his partner, which had led to a temporary protection order. The protection order had expired due to not being able to serve the father timely.

On February 3, 2025, the caseworker texted the father’s partner to complete the scheduled interview by phone due to snow on the roads. The father’s partner’s phone was not in service. The caseworker left a message on the father’s phone.

On February 4, 2025, the assigned caseworker, along with a second caseworker completed interviews to address the allegations and domestic violence assessments with the father and his partner at their home. The conversation documented in the case note is summarized to include discussion with the father’s partner and S.J.H.’s father about their daily household routine, typical discipline practice, and the reward system used for the children. S.J.H.’s father and his partner addressed the allegation, and it was documented that the children had been hit by the father with a bamboo stick during an incident in the home where the children had not been listening. The father was documented as telling the caseworker that law enforcement came to the home in response. He said he destroyed the stick in front of the children. S.J.H.’s father and his partner were offered in-home services, and they declined, stating they did not have time to participate. During separate conversations about domestic violence, the father’s partner confirmed an incident involving physical violence in 2024, denying current concerns. The father denied domestic violence in his current relationship and in his relationship with S.J.H.’s mother. The caseworker spoke to the father about considering services for mental health support and he was documented as saying he had not received mental health services in the past. A walk-through of the home environment was completed.

On February 7, 2025, DCYF received the law enforcement report dated January 31, 2025, which detailed the officer’s response to the request from CPS to assist with interviewing the children, noting the caseworker completed the interviews unassisted. The officer reported the caseworker notified him that they did not believe the children were in “imminent danger”. This intake screened out as it reported duplicative information.

On February 28, 2025, a monthly supervisor review occurred documenting that next steps included collateral contacts and completion of the FAR family assessment.

On March 11, 2025, the second caseworker who assisted with parent interviews went to the family’s home to complete an interview with the oldest child. The caseworker discussed the allegations with the child, who said

they now have timeouts standing still holding their arms up or trying to hold themselves in a push-up position. The caseworker spoke with the father's partner, who said the discipline has not been physical with the children since the incident that had previously been discussed.

On March 20, 2025, a monthly supervisor review occurred, documenting the next steps were to complete collateral contacts and the FAR family assessment.

On March 25, 2025, the caseworker spoke with a teacher at the children's school. It was documented that the teacher denied observing bruises on the two older children. The teacher denied that the children demonstrated behavioral needs within the school setting.

On April 28, 2025, the caseworker attempted to contact a collateral contact, whose contact information had been provided by the father. Three attempts were made without response. The caseworker completed an interview with the school counselor, who was providing support to the oldest child. It was documented that the counselor denied observing any bruising or marks and said they did not have concerns for the children's safety. The caseworker completed a home visit, observing S.J.H. and [REDACTED] father's interactions and speaking with [REDACTED] father. The father's partner was documented as being present but did not participate in the conversation. During the visit S.J.H. was observed to have a bruise on [REDACTED] face, it was described as beginning on [REDACTED] right eye, a line over [REDACTED] nose and continued to [REDACTED] left eye. The caseworker documented their discussion with the father about the injury and the father's explanation that S.J.H. rolled over in [REDACTED] sleep and hit [REDACTED] face on the wall heater. The caseworker documented observation of the wall heater, which had been boarded off and blocked by a baby gate. The caseworker documented a conversation with the father about considering other sleeping arrangements for S.J.H. and the father said [REDACTED] had climbed out of other arrangements, such as a crib. The visit was completed.

On April 29, 2025, the FAR family assessment was completed. The assessment summary documented that the parents were transparent about their actions and were cooperative in adjusting their disciplinary methods as reported by S.J.H.'s father and his partner. The children were assessed as safe, with moderately high risk. S.J.H.'s father and his partner declined in-home parenting services offered by DCYF and the case was submitted for closure.

On May 29, 2025, DCYF received notification that S.J.H. died, with emergency medical services reporting concerns that [REDACTED] experienced non-accidental trauma. S.J.H.'s father was arrested on this date. The father's partner was arrested later. [REDACTED] RCW 74.13.515

[REDACTED] The CPS investigation concluded with the father and his partner being assigned founded findings⁶ of physical abuse of S.J.H. and the mother's three children. [REDACTED] RCW 74.13.515

[REDACTED] To DCYF's knowledge there are ongoing criminal proceedings related to the father and his partner.

⁶RCW 26.44.020(14) defines "founded" as follows: "the determination following an investigation by the department that, based on available information, it is more likely than not that child abuse or neglect did occur."

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.

The Committee had the opportunity to speak with the area administrator who oversees the child welfare office the case was assigned to and the regional administrator for this county. 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 examples of good casework practice and discussed opportunities for improvement. 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 challenges. The identification of improvement opportunities comes from the Committee's comprehensive review and discussion of the case.

The Committee learned about this child welfare office, its workload challenges, and the communities they support within their catchment area. One unique aspect of this office is the division of work between two co-located offices in this county. This office consists only of CPS units, while the other office covers all the Child and Family Welfare Services (CFWS), ongoing court involved cases. The office shared they have struggled with hiring and retaining new staff, impacting workload needs of the entire office. Throughout the Committee's discussion related to case specific details, they incorporated discussion of how workload needs may impact the assessment process and critical thinking skills. The Committee acknowledged the difficulties this office may have and still be experiencing due to their workload needs.

The Committee considered how historical case information is utilized to inform current assessments and spoke with the child welfare office about typical practice in this area. The Committee learned that it is typical practice to review case history but identified that there is not always a predictable pattern of when that occurs given the often-urgent nature of the agency's response to families. The reason for the curiosity about this was that the Committee believed the work with the family between the two different cases did not seem continuous, rather more incident focused on whichever present case was assigned. For example, it was noted in the most recent cases related to physical abuse allegations that the interventions were similar each time and relied on the parent's verbalizing that they had changed their discipline practice and wondered how or if the child welfare staff considered the prior interventions when determining their response to the family. Additionally, the Committee noted inconsistencies in the agency's intake reporting system, noting that in some intakes there were references to needs or concerns but not consistently in all intakes. The Committee believed it would be beneficial if the reporting system allowed critical information, such as domestic violence (DV) indicators, to be carried over through all intake reporting. The Committee discussed how inconsistencies in reports or case documentation may lead to gaps in how information is gathered or followed up on during a new assessment process. **The family needed continuity from the agency response to demonstrate understanding of their prior case involvement to inform the assessment of risk and safety and family and child needs throughout the agency's case involvement.**

The Committee discussed each of the parents involved with the cases, their engagement, and assessment of needs. The Committee discussed the initial case involvement under S.J.H.'s mother's case file. While the first two intakes screened out and the agency did not have contact with S.J.H.'s mother prior to her passing, the Committee wondered if contacting the referrer of one of the initial screen-out intakes may have provided an opportunity to gather a more comprehensive overview of the family during the first CPS investigation. While relatives were contacted during the initial CPS case, the Committee wondered if contacting the Adult Protective Services referrer may have provided additional insight into the family and any potential unmet needs from a system partner's perspective.

The Committee discussed the father and did not feel they had a comprehensive understanding of the father's history or needs based on the case documentation and noted areas which may have benefited from additional information gathering. The Committee briefly touched on information gathering for assessments, stating information gathered should be the same for both CPS investigations and FAR pathway cases. Included are specific areas of information gathering the Committee had curiosity about related to the father. The Committee observed in case documentation a reference to the father possibly benefiting from an interpreter but could not identify how or if it had been determined that he did not require interpretation services based on case documentation. Substance use indicators were present for the father and were primarily referenced in the first assigned CPS investigations. The Committee did not feel they obtained a comprehensive understanding of his substance use over the years of case involvement, how or if it impacted his parenting or if SUD resources had been provided to him during case involvement based on the case documentation.

Domestic violence was referenced in the history of the family's case involvement with S.J.H.'s mother and with the father's partner. The Committee commended the caseworker during the most recent case for their efforts to engage the father in a conversation about domestic violence, noting it was straightforward and engaging. While the father denied domestic violence in his prior and current relationship, the Committee wondered if he may have benefited from educational information about domestic violence. The Committee had curiosity about other domains for the father, including potential trauma history, mental health needs, and cultural connections. **The father may have benefited from additional information gathering in a variety of domains to obtain a more comprehensive assessment of his needs, identification of any unmet needs, and connections to relevant support and service provision.**

The Committee also did not feel they had a comprehensive understanding of the father's partner and her potential needs based on the case documentation. However, the Committee again highlighted the positive aspects of the domestic violence assessment that was completed with two caseworkers speaking to each parent separately in the most recent case. While this was identified as a strong component of the assessment the Committee still felt unclear about the partner's needs within the context of the household and individually. It was also noted that she had prior domestic violence history with one of the fathers of her children and the Committee inquired if it is typical practice to gather (criminal) court records, such as protection orders. The child welfare office shared that obtaining the court records is a complicated process within this county and the assistance they have available is typically reserved for cases with ongoing court involvement. The Committee found it unfortunate that there is not a streamlined process to be able to access information across systems which may help inform the agency's assessment process. The Committee pointed

out the nuanced aspects of DV assessment and the challenges with providing meaningful training opportunities to help build caseworker's knowledge. The Committee recognized a system challenge, that child welfare staff require knowledge in many areas but may not be considered subject matter experts in areas beyond the assessment of child safety even with training.

The Committee identified a family level need, noting that during joint interviews with the father and his partner, they shared that they were experiencing financial stressors. The Committee discussed how concrete goods and financial resources provided by DCYF may be a relationship building opportunity with families who might be reluctant to engage with CPS. **The family may have benefited from the provision of concrete goods to help address the immediate financial stress they were experiencing.**

The Committee discussed each of the children within the family and considered areas that may have benefited from additional attention. For example, the Committee inquired about typical practice in engaging fathers who are non-household members in the assessment process, noting there was minimal documentation of efforts to contact the three school-aged children's fathers. The Committee wondered if gathering additional information about the school-aged children's medical care may have helped to inform the assessment process

S.J.H. may have benefited from additional assessment and information gathering related to ^{RCW 74.13} medical, developmental, and well-being needs to identify and address unmet needs and further assess parental capacity to meet ^{RCW 74} needs. The first two CPS cases alleged negligent treatment of S.J.H.'s complex medical and developmental needs. In the first case, the father engaged with ^{RCW 74} medical providers but in the second case he and S.J.H. could not be located and the case closed. Following case closure, an additional intake was received reporting the father's failure to follow through with the medical appointment. This intake screened out as duplicative information from the prior CPS investigation. The Committee considered whether it would have been prudent to screen the report in for investigation because the case had closed when the family could not be located, so the agency did not know if S.J.H. received the care ^{RCW 74.13} was being recommended for. The Committee, with their knowledge of early learning programs and through discussion with the child welfare office believed it was outside of typical practice that S.J.H.'s father was not connected with early learning and childcare resources. While S.J.H. was the focus of the initial two CPS investigations, in the three subsequent FAR cases, the focus was on the school-aged children and their reported injuries. The Committee again touched on the importance of case history, informing current assessments to ensure that needs do not get overlooked for any members of a household through the assessment process.

The Committee also had the opportunity to discuss system-wide challenges within child welfare and across system partnerships. With the child welfare office, the Committee discussed law changes, including the Keeping Families Together Act and how this created change within child welfare practice. The area administrator was commended by the Committee for placing value on the shift in practice despite some of the new learning challenges it may have created. The Committee believed that shifts in practice require resources, and it was not clear if all necessary resources were provided to the agency and child welfare field offices to support the recent practice changes.

The child welfare office described their perceptions about relationships between child welfare and court partners, verbalizing hardships for child welfare staff navigating within the dependency court system. The

Committee found this conversation disheartening and wondered how this may be impacting families served by the court systems. One Committee member discussed the need for a culture shift to place value on respect and an assumption that all individuals involved with the dependency court system are performing their role to the best of their ability. The child welfare office took professional responsibility for their work, expressing their commitment to continuous efforts to improve their court work but acknowledged they cannot change this system on their own. The child welfare office shared the efforts they are making to build relationships and improve partnerships and were commended by the Committee for their attempts to create change within the child welfare system.