CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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CONTENTS

Full Report

Child

- O.C.

Date of Child's Birth

- December 2016

Date of Fatality

- Unknown; declared legally deceased by a RCW 74.13.515 County Judge on July 11, 2025

Child Fatality Review Date

- October 28, 2025

Committee Members

- Angela Brumfield, SUDP, Substance Use Disorder Professional, Quinault Wellness Center
- Elizabeth Bokan, JD, Acting Director/Deputy Director, Office of Family and Children's Ombuds
- Kelly Warner-King, JD, Manager of Family & Youth Justice Programs, Administrative Office of the Courts' Family & Youth Justice Programs
- Kurtis Smith, Field Administrator Section 3, Department of Corrections
- Jessica Shook, LMHC, Clinical Director Mobile Crisis & Outpatient Mental Health Grays Harbor, Columbia Wellness
- Michelle Hetzel, MSW, CFWS Program Manager, Department of Children, Youth, and Families
- Lindsey Barcklay, MSW, LICSW, CMHS, SUDP, CCTP, Domestic Violence Program Manager, Department of Children, Youth, and Families

Facilitator

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

Executive Summary

On October 28, 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 O.C. and RCW 74. family. O.C. will be referenced by RCW 74. initials throughout this report.[2]

On December 7, 2021, law enforcement notified DCYF that they placed O.C.'s siblings RCW 74.13.515 in protective custody. O.C.'s older RCW 74.13.515 and RCW 74.13 participated in forensic interviews regarding O.C.'s disappearance. Statements made by the children, and O.C.'s parents' unwillingness to cooperate with the investigation, led law enforcement to believe O.C.'s siblings were not safe. RCW 74.13.515 RCW 74.13.515 Law enforcement arrested O.C.'s parents for obstructing the law enforcement investigation related to O.C.'s disappearance. The intake met the legal threshold for a Child Protective Services (CPS)[3] investigation. There has been no new information regarding O.C.'s whereabouts since 2021.

On July 11, 2025, a RCW 74.13.515 County judge declared O.C. was deceased. Once DCYF was notified of this ruling it was determined that pursuant to RCW 74.13.640, a child fatality review was required.

Prior to December 7, 2021, DCYF received 14 intakes involving this family. Of the 14 intakes eight intakes met the legal threshold for a CPS investigation or Family Assessment Response (FAR)[4] intervention. FAR is an alternative response to a CPS investigation. The allegations in FAR intakes present lower risk than those that screen in for a CPS investigation.

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 O.C. or RCW 74. 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 staff who were assigned to this family's case in 2020 and 2021.

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

[3] 2331. Child Protective Services (CPS) Investigation | Washington State Department of Children, Youth, and Families.

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

Case Overview

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

In 2013, DCYF received four intakes regarding O.C.'s mother, her partner, and their seven-month-old RCW 74.13.515 alleging domestic violence, physical abuse, and parental substance use. Two of the intakes screened in for CPS investigations. DCYF staffed the family's circumstances with a Child Protection Team (CPT)[5]. CPTs are composed of community partners who provide confidential consultation with recommendations to DCYF staff regarding situations within families where there is risk of serious imminent harm to children. The CPT recommended that DCYF offer mental health services, domestic violence services, and urinalyses. The adults were minimally compliant with services and DCYF closed the case later that same year.

In 2014, DCYF received one intake alleging a violation of a restraining order which screened in for a CPS Risk Only intervention. O.C.'s mother and the mother's partner did not cooperate with the CPS investigation, DCYF filed a dependency petition, and their child was placed in out of home care. The child's father did not participate in court ordered services. Due to the mother's successful participation in court ordered services, DCYF initiated a transition home, and the court dismissed the dependency case in 2015. At the time of dismissal O.C.'s mother was pregnant with her second child. She was in a relationship and lived with that child's father (who also is O.C.'s father). O.C.'s father had a child from a previous marriage. RCW 74.13.515 RCW 74.13.515

In June 2017, DCYF received allegations that O.C.'s mother yelled profanities at her 17-month-old RCW 74.13.515 RCW 74.13.520 when the child cried. It was also reported that the mother was not accessing necessary medical services related to the child's medical condition. The grandmother had provided a significant amount of care for the three children (nine-month-old O.C., 17-month-old RCW 74.13.515 and four-year-old RCW 74.13 until the children's mother kicked her out of the home. The caller also stated that the mother had borrowed money from her family members and had not repaid them. This information did not meet the legal threshold for assignment and was screened out.

In July 2017, a caller reported that O.C.'s parents were not providing the necessary care for O.C.'s RCW 74.13.51 who had developmental disabilities. RCW 74.13.520 The caller alleged the parents were not adequately feeding the older children. The caller reported that O.C.'s father was using methamphetamines and stealing from family members to support his addiction. The caller also believed domestic violence was occurring in the home and observed the mother had blood on her head. This information resulted in a CPS investigation.

A second intake screened in for a CPS investigation from a medical provider who stated that the mother was not accessing necessary medical care for the sibling with disabilities. DCYF filed dependency petitions as to O.C. and the siblings. The parents refused to produce the children, so law enforcement took the children into custody following issuance of a court order.

On January 26, 2018, the court entered default orders of dependency as to O.C. and RCW 74. two siblings after O.C.'s parents failed to attend the fact finding hearing. On January 31, 2018, O.C.'s mother filed for

[5] For more information about Child Protection Teams see: https://dcyf.wa.gov/policies-and-procedures/1740-child-protection-teams-cpts.

reconsideration and to vacate the orders of dependency. The court denied the motion to vacate the orders. O.C.'s mother continued to appeal the court's decisions. The decision was reversed on appeal, and the case was sent back to RCW 74.13.515 County to establish dependency. It is not clear what date dependency was established as to O.C. and RCW 74.13.515

In August 2018, DCYF filed a petition to terminate parental rights due to the parents' failure to make progress towards reunification. RCW 74.13.515

On January 16, 2019, a permanency planning review hearing was held. RCW 74.13.515 RCW 74.13.515 Also on the same day, O.C. and RCW 74.13.515 cases were heard. DCYF and the court appointed special advocate for the children recommended the primary permanency plan for O.C. and RCW 74.13.515 continued to be adoption with the alternative plan of return to parent. The court maintained the permanency plans.

In February 2019, O.C.'s father completed a parenting curriculum and was recommended by the provider to obtain additional parenting education. This was deferred and was to be addressed by the court ordered psychological evaluation.

In February 2019, O.C.'s mother completed court ordered inpatient substance use treatment. In March 2019, O.C.'s mother completed her second domestic violence evaluation. There were no recommendations from this assessment. The DCYF caseworker contacted the assessor who stated there were no criminal charges and the client denied there was a problem.

On May 8, 2019, O.C.'s parents completed their court ordered psychological evaluations. Later that month another permanency planning review hearing was held. DCYF and the court appointed special advocate for the children recommended the primary (adoption) and alternative plans (return to parent) remain. The court maintained the permanency plans.

On May 14, 2019, the DCYF caseworker was notified that O.C.'s father was discharged from domestic violence treatment due to non-compliance. He was also out of compliance in March, April, and May 2019, with his substance use treatment provider. Since her release from inpatient treatment both O.C.'s mother and father provided negative urinalyses.

On June 14, 2019, another permanency planning review hearing was held. The permanency plans were once again maintained.

In July 2019, the dependency matter related to O.C.'s RCW 74.13.515 was dismissed.

On September 26, 2019, DCYF staffed the case with a CPT to request insight on moving to unsupervised visits and additional services that could assist in reunification.

At the time of the staffing, O.C.'s mother had taken a Drug Offender Sentencing Alternative (DOSA) plea and had been ordered to participate in inpatient substance use treatment. As a result, the mother started to make progress in services related to the dependency case and was engaged in a parenting instruction program with the father, in compliance with substance use treatment, and receiving counseling for domestic violence. O.C.'s mother was pregnant and due in November with her fourth child.

O.C.'s father was engaged in his third round of substance use treatment and domestic violence services after previously failing to successfully complete them. The father's provider had told the DCYF caseworker that he was close to being out of compliance due to a lack of attendance. DCYF expressed concern to the CPT that O.C.'s father was not taking his services seriously.

DCYF also informed the CPT that the parents had expressed frustration with certain aspects of parenting their RCW 74.13.515 again but were not willing to avail themselves of support offered by the caseworker. The caseworker was also concerned that if O.C.'s mother had only participated in her treatment to avoid jail instead of being ready to become sober that she would struggle with long-term sobriety. The parents told the caseworker they did not need anyone other than each other.

The CPT recommended moving to unsupervised visits and a plan to reunify the children with their parents.

The next month, O.C. began the transition home process by starting unsupervised visits in the home. During this transition, RCW 13.50.100(7)(c) reported O.C. made statements about RCW 74. mother hitting RCW 74. father and a lack of supervision of the children during visits. The assigned DCYF caseworker met with O.C. and RCW 74.13.515 regularly and neither O.C. nor RCW 74.13.515 made any concerning statements about their time with their parents. The caseworker documented that the children were doing well visiting their parents and did not appear to struggle with any anxiety when she observed them.

In November 2019, the court changed the primary permanency plan from adoption to return home for both children. O.C.'s mother also gave birth to her fourth child, RCW 74.13.51. Shortly after, the RCW 74.13 started a court approved trial return home. The DCYF caseworker conducted regular health and safety visits with O.C. at the parents' home. The caseworker did not observe any concerns about O.C.'s safety. The caseworker did document the parents' struggle with toilet training for O.C. The caseworker offered support from community providers and O.C.'s previous foster parents, but O.C.'s mother refused.

In April 2020, due to the COVID 19 pandemic, the Governor issued a mandate that DCYF conduct health and safety visits by virtual means; as a result, the DCYF caseworker conducted the rest of the health and safety contacts with O.C. by virtual means, rather than in person.

In June 2020, the court dismissed the dependency cases for O.C. and RCW 74.13.515. All legal parties (DCYF, CASA, and parent attorneys) agreed with the dismissal.

On January 26, 2021, DCYF received a report that O.C. was seen with scratches on RCW 74. face and bruising near RCW 74. eye around Christmas. The caller also reported being told by someone that they passed by O.C.'s home and heard screaming and that O.C. got into a lot of trouble with RCW 74. parents and spent a lot of time in RCW 74. bedroom. The caller also reported hearing that O.C.'s father lost his job due to allegations of substance use. This information screened in for a FAR assessment.

On January 27, 2021, the assigned DCYF caseworker went to the family's home. The caseworker documented that the driveway is about a quarter of a mile long and did not believe the allegation that someone heard yelling from the home while passing by was credible. O.C.'s mother would not allow the caseworker into the home and stated she was afraid of CPS. From outside the home through a sliding glass door, the caseworker observed O.C. and a sibling. O.C. did not want to speak with the caseworker. O.C.'s RCW 74.13.515 was wearing only a

diaper. The caseworker did not observe any marks or injuries to either child. O.C.'s father was reportedly not home at the time.

The caseworker then went to see O.C.'s [redacted] at school. O.C.'s [redacted] did not appear to have any visible injuries. The [redacted] reported being spanked the night before and it hurt but did not make [redacted] cry. [redacted] reported feeling safe at home and that [redacted] would go to [redacted] mother for help. The [redacted] teacher reported visiting the home twice a week for 30 minutes each visit, did not have any concerns about the home or parents, and had never observed any injuries to O.C.'s [redacted]

On March 8, 2021, the caseworker and a coworker went back to the family's home to complete the FAR assessment. O.C.'s mother again denied the workers access into the home and said she did not trust DCYF and would not answer any questions without an attorney present.

The caseworker contacted the family's pediatrician. The physician reported seeing O.C.'s younger [redacted] The last time the physician saw the child was in October 2020. The physician did not have any concerns for the child. The physician was not familiar with O.C. or [redacted]. The caseworker then spoke with the paternal grandfather. The paternal grandparents lived on the same property as O.C. and [redacted] family. The grandfather reported last seeing the family around Christmas and did not have any concerns.

On March 24, 2021, the caseworker called O.C.'s father and left a voice mail. The caseworker called the paternal grandmother, but she did not answer the call. The caseworker then called the father of O.C.'s half-sibling. The father reported that [redacted] visits the home every other week and that O.C.'s mother and father yell and scream but never physically hurt each other. Two months prior, the parent saw a torch on the counter in the home and was concerned they were using substances again because there was no other probable explanation for the presence of a torch.

The caseworker called the person who reported the information in January. The referent reported receiving information from another person and gave the caseworker the other person's contact information. The caseworker then called this person who reported that a relative is concerned for the children due to the yelling and screaming by the parents including texts from O.C.'s mother that O.C. is "evil" and a photo from late December that showed O.C. had a fading black eye.

That same day, the caseworker presented the case to a CPT. The CPT recommended the caseworker reach out to the school to see if there are any services that could be offered to O.C. and then to close the case afterwards.

The caseworker contacted O.C.'s [redacted] teacher. The teacher shared that O.C. briefly attended the preschool but that O.C.'s [redacted] attends three days a week. The teacher said that O.C.'s mother withdrew O.C. from the program because O.C. was overbearing with [redacted] and their mother wanted preschool to be special for her oldest [redacted] The school principal emailed the caseworker and shared that O.C.'s mother was very engaged with the school, and they did not have any concerns about abuse or neglect.

Prior to the case closing, the caseworker obtained information that O.C.'s [redacted] was last seen at [redacted] medical specialist's office in August 2020, and that O.C. was last seen by a physician on the same day. The caseworker learned that O.C. had been referred to an ear, nose, and throat specialist at that time, but the parents failed to follow up. The DCYF case closed on March 25, 2021.

On November 19, 2021, DCYF received two telephone calls regarding the same information. The callers reported that the family's home recently caught fire, according to a Go Fund Me page set up by the preschool to help the family with repairs and household items. The callers reported that the parents did not call emergency services, taking hours to put the fire out on their own, and there was concern that the family was living in an unsafe home because a relative had an insurance adjuster visit who indicated there was structural damage. The callers also thought the fire may have been the result of substance use by the parents. All three intakes were screened out. On November 21, 2021, another intake was called in about the house fire. DCYF screened this intake screened out because it did not provide any new information.

On December 6, 2021, DCYF received a telephone call from O.C.'s RCW 74.13.515 school principal. The principal reported the family had a house fire three weeks prior. The mother told the school that they moved into a motel after a few days. The mother told the principal that O.C. started the fire by lighting the couch on fire with a lighter. The mother said she did call emergency services. The principal said she did not see O.C. the day she visited the family's home reporting that the mother said O.C. was asleep in RCW 74. bedroom. The principal has been back to the home two more times and still has not seen O.C. nor has her coworker who also visited the home recently. RCW 74.13.515 The principal asked O.C.'s RCW 74.13.51 about O.C. to which RCW 74. replied, "There is no O.C." The principal asked more questions, but the child did not want to speak about it. However, RCW 74. did say later that RCW 74.13.515 lived with RCW 74. previous foster parents and wasn't present when the fire occurred. O.C.'s RCW 74.13.51 told the principal that O.C. moved back with RCW 74. foster parents because RCW 74. was "being bad." The intake worker asked if the caller had specifically asked where O.C. was or had been during the fire. The principal said she did not ask that question but was concerned because no one had seen O.C., and she had confirmed that O.C. did not move back in with RCW 74. foster parents. The principal called law enforcement to request a welfare check. DCYF learned that law enforcement went to the home and the parents reported O.C. was with RCW 74. grandfather. The officer called the grandfather who said he had not seen O.C. since Christmas the prior year. This intake resulted in a CPS investigation.

On December 7, 2021, law enforcement informed DCYF that O.C. had disappeared and they were placing O.C.'s siblings into protective custody. Law enforcement arrested O.C.'s parents for obstructing the law enforcement investigation related to O.C.'s disappearance. The intake met the legal threshold for a Child Protective Services (CPS) investigation. There has been no new information regarding O.C.'s whereabouts since 2021.

On July 11, 2025, a judge declared O.C. was legally deceased.

Committee Discussion

The following section reflects the discussion and perspectives of the 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 presumed 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 spoke with multiple DCYF staff who worked with this family at multiple points throughout the case, as well as the current Region 6 Regional Administrator. Some staff who were assigned in 2020 or 2021 were not available to meet with the Committee because they are no longer employed by DCYF.

The Committee commended the CFWS caseworker, who was assigned from August 2017 through the dismissal of the dependency in June 2020, on her work with O.C. and the family. The Committee identified that the caseworker worked hard to create a positive relationship with O.C.'s parents, O.C., and RCW 74 siblings. The Committee appreciated the patience the caseworker had with repeated challenging behaviors by O.C.'s parents.

DCYF staff shared their perspectives on how challenging the case was due to a lack of support when O.C. was reported missing. The staff discussed how their current Area Administrator and Regional Administrator have provided the support and guidance they wished they had received in 2021. The Committee appreciated hearing from the CFWS caseworker that she felt she received support from her supervisor throughout the entire case. The supervisor left DCYF employment before O.C. was declared deceased and was not a part of this review process.

The DCYF staff discussed with the Committee how challenging it is when a critical incident or high profile incident occurs and the expectations for DCYF staff to continue receiving new intakes or new case assignments. They discussed how that differs from when other roles such as first responders encounter critical incidents. The new DCYF administrative policy 11.37 Critical Incident Crisis Response and Peer Support was also discussed. This new policy directs when supportive resources will be accessed and administered to staff. DCYF also recently created the Critical Incident Assignment Guidance, an internal document, that allows a staff person to be reassigned tasks for up to two days after a critical incident. The Committee discussed that while this is progress, that DCYF should do more to support staff during these difficult events.

The Committee asked about the November 2019 court hearing where the identified primary plan changed from adoption to return home. The caseworker shared there were multiple reasons for that change. O.C.'s parents had not engaged in services for over a year, which initially resulted in the primary permanency plan being identified as adoption with return home as the alternative. This resulted in DCYF filing petitions for termination of parental rights for O.C. and RCW 74.13.515. O.C.'s mother had appealed the court finding of dependency which led to a lengthy appeal process. O.C.'s mother took a Drug Offender Sentencing Alternative (DOSA) plea related to a criminal drug charge and around that same time her appeal of the order establishing dependency of the children was granted. The appeal of the defaulted dependency order took about a year from filing to the final ruling. As part of the DOSA plea, O.C.'s mother was court ordered to participate in inpatient substance use treatment. It was at this time that O.C.'s mother started to make progress in services related to the dependency case.

The CFWS caseworker stated she expressed her concerns to the legal parties that the dependency case was moving quickly to a transition home. The caseworker was concerned that long-term sobriety may be

diminished if O.C.'s mother had only participated in treatment to avoid jail instead of identifying that she was ready to become and remain sober.

Due to the challenges of this case, DCYF staffed the situation with the CPT. The CPT did not recommend a delay in the transition home and identified that O.C. should be reunified first. The caseworker also discussed concerns about the mother's frustration with some of O.C.'s behaviors. The caseworker diligently sought and offered suggestions ranging from professional supports to natural community support despite the parents' adamant refusal to engage in them. Some Committee members disagreed with the CPTs recommendation and felt that the transition home was too fast.

There was discussion about how COVID-19 and related requirements may have impacted the trial return home period in 2020. The Committee recognized that the caseworker did a thorough job speaking with and assessing the children by virtual means despite these challenges.

The Committee identified at multiple points from the family's first intake in 2013 through 2021 that O.C.'s mother isolated her children and partners from interactions with DCYF. The Committee discussed the challenge in identifying and assessing the impact of isolation. The Committee suggested more training and education for DCYF staff and school personnel. They also discussed isolation in the context of domestic violence and how offenders often isolate their partners and children as a means of control. One committee member, DCYF's domestic violence program manager, discussed power and control dynamics that they identified in the mother based on their review of the case, and noted that DCYF is updating its caseworker training and guidance to help staff assess and respond to domestic violence. The Committee discussed O.C.'s father, who appeared to be honest during his domestic violence assessments and received much more lengthy service requirements, while the mother was not honest and denied allegations, resulting in minimal service requirements.

The Committee discussed that the DCYF staff took multiple measures throughout the case to combat possible bias or group think at critical junctures, as demonstrated by the multiple utilizations of CPTs and shared planning staffings. The Committee appreciated that the staff were aware of differing kinds of bias.

The Committee identified missed opportunities related to the January 2021 intake. The Committee identified that certain collateral contacts could have been increased, such as interviewing the half-sibling who visited the family and speaking with the maternal and paternal relatives. The Committee also recognized opportunities for more enhanced documentation. The DCYF staff shared they made multiple attempts to obtain the photograph mentioned in the January 2021 intake, but those attempts were not documented. The Committee appreciated that the CFWS caseworker went out to the home with the CPS investigator in 2021 in the hope that she could help engage O.C.'s mother because of their positive relationship during the dependency case. The Committee also suggested that more documentation of the mother's tactics isolating and manipulating partners, the children, and relatives could have assisted staff. The Committee only recognized the extent of these behaviors on the case, including the role in placement unavailability, after speaking with staff.

O.C.'s foster parents struggled with the decision made to transition the children back to their biological parents' care. The foster parents were understandably grieving. The Committee discussed concerns related to allegations made by the foster parents about O.C.'s parents.

The DCYF staff shared their concerns that they and family resource homes (i.e. foster parents, fictive kin, relative placement) could benefit from more training and support pertaining to placement transitions. The DCYF staff and Committee agreed that more can be done to support DCYF when they prepare to have conversations about returning children home as well as supporting the caregivers who may grieve the child leaving their care. The Committee identified that it may benefit children to have a system in place to provide resources for children during that transition as well.

The Committee discussed some of the professional evaluations conducted during the 2017-2020 dependency case. One Committee member did not believe that the domestic violence assessments followed the Washington Administrative Code associated with this type of assessment. This discussion did not include any indication of fault by DCYF staff related to this issue.

The Committee also expressed concern about the psychological evaluation. The Committee's opinion was that the report did not fully address O.C.'s mother's history of violence and controlling behaviors involving partners, children, and relatives. In discussing this, the Committee identified several contributing factors. They noted that contracted providers have, in the past, raised concerns about the compensation structure for assessments and evaluations. The Committee framed this as a broader financial and contracting issue rather than a reflection on the quality or ethics of any individual provider. The Committee discussed the concerns they had regarding the DV assessment and psychological evaluation as a broader systems improvement opportunity, not as an issue directly related to the critical incident.

The Committee had robust discussions regarding the mother's refusal to engage in suggested professional and natural supports during the trial return home. They also discussed the mother's refusal to allow caseworkers inside the home or access to O.C. during the 2021 investigation. The Committee recognized that DCYF lacks legal authority to enter a home, inspect a child, or require parents to participate in services as part of a CPS assessment or investigation, absent an established dependency.

The Committee discussed that it may benefit families if judicial officers were required to participate in dependency-specific trainings in preparation for and during their assignments to the dependency court bench. The Administrative Office of the Courts' Family & Youth Justice Programs[6] offers many such training opportunities to all judicial officers in the state.

The Committee identified a systemic gap for families living in small or rural areas. The Committee discussed with the DCYF staff the issue with obtaining another child care or preschool for O.C. after the mother refused to allow O.C. to continue in the only preschool option for the community because of allegations that O.C.'s personality negatively impacted RCW 74.13.515 who was also attending the school. The Committee noted that having multiple preschool or child care options in an area is beneficial to families and children but is often limited in small or rural communities.

O.C.'s mother's mental health was also discussed at length. Multiple comments were made that at differing times between 2013 and the completion of the 2021 investigation, O.C.'s mother's mental health was not assessed or identified as a concern to the extent that substance use was focused on. The Committee believed O.C.'s mother's mental health needs were significant. The Committee's opinion was based on her socially

[6] For information about the Administrative Office of the Courts' Family & Youth Justice Programs, see https://fyjp.org/.

isolating her children and partners, and her inability to maintain relationships with relatives and friends, including concerns that O.C.'s mother manipulated O.C.'s father to such an extent that it resulted in the demise of his first marriage, use of substances, and loss of employment. DCYF staff shared events from O.C.'s mother's youth that may have contributed to mental health issues.

The DCYF staff described in detail how they assessed whether O.C.'s parents were using substances. They described behaviors and visual cues that were consistent with either parental identification of or testing results confirming substance use. The staff discussed how they incorporated this into their ongoing assessment of child safety at critical junctures of the case such as return home. The Committee acknowledged challenges associated with balancing periods of sobriety against reunification timelines and the impact to child well-being.

The staff and Committee discussed that an unmet need for families experiencing substance use in Washington state is availability and access to inpatient treatment facilities. DCYF staff shared that there are few co-occurring treatment facilities where patients can simultaneously receive substance use and mental health treatment. After O.C.'s disappearance an increase in funds for Pregnant and Parenting Women (PPW)[7] was created specifically for this community, but due to the lack of identified agencies to provide this treatment the funding could not be delivered. Another systemic challenge present through the 2020 dismissal of the dependency cases as to the children was the varying uses of the terms 'progress' and 'compliance' by treatment providers, as compared to how DCYF staff use these terms. The DCYF staff discussed that it would be helpful if there was guidance or support from DCYF leadership. Also, some DCYF offices historically had substance use treatment professionals co-housed within DCYF offices. The Committee identified that it may benefit DCYF staff as well as the families they serve if that practice returned.

The Committee asked whether DCYF had considered utilizing an attachment and bonding assessment. The DCYF staff stated that this type of assessment is not readily available in their area and is rarely utilized. The Committee identified that the family may have benefited from this assessment if it were available, as they believed bonding and attachment may have been impacted during the 2017-2020 dependency case due to lack of visitation and difficulty visiting while the mother was in inpatient treatment.

[7] For information about Pregnant and Parenting Women substance use treatment services, see: https://www.hca.wa.gov/assets/program/fact-sheet-pregnant-parenting-women-services.pdf.