

CHILD FATALITY AND NEAR FATALITY REVIEW



Washington State Department of
CHILDREN, YOUTH & FAMILIES



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Full Report

Child

- C.T. and H.T.

Date of Child's Birth

- July 2024 and January 2023

Date of Fatality and Near Fatality

- Unknown, but law enforcement found them on February 25, 2025

Child Fatality and Near Fatality Review Date

- April 29, 2025

Committee Members

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Executive Summary

On March 6, 2025, the Department of Children, Youth, and Families (DCYF) conducted a Child Fatality Review (CFR) and Child Near Fatality Review (CNFR)¹ to examine DCYF's practice and service delivery C.T., H.T. and their family. The children, C.T. and H.T., will be referenced by their initials throughout this report.²

On February 25, 2025, DCYF was notified that law enforcement responded to the family's apartment after the mother called 9-1-1 to report that she believed her baby was dead and she was considering killing herself. When law enforcement arrived at the home they found that seven-month-old C.T. was deceased and two-year-old H.T. was near death. H.T. was transported to a local hospital and then sent by helicopter to Seattle Children's Hospital due to [REDACTED] level of care needs. This information resulted in a Child Protective Services (CPS) investigation. Allegations of abuse or neglect that meet the legal sufficiency result in a screened-in intake to either CPS or Family Assessment Response (FAR).³ FAR intakes are an alternative response to CPS investigations. The allegations in FAR intakes are lower risk than those in CPS investigations.

Prior to DCYF learning of the fatality and near fatal event, DCYF received seven intakes regarding the family. Of the seven intakes, four met sufficiency for a CPS investigation or FAR assessment. At the time of intake, the family had an open CPS case due to allegations of parental neglect. A FAR case was opened in January due to allegations that the mother's home was unsanitary and unsafe for the children.

A CFR/CNFR 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 C.T., H.T. or their 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 2023, 2024, and 2025.

Case Overview

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

On February 2, 2023, DCYF screened out an intake alleging H.T.'s mother smoked Percocet pills and used methamphetamines while she was pregnant with H.T. H.T. was born nine days prior to the call. H.T.'s 18-year-old mother and 19-year-old father lived in a home with other "teenagers" and two "older parents." The caller reported that the 19-year-old father signed the birth certificate but is not H.T.'s biological father but he did marry [REDACTED] mother recently. The caller also reported that the mother dropped out of high school and doesn't

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 C.T. and H.T.'s name are not used in this report because their names are 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>.

speak to her parents. The caller also reported a “nasty, violent” rash on H.T.’s face and when asked to describe what that meant the caller said [RCW 74.13.520]

The next call was received on October 20, 2023. A community service provider working with the mother reported that the home was littered with cat feces, there were at least 11 cats in the home and multiple, unkempt litter boxes. H.T. was eight-months-old and crawling. H.T. lived with [RCW 74.] mother only. This information resulted in a FAR assignment.

The assigned caseworker made multiple attempts between October 21 and 23, to see the mother and child at their home. It wasn’t until October 25 that the caseworker was able to meet with them in their home. The caseworker observed eight cats and six kittens, the home was cluttered and messy. The mother said that H.T. was going to stay with the maternal grandparents while she cleaned her home. The mother’s boyfriend was at the home but refused to provide identification.

On November 13, 2023, another intake was received and this time it screened in for a CPS investigation. The allegations were that the mother was smoking cannabis in her home, abusing alcohol, using cocaine, taking her baby to parties where substances were abused, and leaving her baby with random people. The caller also reported that the mother has 11 cats and the home has cat feces and urine throughout as well as concerns that H.T. appears “a little underweight” and is not having [RCW 74.] diapers changed timely.

The same caseworker was assigned to this intake. He went to the home the day after the November intake. The mother did not answer the door when he knocked. The caseworker contacted law enforcement to assist with a welfare check. The conditions in the home were documented to be messy with a strong smell of cat urine and dirty diapers throughout the home. There were cannabis pipes, lighters and a torch within reach of the child. The mother denied using cocaine and said she is smoking cannabis for pain related to [RCW 74.13.520] [RCW 74.13.520]. The law enforcement officer told the mother that the conditions of the home were not safe for H.T. to remain there. The mother said that her child will stay with the maternal grandparents.

That same day the CPS caseworker’s supervisor sent a request to a contracted medical provider asking for information about the impacts of exposure to large amounts of cat urine. The supervisor and caseworker called and spoke with the maternal grandfather. He shared that his daughter started having behavioral issues around the age of nine-years-old. They attempted counseling and she refused to take medications. The mother had been adopted by her parents after she was born substance exposed. The grandfather knew the mother’s biological father and was aware of both biological parents substance use issues.

The grandfather said that he and his wife are willing to help and that his daughter is open to help. He also agreed to attend a Family Team Decision Making meeting (FTDM)⁴. The DCYF staff held a Safe Child Consultation (SCC)⁵ and the recommendations included more collateral contacts, utilizing Parent Locator staff to find and contact H.T.’s father, and the FTDM that was scheduled for November 16, 2023.

⁴ For information about Family Team Decision Making meetings, see: <https://dcyf.wa.gov/1700-case-staffings/1720-family-team-decision-making-meetings>.

⁵ “Safe Child Consultations occur prior to filing a petition with the Juvenile Court to removal a child. A child welfare caseworker first completes a safety assessment. If the assessment indicates an imminent risk of physical harm that cannot be managed through a safety plan, then a Safe Child Consultation is scheduled. These consultations offer support for the caseworker to determine if there are additional measures that can be taken in the safety plan for the family to prevent the need to remove the child from the home.” For more information about Safe Child Consultations, see: <https://dcyf.wa.gov/practice/practice-improvement/HB-1227>.

On November 16, 2023, the caseworker contacted H.T.'s father. He denied knowing the family. The FTDM was held. The mother, her parents, and her friend attended the meeting. The meeting outcome was that H.T. would remain with [REDACTED] grandparents on a Voluntary Placement Agreement (VPA)⁶ until the home was clean enough for [REDACTED] to return. The mother made some progress cleaning the home but not enough for H.T. to return. This was observed by the CPS caseworker and supervisor after the FTDM.

On November 20, the caseworker arrived at the mother's home for a scheduled home visit. She was not home. The mother later emailed the caseworker stating she was at a friend's home and was ill. They rescheduled for the following day. That same day the caseworker met the grandfather and H.T. at the grandparents' home. On November 21, the mother was still not home when the caseworker arrived at their scheduled appointment time. He went back to the home an hour later but no one answered the door. He went to the home again the following day and he heard music playing but no one answered the door. She later called the caseworker and told him she was looking for a job and trying to get information on how to obtain her GED.

Over the observed holiday in late November, the grandfather left the CPS supervisor messages about the mother threatening to come and take H.T. from the grandparents. The grandfather reported that later the mother said she was going to "check herself in some place" and the grandfather expressed concerns for her anger and mental well-being.

Multiple attempts were made by the caseworker to see the mother at her home. On November 28, 2023, the caseworker was finally able to meet with the mother in her home. The home had been cleaned up a bit more than the last contact but still had a very strong urine smell and she still had cats in her home even though she had agreed to find them homes elsewhere. The caseworker also facilitated a telephone conversation between the mother and the Project Safe Care (PSC)⁷ provider. The provider had previously notified the caseworker that the mother was not making herself available to meet. During that call a meeting was scheduled for the following week.

The caseworker received a call from the visitation supervisor. The visitation supervisor stated that the mother was not cooperative in setting up visitation with H.T. The caseworker went to the mother's home to discuss this but she did not answer the door. DCYF scheduled another FTDM for December 7, 2023. The mother, her parents, the PSC provider, and DCYF staff attended the meeting. The plan following the meeting included H.T. returning to [REDACTED] mother's care and that the mother would engage in Family Voluntary Services (FVS) and maintain working with PSC.

On December 8, the CPS caseworker contacted the mother's friend for a collateral resource. The friend shared concerns that the mother did not provide care for H.T. when the child was crying and would often leave [REDACTED] unattended or with different men that the mother called roommates. The friend also shared that the mother was posting on social media that she was seven weeks pregnant and that three weeks ago the mother was

⁶ For information about Voluntary Placement Agreements, see: <https://www.dcyf.wa.gov/4300-case-planning/4307-voluntary-placement-agreement>.

⁷ For information about Plan of Safe Care, see: <https://dcyf.wa.gov/policies-and-procedures/1135-infant-safety-education-and-intervention>.

drinking heavily and using cocaine after breaking up with her boyfriend. She said she had photos of the cocaine use in the mother's home. The friend also shared that she felt the home conditions were disgusting.

The same day the FVS caseworker went to the mother's home. The caseworker documented that the home had a "foul odor of cat urine," was messy with trash on the floor, and the kitchen sink was overflowing with dirty dishes. There were litter boxes spilling over and cats running throughout the home. The mother told the FVS caseworker that she and H.T. would stay with her parents until the home was cleaned and safe to return.

On December 11, the FVS caseworker returned to the mother's home. Some progress had been made. H.T. was found standing in ^{RCW 74} crib. The kitchen still had a cat urine smell and there was also a strong odor of feces. The PSC provider met with the mother four days later. The provider reported back to the FVS caseworker her concerns about the home continuing to having a strong odor of cat urine and that the litter boxes were overflowing. The provider gave the mother information about the harm that could come to H.T., the mother, and unborn baby by continued exposure to this environment. The provider shared that she will be wearing an N95 mask and using gloves at future meetings.

At the next contact on December 18, the FVS caseworker observed the home to have a significant odor of cat urine throughout the home. The floors had spilled food and drinks and the kitchen sink was full of dirty dishes. H.T. was observed to be in ^{RCW 74} crib again. A couple days later the PSC provider notified the caseworker that the mother failed to make herself available for their scheduled visit. She said she could smell cat urine and feces from outside the door to the apartment.

On January 4, 2024, the caseworker went to the mother's home. The mother did not answer the door until the caseworker texted her. When the caseworker entered the home there was still a strong cat urine smell as well as a strong lemon odor from cleaning products. The floor and dishes had been cleaned. H.T. was once again in ^{RCW 74} crib, in ^{RCW 74} bedroom. The caseworker expressed concern that every time she is at the home H.T. is alone in ^{RCW 74} room in the crib. The mother said that H.T. kicked her in the stomach causing her to bleed and that she was fine being separated from ^{RCW 74.1}. The caseworker discussed that taking a break is fine but detailed her concerns with leaving H.T. alone, in a dark room, for extended periods without interaction.

The PSC provider met with the mother the following day. The provider said the odor was better and that she did not need to wear a mask. Another FTDM was held on January 10, and the same participants were present as were at the last meeting.

On January 18, 2024, a second SCC was held. The recommendation was to continue FVS and PSC and reassess in 30 days. On January 29, the FVS caseworker called H.T.'s father. He denied having ^{RCW 74.13.515}. The caseworker asked for him to send a copy of his ID to verify that she had the incorrect person and he agreed. He did not follow through. The FVS caseworker then contacted the maternal grandmother. She shared that the mother married H.T.'s legal father before the birth but he was not the biological father. The grandmother shared the name she had heard was the biological father. They also discussed how the mother was doing.

During a home visit on February 22, 2024, the caseworker asked the mother about the male that was at the home during a home visit. The mother stated that it was the legal father of H.T. The caseworker asked who the father of the unborn child was and the mother shared the name that the grandmother had previously shared as H.T.'s biological father. Then the mother said that the legal father was in the home but in the

bathroom. She texted him to join them and he did. The caseworker tried to discuss the previous contacts with him but he denied engaging in those contacts. The caseworker then spoke with the mother about her ongoing positive urine tests. Her tests have all been positive for cannabis. The mother said she consumes THC gummies to help with morning sickness and that her doctor is aware.

Between February 22 and March 26, the FVS caseworker had multiple contacts with the PSC provider and other collateral contacts. The PSC provider expressed some concern that the mother was again leaving H.T. alone in ^{RCW 74} crib and struggled learning how to play and interact with H.T. The mother also was not cooperating with a referral to Parent-Child Assistance Program (PCAP)⁸.

On March 27, the caseworker met with the mother again at her home. The caseworker documented that the home was free of odors and was fairly clean. The caseworker went out again two days later. This was an unannounced home visit. H.T. was in ^{RCW 74} crib with a bottle. They discussed needing to get H.T. off of the bottle. The caseworker told the mother that DCYF was abiding by her request to close the case. The case closed on April 4, 2024.

On June 7, 2024, information was received that resulted in a CPS investigation. Allegations of ^{RCW 74.13.515} assault to ^{RCW 74.13.515} by the father of the unborn baby were reported ^{RCW 74.13.515}. This occurred September 2023 and H.T. was in the home.

DCYF after hours staff went out that same evening but no one answered the door. They called the mother's telephone number. They received a response stating that they were busy but could text. When the caseworker responded about the investigation the person stopped responding. After hours staff went out again the following day. No one answered the door. The mother responded to a telephone call by stating she will not meet with any DCYF workers.

On June 10, two CPS caseworkers went to the mother's home. The caseworkers knocked multiple times and eventually the mother answered the door. The father of the unborn child (C.T.) who is also the alleged ^{RCW 74.13.515} offender in the investigation, was in the apartment along with the mother and H.T. The mother told the caseworkers that they could not be in her home. She took H.T. outside to conduct the initial face-to-face. When told of the allegations the mother said that the incident happened a long time ago and she has forgiven him. She also shared that their relationship dynamic has changed and they are going to church and not allowing sin into their relationship. She also made the statement, "Nobody took it seriously so I decided to forgive him."

The assigned CPS caseworker called the maternal grandfather. He said that H.T. spends every other week with the grandparents and they did not have any concerns for ^{RCW 74} well-being. The caseworker also reached out to the local law enforcement jurisdiction to see if there were any reports filed regarding the incident. This incident had not been reported. On June 26, the mother and maternal grandfather met with the caseworker at the DCYF office. They once again discussed the ^{RCW 74.13.515} assault. The grandfather shared that he has seen both

⁸ Parent-Child Assistance Program is an evidence based, voluntary program provided through the University of Washington for pregnant and parenting mothers who experience substance use disorders. For more information see: <https://pcap.psychiatry.uw.edu/>. Site last accessed on April 2, 2025.

parents make progress and that he is proud of his daughter. The mother then consented to a walk through of her home. The caseworker observed the home to be clean and safe.

On July 17, the caseworker called the referral source. She left a voice mail message. On July 25, the caseworker called to speak with C.T.'s father to discuss the case as well as the legal father to H.T. Neither answered the calls and the caseworker left voice mail messages. The mother gave birth to C.T. in July.

On August 5, the caseworker again called C.T.'s father and left a voice mail message. She also texted the mother to set up another home visit. The mother did not respond. The caseworker then called the pediatricians office. They did not have any concerns for H.T.'s well-being. The caseworker also called H.T.'s legal father's mother. She reported that her son is not the biological father to the child but he signed the birth certificate because they were married at the time of H.T.'s birth. He does not have any visitation with H.T. The caseworker subsequently spoke with the legal father. He provided the same information as his mother. Finally, the caseworker spoke with a community service provider who confirmed that the mother was participating in parenting classes.

After two more failed attempts to schedule a home visit with the mother, the caseworker called the maternal grandfather for assistance. He called his daughter then told the caseworker to call her. The mother did not answer the call. The caseworker then spoke with the grandfather again. He reported concerns that his daughter is sleeping excessively and the home is becoming dirty. The grandparents reported seeing H.T. on the weekends and have not seen any signs of neglect or abuse to RCW 74. physically. The caseworker made multiple attempts again to see the mother and the home but the mother never answered the door and did not respond to text messages or telephone calls. On September 11, 2024, the caseworker again went to the home. She knocked on the door multiple times and then called C.T.'s father. He stated they were not home. The caseworker then called the grandfather. He said his daughter is upset with them because the grandparents are trying to hold her accountable. He said he did not believe that H.T. was in immediate danger but that the parents are often away and are not regularly parenting H.T.

After further attempts to see H.T., RCW 74. mother and the home, the caseworker was able to enter the home on September 18, 2024. The caseworker was able to observe the newborn C.T. and RCW 74.13.515 H.T. The caseworker discussed and observed safe sleep⁹ as well as discussed the Period of Purple Crying¹⁰. The home was cluttered and there was an odor but no obvious safety threats. The caseworker offered the mother voluntary services to assist in getting the home cleaned and organization. The mother did not want any assistance other than with diapers. On September 19, 2024, the case closed.

On January 13, 2025, a new intake was received and resulted in a FAR assignment. The maternal grandparents reported concerns for RCW 74.13.515 The mother left both children in their care for three weeks. Three weeks prior, the grandfather found the apartment to be filthy and unsafe. The grandparents will not return the children until the home is clean and safe. The mother was sleeping and not caring for the children. The

⁹ For information about DCYF policy related to safe sleep, see: <https://dcyf.wa.gov/policies-and-procedures/1135-infant-safety-education-and-intervention>.

¹⁰ Period of Purple Crying® for information see: <https://dontshake.org/purple-crying>, last accessed April 4, 2025.

grandparents said they are struggling because of their own employment needs and they do not have child care for the children.

On January 14, the assigned FAR caseworker called the mother. She said she could not meet with the caseworker because she was sick. The mother gave permission for the caseworker to see the children while they were with the maternal grandparents. The caseworker called and spoke with the grandmother. She confirmed the reported information and they arranged for a visit the following day. The grandmother said that they were going to pay to have the mother's home professionally cleaned. The caseworker met with the grandparents and children the following day at McDonalds. The caseworker also assisted the grandparents with finding child care. On January 17, the caseworker called the mother to arrange a home visit. The mother said he could not come over that day and they set an appointment for five days later. When the caseworker arrived five days later, the mother did not answer the door. The caseworker called the mother. She answered the call and sounded very tired. She said she forgot about the appointment. She said she stubbed her toe and was in too much pain. She refused to allow the caseworker into the home. She agreed to allow the caseworker to come back on January 23, two days later.

On January 23, the caseworker was able to see both children and the mother in their home. The caseworker brought gift cards for the mother so she could obtain cleaning supplies and formula. They also discussed child care. The home was observed to be cluttered but no safety threats were observed. The caseworker attempted another home visit on January 28 but the mother did not answer the door. Later that day DCYF received information that resulted in a screened out intake. The daycare provider called DCYF and reported the H.T. had a large red mark on ^{RCW 74.} forehead. H.T. told the provider that ^{RCW 74.} was standing behind a bathroom door at church, it opened and hit ^{RCW 74.13}. The mother confirmed the story.

The caseworker attempted an unannounced home visit seven days later. No one answered the door. The mother's car was parked outside of the apartment. On February 6, the caseworker called the maternal grandfather. He said that the mother's apartment was dirty again and he was concerned. The grandfather was frustrated that the caseworker did not observe the home in the same condition that the grandfather knew it to be in and that **RCW 74.13.515** remained in the home in conditions he deemed to be unsafe. The caseworker attempted another unannounced home visit the following day and on February 12. The mother did not answer the door but her car was again parked outside. On February 12 the caseworker also called the mother and stated he needed her to return his call as soon as possible.

On February 25, 2025, DCYF was notified that the children were found alone in deplorable conditions. C.T. was found deceased and H.T. was found near death. This resulted in a CPS investigation and law enforcement investigation. The ^{RCW 74.13.5} mother was arrested and charged for crimes related to this investigation.

Committee Discussion

The Committee appreciated the information shared by the area administrator regarding a practice change since this critical incident. The practice change is that the office now will restaff a case when a parent requests case closure with FVS prior to completion of services. This staffing will include the previous CPS staff. This case specifically had that issue when the mother wanted to close her case prior to completing Project Safe Care and when there were identified parenting deficits (inability by the mother to read cues and large gaps in her understanding about basic nutrition/feeding).

The Committee appreciated that the staff leaned into the mother's natural supports, the maternal grandparents, and continued efforts to offer services even though mom did not avail herself of them. They also identified utilizing the regional medical consultant regarding the children's exposure to animal urine and conducting a SCC were positive aspects of the case.

The Committee identified that more collateral contacts may have been helpful. The Committee identified that the conditions of the mother's home was possibly a symptom of a larger issue and that the cause of the issue needed to be addressed. They were also concerned that the mother did not seem to comprehend the education provided by the PSC provider and that the mother was unable to make lasting changes even after her parents paid for professional cleaning services.

Some of the DCYF staff identified that the mother likely had more deep-seeded issues that were possibly mental health related. There is information in Famlink that identified the mother had been diagnosed ^{RCW 74.13.520} **RCW 74.13.515** However, the grandparents told DCYF staff that the mother did not have any diagnosis. The Committee identified that it is difficult for DCYF staff to read all of the historical information about a case including a parent's history as a child when we have so many competing priorities. Medical records were not requested after the FVS case, or in subsequent open cases. Prenatal records and birth records were not obtained for either pregnancy or child.

The Committee discussed that further work towards assessing and addressing mental health needs and substance use issues would more than likely have required legal intervention due to the mother's stated desires to not continue working with DCYF. The Committee did not identify that the circumstances identified an imminent danger to the children and therefore would not meet the legal threshold for legal intervention.

The Committee did discuss that during the 2025 investigation prior to the critical incident a LE welfare check or reaching out to the daycare may have been helpful especially since the grandfather strongly expressed concern and that the grandparents were the only known support for the mother.

The Committee discussed that DCYF staff are not, and should not be, expected to be medical experts. DCYF staff must rely on our collateral contacts and medical consultants. One Committee member, with medical expertise, mapped the children's growth on growth charts. She identified that the children were below 5% and believes that this should have been identified as a significant concern and shared with DCYF. The Committee also discussed that the DCYF appropriately so, relied on the assessment by the pediatrician of the children's care. Another Committee member also shared that DCYF headquarters is creating a training regarding stages and ages of development and that a large focus is also on malnutrition.

The Committee acknowledged challenges DCYF staff face when community partners do not share information. Specifically identified for this case, the mother's criminal case involving animal cruelty, the grandmother not sharing during the case in January 2025 that her daughter had been in the hospital and needed help, or that the daycare did not notify the caseworker when the children's mom stopped bringing ^{RCW 74.13.515}

Committee members discussed how vital clinical supervision is in casework especially when DCYF staff are new or new to their positions. The FVS caseworker was new to FVS and this was her first case. The CPS caseworker in 2025 only started carrying cases 5 months prior. And the CPS supervisor in 2025 was new to supervision. There had also been a change in area administrators from when the case originally opened and

the critical incident. Staffing changes are challenging and adds an extra layer of need for critical thinking and shared decision making. The Committee appreciated that the office utilized shared decision-making opportunities during this case.