CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

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Full Report

Child

- D.G.

Date of Child's Birth

- February 2008

Date of Fatality

- February 2025

Child Fatality Review Date

- February 23, 2026

Committee Members

- Carissa Stone, MSW, LICSW-A, Therapist, Calming Stones PLLC
- Caesy Morphis, MSW, LICSWA, District School Social Worker, Central Valley School District
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- Ryann Charvat, MSW, Child Welfare Safety Program Manager, Department of Children, Youth, and Families
- Melissa Wood, MS, BCBA, Adults with Disabilities Program Manager, Department of Children, Youth, and Families

Facilitator

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

Executive Summary

On February 23, 2026, the Department of Children, Youth, and Families (DCYF) conducted a Child Fatality Review (CFR)[1] to examine DCYF's practice and service delivery to D.G. and D.G.'s family. D.G. will be referenced by initials throughout this report[2].

D.G.'s death occurred on February 7, 2025, in Illinois. Both D.G.'s mother and stepfather were arrested related to D.G.'s death. D.G. was reportedly beaten and starved. DCYF's Critical Incident Review unit was notified of this death late December 2025. Due to having had an open DCYF child welfare case within the 12 months preceding D.G.'s death, DCYF initiated a child fatality review.

At the time of D.G.'s death, the mother, D.G., and the stepfather were living in Illinois. They moved from Washington state to Illinois in November 2024. While living in Washington, DCYF received information that resulted in 19 intakes. Of the 19 intakes five were assigned for a Child Protective Services (CPS) investigation or Family Assessment Response (FAR) intervention. FAR intakes are an alternative response to CPS investigations. The allegations in FAR intakes are lower risk than those in CPS investigations.

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 D.G. or 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 the area administrator (AA) for the DCYF child welfare office who handled the cases in 2023 and 2024.

Case Overview

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

Between 2009 and 2022, DCYF received information alleging unsanitary living conditions, verbal abuse, truancy, untreated parental mental health needs, parental substance use, domestic violence, lack of supervision (leaving the children alone for days at a time), not providing adequate food, and exposure to a registered sex offender (D.G.'s stepfather). D.G was 18 months old, and the sibling was five years old when DCYF received the first intake. Both D.G. and the sibling were reported to be diagnosed with autism. D.G.'s mother was compliant with DCYF contact prior to her relationship with D.G.'s stepfather.

On February 24, 2023, DCYF received information that D.G. was scared to go home from school. The referral source reported concerns by D.G. that the stepfather doesn't allow D.G. to leave the bedroom other than to

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

use the restroom and that D.G. is not allowed to interact regularly with the mother and stepfather. It was reported that the stepfather stated that D.G.'s mother hates D.G. and D.G. believes that statement. D.G. also stated that the mother does not intervene when the stepfather is saying mean things. D.G. reported that the parents smoke cannabis and when the stepfather is "high" he is less angry. The referral source also reported that D.G. is not allowed to shower more than once a week and D.G. asked to brush D.G.'s teeth at school because D.G. was not allowed to use the bathroom at home. D.G. also previously told school staff that the stepfather made D.G. leave the home as much as an hour and half before the school bus arrives.

The school previously called the mother to discuss the showering concerns. The stepfather took the phone from the mother. He told the school personnel that D.G. is assigned certain days to shower, three days out of the week. The caller also made statements about withholding food to D.G. by the mother and stepfather. This information resulted in a FAR assignment.

The assigned FAR caseworker met with D.G.'s school counselor. The school counselor said that she contacted D.G.'s mother about food. The stepfather denied that they withheld food. He stated they were struggling financially and did not qualify for food assistance. The school created a plan that allowed D.G. to have a free school lunch by working as an aid in the cafeteria. D.G.'s mother and stepfather previously told the school that due to financial strain they restrict the number of showers per week. The counselor said that D.G.'s attendance had improved, D.G. had good grades, and was a "joy" in class. D.G. had an Individual Education Plan (IEP) due to the autism diagnosis.

The caseworker met with D.G. and the counselor. D.G. requested the counselor to stay during the interaction. D.G. appeared guarded at times and was concerned about the mother and stepfather knowing what was told to the caseworker. When asked about the mother, D.G. said she was the "best person ever" and didn't "deserve someone like me". When asked why D.G. believed that D.G. reported messing things up. When asked about the stepfather D.G. said he is "cool half the time." D.G. did not want to talk any longer after that statement.

The caseworker then went to the family's home. Both D.G.'s mother and stepfather were home. They denied forcing D.G. to eat meals in the bedroom. They acknowledged that D.G. struggled with discord and that recently they discussed their relationship and possibly separating which probably negatively impacted him.

They both admitted to daily cannabis use. They stated they smoke outside and never in D.G.'s presence. D.G.'s mother stated the cannabis is secured in a lock box in her bedroom.

They shared that D.G. is allowed to shower on Mondays, Wednesdays, and Fridays as well as one day on the weekend. This schedule is due to financial strain. D.G.'s stepfather denied making D.G. leave the home earlier than necessary, instead stated that it was D.G.'s decision to leave early.

During this contact, D.G.'s mother shared that D.G.'s father verbally and emotionally abused her and that she had sole custody of D.G. She also stated that D.G.'s father was not involved. She said she was employed full time and was an active military reservist between 2007 and 2015. She was diagnosed with PTSD and received counseling through Veterans Affairs. She said she used methamphetamines a couple times with a previous partner in 2017 but had not used methamphetamines since.

D.G.'s stepfather said he was unemployed, denied any mental health diagnosis, and denied any criminal charges in Washington state. He acknowledged he had to register as a level one sex offender but denied any restrictions. He said he started experimenting with substances at 11 years old and struggled with methamphetamine use. He said he became sober five years ago and had not had any relapses since. The caseworker shared local resources to help with food.

The caseworker requested law enforcement records from a local agency. After reviewing the response, the caseworker documented that there were no reports to local law enforcement beyond the prior CPS involvement. The caseworker submitted the case for closure. The supervisor approved the case closure the end of March 2023.

On June 2, 2023, DCYF received information regarding an interaction between D.G.'s school and the mother and stepfather. D.G.'s stepfather was aggressive and threatening to the school staff. The school had called D.G.'s mother because D.G. was crying, didn't want to go home, and missed the bus, so D.G. needed to be picked up. D.G. made statements about being scared to die, that D.G. didn't get a lot of water and that the stepfather doesn't like it when school staff give D.G. anything including water. D.G. was scared to be taken away by the mother and stepfather and not allowed to return to school. The school reported that earlier in the year D.G.'s stepfather, as punishment, shaved D.G.'s head. D.G. liked having long hair. This information was screened out.

On March 12, 2024, a school employee called DCYF to report that D.G. was taken out of school by the stepfather. D.G. had spoken about exploring gender identity and a student offered D.G. a razor for shaving. D.G. shaved D.G.'s legs at school. D.G. reported the next day at school that the parents called D.G. a "fag" and D.G. had run away from home. The school was required to notify the parents. When D.G.'s parents came to the school they took D.G. out of class and to the police station. Then they withdrew D.G. from school. This information resulted in a FAR assignment.

The next day the caseworker went to the family's home. The caseworker documented that when the door was opened, it smelled strongly of cigarettes and cannabis. The caseworker observed a water bong, vape pens, and cannabis on the living room table. The parents stated they usually keep the items locked away. The caseworker documented that the rest of the home appeared clean.

The caseworker interviewed D.G. D.G. did not want to discuss the gender exploration topic, reported being safe and when asked if D.G. could change anything about the parents, D.G. wanted to change the stepfather's bad temper. The caseworker then spoke with D.G.'s mother and stepfather. D.G.'s stepfather stated they removed D.G. from school because the school was promoting gender exploration. He said they were going to move to Illinois, where they have familial support and more conversative values. D.G.'s mother also said that D.G.'s now adult sibling identifies as transgender which upset her.

On March 15, 2024, a relative called DCYF to report that D.G.'s mother and stepfather came to their home and accused them of kidnapping D.G. They said that the parents had previously accused them of kidnapping D.G.'s sibling as well. The relative said that D.G.'s mother lost her job, they were about to lose their home, they did not allow D.G. to leave the bedroom, and they would not allow D.G. to have contact with the sibling. The caller also expressed concerns that D.G. appeared "boney" and was not being fed properly. The relative expressed

concern that the stepfather was controlling and would not allow D.G.'s mother to have contact with anyone, friend or family, and he must always be with her. This information was screened out.

The assigned caseworker contacted the family a week later to provide them with a store voucher. The case note did not document a discussion about the screened-out intake but did state the parents appeared well groomed and the home was clean with no odor.

The caseworker called the referral source from the March 12 intake and spoke with D.G.'s father. D.G.'s father said he had not had contact with either of his children in over 15 years. He was concerned that D.G. was not in school but stated that D.G.'s mother was in charge of decision making. D.G.'s teacher expressed concerns that D.G.'s mother and stepfather did not show for the IEP meeting and that if D.G. did not return to school, it will interfere with D.G. becoming an independent adult. She also said that the parents have been offered resources within the school and community to support D.G. and the family. However, they become upset with the offers and D.G. gets in trouble for accepting any food offered by the school. D.G.'s teacher also reported that D.G. had asked the staff at school to use the name Lily.

The caseworker then attempted a home visit, but no one answered the door. There were no cars in the driveway and the home appeared vacant. The caseworker received a call from D.G.'s stepfather who stated they did miss the school meeting but plan on having D.G. get a GED. He also said they do not need anything from DCYF.

The caseworker called D.G.'s pediatrician's office. The office reported they had not seen D.G. since 2019. The caseworker then searched D.G.'s stepfather's history in Illinois. She found that he may have been out of compliance with his sex offender registration. The caseworker, after consultation with her supervisor, notified law enforcement. After speaking with law enforcement in Illinois the caseworker was told that because the stepfather was not living in Illinois, he was not tracked by law enforcement in that state. On May 1, 2024, the supervisor approved the case for closure.

DCYF received three intakes between September and November 2024, with concerns about D.G. not attending school, the stepfather being mean to D.G., that D.G. was on the run multiple times, and that the stepfather called the school to tell them to stop sending letters about lack of attendance. Information in an intake also indicated school records did not show that D.G. was withdrawn from the school, only that D.G. was not attending school. All three intakes were screened out.

On February 7, 2025, D.G. died as a result of physical abuse and malnutrition. Both D.G.'s mother and stepfather were arrested related to D.G.'s death. At the time of death, D.G. lived with the mother and stepfather in Illinois. DCYF has no information on when the family moved from Washington to Illinois.

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 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 the AA who supervises the office that interacted with this 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 believes that D.G. may have benefited from more comprehensive assessments during the interventions with DCYF. Specifically, more collateral contacts such as relatives, D.G.'s sibling, D.G.'s father, and requesting a medical evaluation related to the allegations involving withholding food. In prior contacts there were paternal relatives identified. D.G.'s father had not had contact with his children for an extended period of time. However, further inquiry regarding his prior relationship with the mother may have provided more insight into the family dynamics.

The Committee also identified further exploration into the response and support surrounding D.G.'s autism diagnosis. D.G.'s stepfather cut D.G.'s hair, took away soothing support items, and did not allow D.G. to pace, which D.G. reported was a soothing activity. They also discussed engaging subject matter experts within DCYF headquarters to assist with suggestions related to engaging with families where neurodivergent diagnosis exist. Considering extensions in timeframes due to identified disabilities was discussed.

The Committee also identified that further exploration of aspects related to domestic violence, control, and isolation may have been helpful for the family. D.G.'s stepfather exhibited controlling behaviors and was alleged to have isolated D.G.'s mother. Interviewing the mother away from the stepfather would be consistent with best practice. The Committee discussed that D.G.'s mother was more amendable to communication and interaction with DCYF in prior contacts before the stepfather joined the family.

The Committee appreciated hearing from the AA about the agency's response to reflective review of the case. That included more emphasis and training related to case closure and monthly clinical supervision between a caseworker and supervisor. The AA also shared that her office is working collaboratively with staff in the Integrated Health Services Unit. This is a unit in the Partnership, Prevention, and Services Division, within DCYF. These staff can provide case consultation and help identify resources to support staff who interact with families where there are malnutrition allegations, disabilities, and other medical conditions.

The Committee discussed that statewide there is a lack of community resources for youth identifying within the LGBTQ+ population, mental health services, and accessibility to services related to an autism diagnosis. All were areas that impacted this family.