

Office of the Family and Children's Ombuds

Child Fatalities and Near Fatalities in Washington State

A report on data and reviews

April 2016



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EXECUTIVE SUMMARY

The Office of the Family and Children’s Ombuds (OFCO) was established to ensure that government agencies respond appropriately to children in need of state protection, children residing in state care, and children and families under state supervision due to allegations or findings of child abuse or neglect. As part of its oversight of the state child welfare system, OFCO examines child fatalities, near fatalities and cases of recurrent child maltreatment, as well as the implementation status of the recommendations produced from executive reviews of child fatalities and near fatalities. Through this process, OFCO promotes public awareness about the child protection and welfare system, identifies issues related to these critical incidents, and facilitates broad-based systemic improvements.

OFCO CRITICAL INCIDENT REVIEWS

Section I of this report provides an account of OFCO’s critical incident review activities from January 1, 2014 through December 31, 2015. The critical incidents discussed include:

- **Child Fatalities:** When there is an open case on the family at the time of the fatality or any Children’s Administration (CA) history with the family within twelve months of the fatality, including “information only” referrals; or when the fatality occurred in a CA or Department of Early Learning (DEL) licensed, certified, or state operated facility.
- **Child Near Fatalities:** When the near fatality is a result of alleged child abuse and/or neglect on an open case or on a case with CA history within twelve months; or the near fatality occurred in a CA or DEL licensed, certified, or state-operated facility. A near fatality is defined as an act that, as certified by a physician, places the child in serious or critical condition.
- **Recurrent Maltreatment:** When children in the same family experience recurrent maltreatment— defined as three founded reports of alleged abuse or neglect within the last twelve-months.

OFCO conducts administrative reviews of all child fatalities and near fatalities both involving child abuse or neglect and cases unrelated to child maltreatment, of children, whose family had an open case with DSHS within one year prior to the incident. As described in this report, OFCO examined **114 child fatality cases** and **45 near fatality cases** between calendar year 2014 and 2015. Through these reviews OFCO identifies common factors and systemic issues regarding these critical incidents.

Key points discussed in this report include:

- The vast majority of child fatalities and near fatalities related to maltreatment involved children under the age of three years. Unsafe sleep practices continue to be a leading factor associated with infant deaths.
- Fatalities of Native American and African American children are disproportionately high relative to their representation in the state population.
- Major risk factors in these child fatalities include: **substance abuse** by and/or **mental health** problems of a caregiver; and/or a history of **domestic violence** in the family. Opioid use specifically has been increasing both nationally and across Washington in recent years. From 2012 to 2015, OFCO identified 32 maltreatment related child fatalities where a caregiver's opioid use was a known risk factor.

OFCO also conducted **225 reviews of cases of recurrent maltreatment**. As noted in previous reports, child neglect continues to constitute the largest number of the founded reports in recurrent maltreatment cases and is more likely to recur than physical or sexual abuse.

IMPLEMENTATION OF CHILD FATALITY AND NEAR FATALITY REVIEW RECOMMENDATIONS

State law requires CA to conduct a child fatality or near fatality review when the death or near-death of a child was suspected to be caused by child abuse or neglect, and the child was in the care of or receiving services from DSHS/CA at the time of death, or in the year prior. The purpose of reviewing these incidents is to increase the agency's understanding of the circumstances around the child's injury or death and to evaluate practice, programs, and systems to improve the health and safety of children.

Section II of this report describes the implementation status of recommendations made in child fatality and near fatality reviews conducted by CA between May 1, 2014 and July 31, 2015. During this time period, CA conducted reviews in the deaths of **18 children** and the near-deaths of **8 children**.

The 18 fatality reviews resulted in **49 recommendations**, while the 8 near-fatality reviews resulted in **13 recommendations**. Based on information provided by CA, OFCO found that **91.9 percent of the recommendations were either completely implemented or in the process of implementation**, and 4.8 percent were considered, but not implemented. The vast majority of recommendations addressed either statewide issues (51.6 percent) or local office concerns (43.6 percent), while a much lower number were tailored to remedy regional concerns (4.8 percent).

Recommendations made in child fatality and near fatality reviews have led to significant changes in state law, department policy, and child welfare practices at the local, regional, and state levels.

TERMS AND ACRONYMS

AAG	Assistant Attorney General
ACES	Automated Client Eligibility System
AIRS	Administrative Incident Reporting System
Alliance for Child Welfare Excellence	Partnership/entity providing child welfare training for CA staff, foster parents and other professionals
ARY	At Risk Youth
BRS	Behavioral Rehabilitation Services (a program within CA for children with high level service needs)
CA	Children’s Administration
CASA	Court Appointed Special Advocate
CATS	Children’s Administration Technology Services
CHINS	Child in Need of Services
CPS	Child Protective Services
CPT	Child Protection Team
CFWS or CWS	Child and Family Welfare Services or Child Welfare Services
DCFS	Division of Child and Family Services
DDA	Developmental Disabilities Administration
DEL	Department of Early Learning
Dependent Child	A child for whom the state is acting as the legal parent
DOH	Department of Health
DLR	Division of Licensed Resources
DSHS	Department of Social and Health Services
ECFR	Executive Child Fatality Review
ECNFR	Executive Child Near Fatality Review
FamLink	Statewide Automated Child Welfare Information System (CA’s electronic record-keeping system)
FAR	Family Assessment Response
FRS	Family Reconciliation Services
FVS	Family Voluntary Services
FTDM	Family Team Decision Meeting
ICPC	Interstate Compact for the Placement of Children
ICWA	Indian Child Welfare Act
LMS	Learning management system
Med-Con	Child Protection Medical Consultants, statewide physician consultation service available to CA for child abuse cases
NAS	Neonatal Abstinence Syndrome
NICU	Neonatal Intensive Care Unit
NFP	Nurse-Family Partnership®
OCIO	Office of the Chief Information Officer
OFCO	Office of the Family and Children’s Ombuds
OFM	Office of Financial Management
SDM	Structured Decision Making (an element of CA’s Safety Framework model for casework practice)
SIDS	Sudden Infant Death Syndrome
SUID	Sudden Unexpected Infant Death
VSA	Voluntary Service Agreement

SECTION I

OFCO CRITICAL INCIDENT REVIEWS

BACKGROUND

The department notifies OFCO when a critical incident, such as a child fatality or near fatality, occurs through the Children’s Administration’s Administrative Incident Reporting System (AIRS). OFCO then immediately begins an independent administrative review of the circumstances surrounding the incident and the department’s involvement. Critical incidents include:

- **Child Fatalities:** When there is an open case on the family at the time of death or any Children’s Administration (CA) history with the family within twelve months of the fatality, including “information only” referrals; or when the fatality occurred in a CA or Department of Early Learning (DEL) licensed, certified, or state operated facility.¹
- **Child Near Fatalities:**² When the near fatality is a result of alleged child abuse and/or neglect on an open case or on a case with CA history within twelve months; or the near fatality occurred in a CA or DEL licensed, certified, or state-operated facility. A near fatality is defined as an act that, as certified by a physician, places the child in serious or critical condition.³
- **Recurrent Maltreatment:**⁴ When children in the same family experience recurrent maltreatment — defined as three founded reports of alleged abuse or neglect within the last twelve-months.
- **Other Critical Incidents:** OFCO is regularly notified of other critical incidents including child abuse allegations in licensed foster homes or residential facilities, high-profile cases, incidents involving CA clients (such as dangerous behavior by foster youth), or incidents affecting CA staff safety. OFCO briefly reviews each of these cases to assess whether there is any unaddressed safety issue, and if so, may conduct a more thorough review.

This report discusses critical incidents occurring from January 1, 2014 – December 31, 2015. Over this two year period, OFCO conducted:

- **114** administrative reviews of child fatalities involving both child abuse or neglect and cases unrelated to child maltreatment;
- **45** administrative reviews of child near fatalities;
- **225** reviews of cases of recurrent maltreatment; and
- Approximately **4-8** brief reviews of other critical incidents per week.

¹ When a report does not meet the legal definition of child abuse or neglect intake staff documents this information as an “Information Only” intake in the CA database.

² RCW 74.13.640(2) requires the department to promptly notify the Ombuds in the event of a near fatality of a child who is in the care of or receiving services from the department or a supervising agency or who has been in the care of or received services from the department or a supervising agency within one year preceding the near fatality. The department may conduct a review of the near fatality at its discretion or at the Ombuds’ request.

³ RCW 74.13.500.

⁴ RCW 26.44.030(15).

In order to more accurately describe and contextualize specific issues such as fatalities caused by abuse or neglect, racial disproportionality, infant fatalities and opioid use, some sections of this report include data from 2012 – 2015.

OFCO’S ADMINISTRATIVE REVIEW PROCESS

OFCO maintains a database of child fatalities, near fatalities, and critical incidents that organizes relevant case information including: family and child-specific identifying information; current allegations of child abuse or neglect; prior involvement with child welfare agencies, the court, or criminal history; risk factors such as substance abuse or domestic violence; and information about the alleged perpetrator and the relationship to the child. OFCO also creates a chronology for each case describing significant events. Through this process, OFCO identifies common factors and potential systemic issues regarding these critical incidents, as well as areas of concern in specific cases.

OFCO treats each fatality, near fatality, and recurrent maltreatment notification as emergent in order to identify any safety issues regarding children remaining in the home. When conducting critical incident reviews, OFCO focuses on whether child maltreatment was a contributing factor, and whether there were any opportunities for the child welfare system to assist the family and protect the child prior to the incident. This allows OFCO to not only take any needed action to protect the children involved in the critical incident during the aftermath, but also provides an opportunity to conduct systemic investigations and issue recommendations as needed, to better protect our state’s most vulnerable population.

SUMMARY OF OFCO CRITICAL INCIDENT DATA

CHILD FATALITIES

- Between January 1, 2014 – December 31, 2015 OFCO examined 114 child fatality cases, both involving child abuse or neglect and cases unrelated to child maltreatment.
- Twenty six child fatalities (23 percent) were directly attributed to physical abuse or neglect and of these, twenty involved children under the age of three years.
- Fatalities of Native American and African American children are disproportionately high relative to their representation in the state population. Almost 11 percent of fatalities were those of Native American children, while they make up only 1.5 percent of Washington children.
- Unsafe sleep environment continues to be a leading risk factor associated with infant deaths.
- Other major risk factors in fatalities include: substance abuse by and/or mental health problems of a caregiver; and/or a history of domestic violence in the family.
- Opioid use has increased both nationally and across Washington in recent years. From 2012-2015, OFCO identified 32 maltreatment related child fatalities where a caregiver's opioid use was a known risk factor.

CHILD NEAR FATALITIES

- OFCO reviewed 45 near fatality cases from calendar year 2014 – 2015, which is consistent with the previous two year period (46 near fatalities reviewed in 2012 – 2013).
- Children involved in near fatal incidents are older than those involved in fatalities. Sixty-six percent of children involved in near fatalities are over the age of one year compared to only 34 percent of child fatalities.

RECURRENT MALTREATMENT

- OFCO received 225 notifications of recurrent maltreatment over the past two years, a seven percent decrease over the previous two year period.
- The vast majority of founded reports constituted child neglect (78 percent), which is more likely to recur than physical or sexual abuse.
- Caregiver substance abuse remains the most prevalent risk factor in these cases.
- CA has recently taken several steps to develop a multifaceted strategy for reducing repeat maltreatment.

CHILD FATALITIES EXAMINED BY OFCO

OFCO examines all fatalities in which the child's family had an open case with CA at the time, or any CA history within twelve months of the fatality, regardless of whether the subject child received services from the department, and regardless of whether the child's death was suspected to be caused by child abuse or neglect.⁵

OFCO examines these fatalities to:

- identify current safety issues for any children remaining in the home;
- determine whether the fatality appears to have resulted from abuse or neglect, thus requiring CA to conduct an executive child fatality review; or whether ongoing child maltreatment concerns in the child's family may have contributed to the fatality;
- identify any problematic casework practice or decisions by the agency, to ensure more effective protection of any other children in the family OR to improve agency services and case management in similar cases in the future; and
- assist policymakers in developing stronger policies to protect children.

Like OFCO, CA conducts a similar administrative review of all critical incidents and in some cases convenes an executive child fatality review committee.⁶ Because OFCO uses slightly broader criteria to determine whether further examination of a fatality is warranted, fatality data compiled by CA and OFCO may vary.

OFCO examined **48 child fatalities in 2014** and **66 in 2015**.⁷ With the exception of 2008, child fatalities meeting OFCO's criteria for further examination have held relatively constant since 2007, as shown in Figure 1. Not all fatalities OFCO receives notice of are related to maltreatment. For example, OFCO may receive notice of an expected medical death of a child whose family has had contact with the department in the past twelve months.

Maltreatment related fatalities, on the other hand, are those in which:

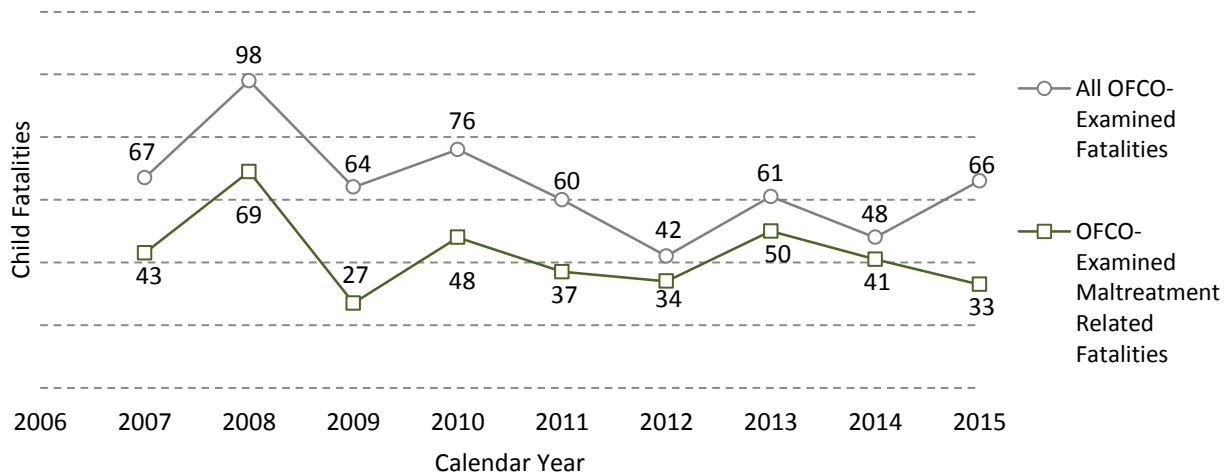
- the child's death was directly caused by abuse or neglect; or
- the child's death was not a direct result of maltreatment, but the family has a history of abuse or neglect of that child and/or other children in the family that may have contributed to the child's death.

⁵ "CA history" may include reports to CPS that were not screened in for investigation.

⁶ State law requires DSHS to conduct an executive child fatality review when the child's death is suspected to be caused by child abuse or neglect, and the child was either in the department's custody or receiving services in the 12 months before the death.

⁷ Calendar year

Figure 1: **OFCO-Examined Fatalities by Year**
by Calendar Year (January 1st – December 31st)



Child Mortality in Washington

Fatalities of children whose families have had contact with CA within twelve months of death make up a small proportion of child fatalities in any given year. Of these fatalities, those that are maltreatment related make up an even smaller proportion. The number of children in Washington from birth to 17 years who died each year is shown below.

Child Fatalities in
Washington (ages 0-17)

2007	2008	2009	2010	2011	2012	2013	2014
700	777	701	655	624	713	614	625

Source: *Death Data*. Washington State Department of Health. Death Tables By Topic – Age by Sex for Residents:
<http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsandPopulationData/Death/DeathTablesbyTopic>

In order to identify any possible patterns or trends, OFCO presents data on maltreatment related fatalities covering the last **four years**.⁸ From January 1, 2012 to December 31, 2015, OFCO examined the deaths of 217 children, 59 of which were not maltreatment related. The following data describes the profile of the remaining **158 maltreatment related child fatalities examined by OFCO** during this four-year period.

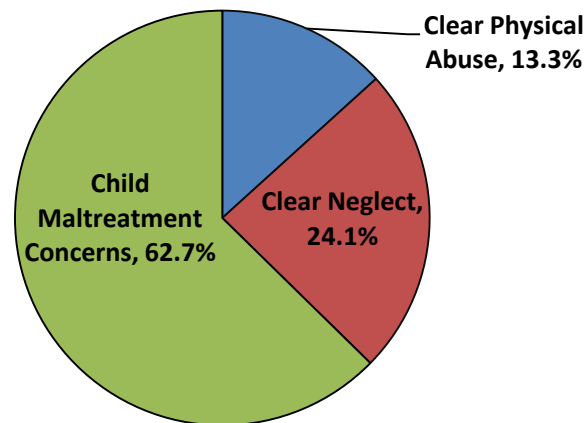
⁸ Data for each calendar year is presented in Appendix A

MALTREATMENT RELATED CHILD FATALITIES

Of the 217 child fatalities reviewed by OFCO from 2012 to 2015, **158 were found to be either directly caused by child abuse or neglect, or cases in which abuse or neglect concerns *may have contributed to the fatality.***⁹ Almost a quarter of the children (38, or 24.1 percent) died as a direct result of neglect and 21 children (13.3 percent) died from physical abuse.¹⁰ OFCO found that child abuse or neglect concerns were present and may have contributed to the child’s death in the remaining 99 cases.

Figure 2: **Maltreatment Related Child Fatalities, 2012 – 2015**

(n = 158)



CHILD MALTREATMENT DEFINITIONS

Clear Physical Abuse: A CPS investigation concluded that circumstances of the child’s death clearly indicated physical abuse by a caretaker caused the child’s death. Law enforcement reports, medical records, and/or an autopsy report may also have concluded that intentionally inflicted physical injuries caused the child’s death.

Clear Neglect: A CPS investigation concluded that circumstances of the child’s death clearly indicated that neglect by a caregiver (e.g. an infant or toddler left unattended) caused the child’s death. Law enforcement reports, medical records, and/or an autopsy report may also have concluded that negligent treatment/maltreatment caused the child’s death.

Child Maltreatment Concerns: Factors associated with child abuse or neglect were present in the family’s history and while not a direct cause, may have contributed to the child’s death. These factors include: substance abuse; domestic violence in the presence of children; mental health issues that impair a parent’s ability to appropriately care for a child; and prior substantiated abuse or neglect of the deceased child or of other children in the family.

⁹ The investigation and manner of death for one fatality which occurred in 2015 was pending at time of writing. This fatality is not included in the number of OFCO examined fatalities.

¹⁰ In many cases of clear neglect or physical abuse, the child’s death caused a CPS report to be made, and the CPS investigation resulted in a founded finding for neglect or physical abuse. OFCO data indicates that 50 of the 158 deaths examined during this period resulted in a “founded” finding for maltreatment while 57 investigations concluded as “unfounded” for either abuse or neglect.

FATALITY CASE EXAMPLES BY MALTREATMENT TYPE

Example 1: CLEAR PHYSICAL ABUSE

A 5-month old child was killed as a result of physical injuries inflicted by the mother. The child was taken to the emergency room for difficulty breathing and died shortly thereafter. While the child had no observable injuries at the time of death, the autopsy showed injuries consistent with Abusive Head Trauma (previously known as Shaken Baby Syndrome).

Two prior CPS reports were made by a relative one month before the fatal incident, alleging the mother leaves her children with relatives or strangers and does not return for days at a time. One report screened in for investigation. Relatives told the CPS caseworker that they had concerns about the mother but felt that the extended family members were able to assure the children's safety. The investigator provided the family with information regarding community resources including how to obtain third party custody of the children.

The CPS investigation into the fatality resulted in a founded finding of physical abuse by the mother.

Example 2: CLEAR NEGLIGENCE

A four-month old infant was found unconscious and unresponsive on the bedroom floor. The parents said they placed the baby on an adult bed and did not check on the child for approximately eleven hours. The death investigation revealed that the child rolled off the bed and suffocated on a plastic bag. The family's case had been open with CPS for Family Voluntary Services in the months prior to the infant's death and was pending closure when the infant died.

The mother had two older children and the family's history included four reports to CPS alleging neglect of these children, which did not meet standards requiring an investigation. A CPS report made by hospital staff at the time of the infant's birth was accepted for investigation. During the investigation, the investigator provided the parents with information about infant safe sleep and offered in-home services which the parents declined.

The CPS investigation conducted into the fatality incident resulted in a founded finding of neglect against both parents. The father was criminally charged and convicted.

Example 3: CHILD MALTREATMENT CONCERNS

A one-month-old infant died of suspected Sudden Unexpected Infant Death after the mother and child fell asleep together on the couch. An older sibling (a toddler) had fallen asleep in a high chair nearby and was still there when the mother awoke five hours later. CPS received several reports on the family concerning lack of prenatal care, chemical dependency of the parents, domestic violence, and suspected physical abuse and neglect of the toddler. The family was intermittently engaged in various services through CPS for the previous two years. The infant was born with neonatal abstinence syndrome, due to prenatal exposure to illegal or prescription drugs. One prior CPS investigation resulted in a founded finding of physical abuse of the older sibling.

MANNER OF DEATH

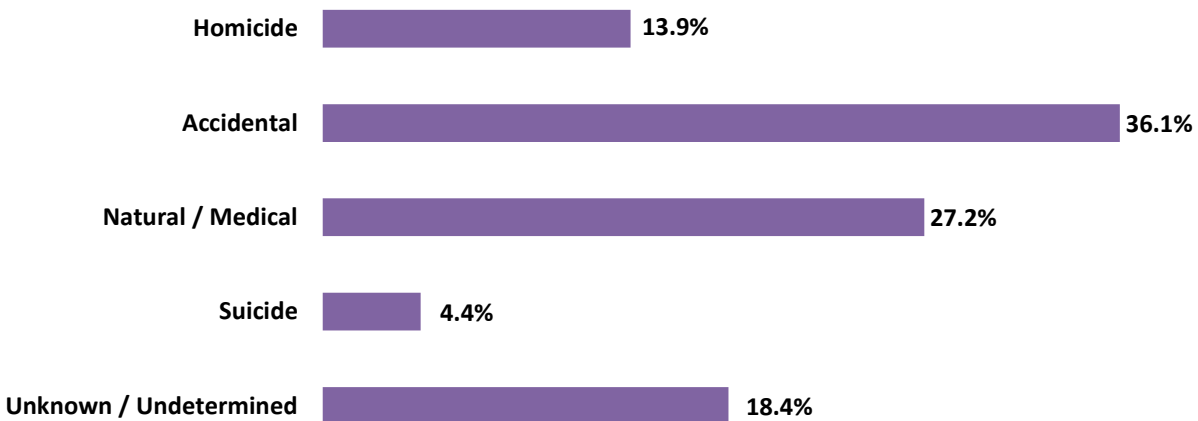
The manner and cause of death is determined by a medical examiner or coroner. The manner of death describes the context or circumstances of the death and is assigned to **one of five categories**:

1. natural or medical;
2. accidental;
3. homicide;
4. suicide; or
5. unknown or undetermined.

The cause of death details how the death occurred. For example, the manner of death is determined as natural / medical when the cause of death is pneumonia, or the manner of death is determined as accidental when the cause of death is a drug overdose. Based on the scene investigation and other factors, a death caused by drug overdose could also be determined to be suicide.

Figure 3: **Manner of Death, 2012 – 2015**

(n = 158)



Sudden Unexpected Infant Death (SUID) is a broad category of infant death (birth to 12 months) that includes Sudden Infant Death Syndrome (SIDS) as well as deaths due to accidental suffocation and other infant deaths of unknown cause.¹¹ SIDS is generally considered a subset of natural or medical death. If significant risk factors were present during the scene investigation however, such as an unsafe sleep environment like co-sleeping or inappropriate bedding, then the manner of death might be classified as accidental or unknown / undetermined.

¹¹ Health of Washington State: Infant Mortality. Washington State Department of Health; 2013. <http://www.doh.wa.gov/Portals/1/Documents/5500/MCH-IM2013.pdf>

CHILD FATALITIES AND RACIAL DISPROPORTIONALITY

Racial disparities exist across all child fatalities in Washington. American Indian and Alaska Native infants, for example, have an infant mortality rate in Washington twice that of Asian and Caucasian infants. Overall infant mortality for Native American children has actually *increased* in recent years. African American infants also have higher mortality rates in Washington compared to Asians and Caucasians.¹²

As in previous years, maltreatment related child fatalities continue to be disproportionately high for Native American and African American children. For example, while Native American children make up 1.6 percent of the children in Washington State, **10.8 percent of maltreatment related child fatalities examined by OFCO were those of Native American children.** Similarly, African American children make up 4.1 percent of the state’s child population, yet represent **8.9 percent of fatalities** examined by OFCO. It is encouraging to note, however, that the number of maltreatment related fatalities of Native American children examined by OFCO dropped sharply, from 23 percent in 2010-13 to 10.8 percent in the current reporting period. National data also shows significant disparity between maltreatment related fatalities of white children and children of color. For example, although African American children are approximately 16 percent of the child population nationally, they make up 30 percent of the child abuse and neglect fatalities nationwide.¹³

Table 1: Race and Ethnicity in Maltreatment Related Child Fatalities, 2012 – 2015

(n = 158)

	OFCO Examined Child Fatalities		WA Children in Out of Home Care*	WA State Children**
	#	%		
Caucasian	90	57.0%	66.9%	71.0%
African American	14	8.9%	9.0%	4.1%
Native American	17	10.8%	6.2%	1.6%
Asian or Pacific Islander	7	4.4%	1.5%	7.4%
Other	7	4.4%	0.1%	6.1%
Multi-Racial	23	14.6%	15.2%	9.8%
Latino / Hispanic	14	8.9%	18.5%	19.4%
Non-Hispanic	144	91.1%	81.5%	80.6%

*Data reported by Partners for Our Children (partnersforourchildren.org, 2015)

**U.S. Census Bureau, 2009-2013 American Community Survey 5-Year Estimates

¹² Health of Washington State: Infant Mortality. Washington State Department of Health. 2013
<http://www.doh.wa.gov/Portals/1/Documents/5500/MCH-IM2013.pdf>

¹³ Within our Reach: A National Strategy to Eliminate Child Abuse and Neglect Fatalities, 2016 (page 61).
<http://eliminatechildabusefatalities.sites.usa.gov/files/2016/03/CECANF-final-report.pdf>

Washington State Disproportionality Advisory Committee

Racial disproportionality is defined as the overrepresentation of children of color in the child welfare system compared to their numbers in the general population.

In January 2015, The Washington State Disproportionality Advisory Committee issued its sixth annual update to the Legislature regarding “the efforts of DSHS to remediate racial disproportionality in the Washington state child welfare system.”¹⁴ This report summarizes the steady progress regarding eight major recommendations made by the committee to reduce disparate outcomes for children of color in the child welfare system. CA has several metrics used to measure changes in racial disproportionality, including rate of disproportionality in CPS intakes and placement stability.

*While the advisory committee tracks data on children of color at various points in the child welfare system, such as intake, investigation, and placement, it has not studied fatalities related to child maltreatment. OFCO suggests that this committee also develop recommendations to reduce racial disproportionality in maltreatment related child fatalities.*¹⁵

The full report can be found at:

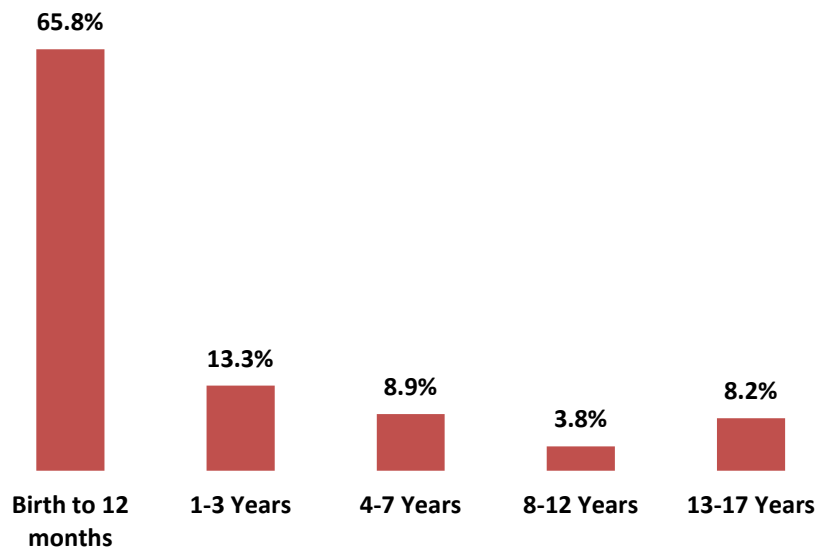
<https://www.dshs.wa.gov/sites/default/files/CA/acw/documents/LegRacialDispro01-2015.pdf>

¹⁵ Id. Chapter four of this report discusses strategies to reduce disproportionality in child maltreatment-related fatalities.

CHILD’S AGE AT TIME OF DEATH

As in previous years, an overwhelming majority of maltreatment related fatalities (79 percent) examined by OFCO involved children under the age of three. Infants (birth to twelve months) accounted for 65.8 percent of the fatalities.

Figure 4: Age of Child at Time of Death, 2012 – 2015
(n = 158)



Trends in the manner of children’s deaths differ by age. Table 2 displays the leading manners of death in maltreatment related fatalities for each age group. Infants make up the largest portion of the OFCO-examined child fatalities, but by looking at the manners of death for different age ranges, OFCO can think critically about the needs of and risks facing older children. For example, while deaths by suicide make up only 4.4 percent of all OFCO examined fatalities, they are the leading manner of death for teenagers (54 percent of children ages 13-17).

Table 2: Leading Manners of Death by Age Group, 2012-2015
(n = 158)

Age	Leading Manner of Death in Maltreatment-Related Fatalities	Examples
Less than 12 months	Accidental (38.5%)	suffocation or asphyxiation in unsafe sleep environment
1-3 years	Accidental (38.1%)	head injury from fall
	Homicide (38.1%)	physical injury inflicted by caregiver
4-7 years	Natural/Medical (35.7%)	medical condition
	Homicide (35.7%)	physical injury inflicted by caregiver
8-12 years	Accidental (50%)	automobile accident
	Natural/Medical (50%)	medical condition
13-17 years	Suicide (54%)	death by suicide

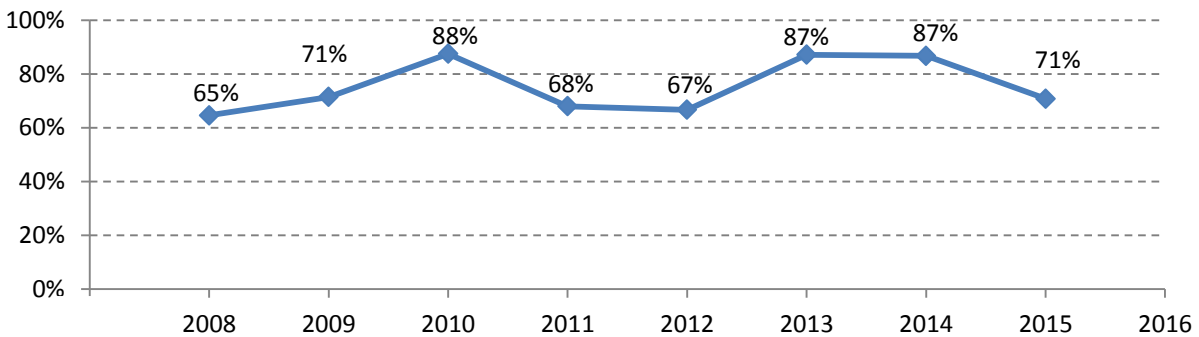
INFANT SAFE SLEEP ENVIRONMENT

An unsafe sleep environment continues to be a factor in the vast majority of infant fatalities. Unsafe sleep practices include:

- adults, older children, or pets sleeping with an infant;
- putting an infant to sleep on an adult bed, couch, sofa bed, or other soft surface not designed for an infant; and
- the presence of soft items such as pillows, blankets, or stuffed animals in the infant’s crib.

The average age of infants whose deaths were related to an unsafe sleep environment between 2012 and 2015 was birth to four months. Over 86 percent of infant fatalities (26 deaths) examined by OFCO in 2014 involved unsafe sleep practices. Eighteen of these deaths involved a parent or another adult co-sleeping with the child. In 2015, **71 percent of infant deaths examined by OFCO involved unsafe sleep practices**. While the decrease from 2014 to 2015 is encouraging, these deaths were still higher than in 2011 and 2012. Strong efforts to educate the public about safe sleep environments must be continued in order to prevent child deaths involving unsafe sleep practices.

Figure 5: **Unsafe Sleep Environment in OFCO-Examined Infant Fatalities**
by Calendar Year (January 1st – December 31st)



The following examples typify fatalities in which the infant’s sleep environment may have been a contributing factor.

FATALITIES INVOLVING UNSAFE SLEEP

A one-month-old infant died while sleeping between the mother and the mother’s partner in an adult bed. The family was receiving CPS Family Voluntary Services after the mother and infant tested positive for methamphetamine at the child’s birth. The family’s service plan included a chemical dependency evaluation for the mother, and during this time her drug tests were negative. The medical examiner determined the cause of death to be SIDS.

A five-month-old infant died while sleeping on the floor with older siblings. The Medical Examiner’s report indicated the most likely scenario was that an older sibling accidentally suffocated the infant while sleeping. The family was experiencing homelessness and had recently left a shelter to stay in the home of friends. The family had eight prior reports to CPS, most of which were related to parental substance abuse and chronic neglect.

A one-month old infant died while sleeping in a baby swing. The family had an open CPS investigation at the time of the child’s death. The mother was a minor and had recently run away from home with the infant, resulting in the filing of an At-Risk Youth petition in order to obtain court-ordered services for the mother.¹⁶ A CPS report alleging that the mother was co-sleeping with the baby had been screened in for assessment and possible services, prior to the infant’s death.

¹⁶ An at-risk youth is defined as a child under the age of 18 who meets at least one of the following three requirements: (1) is absent from home for at least 72 consecutive hours without parental consent; or (2) is beyond parental control such that his/her behavior endangers the health, safety, or welfare of the child or any other person; or (3) has a substance abuse problem for which there are no pending criminal charges relating to the substance abuse. RCW 13.32A.030

IMPROVING CHILD SAFETY: CHILDREN AGES 0-3 YEARS

Critical incident reviews conducted by both OFCO and CA identify children ages zero to three years as the primary victims of child fatalities and near fatalities. These young children are also the most vulnerable and at greatest risk of maltreatment. OFCO participated in a state-wide workgroup to improve safety outcomes for this especially vulnerable group of children.¹⁷ This work group resulted in significant changes in policy and practice by the end of 2014, including:

- An extensive infant safety training titled “Baby 101” was incorporated into the core training provided to CA staff through the Alliance for Child Welfare Excellence. The training is a day and a half in length, a reflection of the importance of this topic in a comprehensive child welfare training curriculum.
- Several policy changes regarding casework practice with families who have an infant took effect in November 2014:¹⁸
 - For families with newborns, all DCFS and DLR workers now **complete a Plan of Safe Care** if the newborn is substance-affected or born to a dependent youth.
 - For families with infants from birth to 6 months, the assigned worker **must verify that parents and any other caregivers have received the Period of Purple Crying** booklet and DVD, and if not, must not only provide these resources, but review and discuss the contents with the caregivers.
 - For families with infants (birth to twelve months), the caseworker **must complete a Safe Sleep Assessment**, and engage the parent or caregiver in creating a safe sleep environment if one does not exist.
- In 2015, resulting from the recommendation by a child near fatality review of the near-death of a two year-old child from physical abuse, CA enacted a significant policy change to require that **any CPS report of physical abuse to a child aged 0-3 be screened in for a CPS investigation**, with a response time of within 24 hours.¹⁹

¹⁷ This work group was established by CA in June 2013.

¹⁸ CA Practices & Procedures Manual, Section 1135: Infant Safety Education and Intervention.

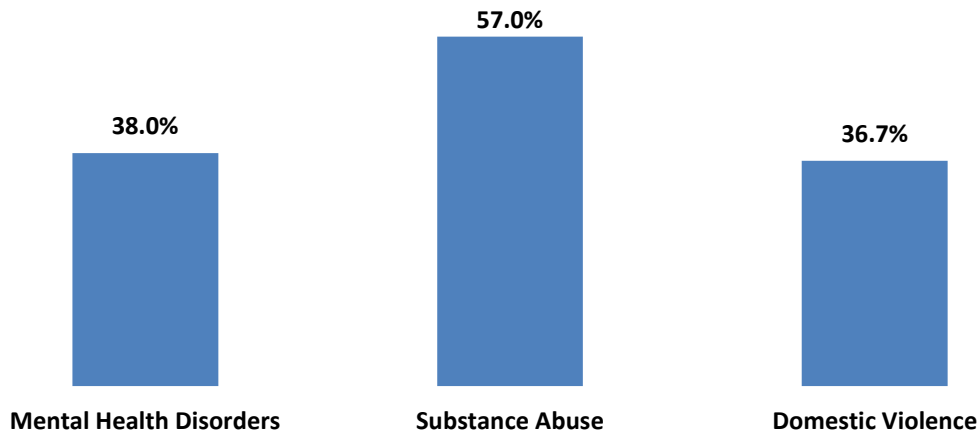
¹⁹ Previously, if such allegations involving the youngest children were deemed low-risk, they could be screened to FAR or for a less immediate CPS investigation, or even screened out.

FAMILY RISK FACTORS ASSOCIATED WITH FATALITIES

More than half of the children who died came from families with a history of drug or alcohol abuse (57 percent). Domestic violence and mental health disorders were also identified as significant risk factors in many of these fatalities. At least one of these three risk factors was present in 82.3 percent of the fatalities examined by OFCO, while all three risk factors were identified in 11.4 percent.

Figure 6: **Family Risk Factors in OFCO-Examined Child Fatalities, 2012 – 2015**

(n = 158)



The co-occurrence of caregiver substance abuse and infant unsafe sleep is particularly troubling. Of the 82 infant fatalities examined by OFCO from 2012 to 2015 that involved unsafe sleep practices, 54 of them (66 percent) also involved substance abuse by at least one of the caregivers. Children ages 0 – 3 years are particularly at risk when their caregivers use drugs or alcohol, even when that substance is prescribed by a doctor, such as methadone, painkillers, or other prescribed narcotics.

THE OPIOID EPIDEMIC

Opioid use, ranging from prescription medications to illicit heroin use, has increased both nationally and across Washington. Washington crime lab data for police evidence testing indicate that there has been an 85 percent increase in statewide opioid use from 2002-2004 to 2011-2013.²⁰ The increase in opioid use has had a significant impact on our child welfare system. Nationally, there has been a rise in opioid affected infants. The rate of Neonatal abstinence syndrome (NAS)²¹ cases increased from 0.7 per 1,000 live births in 1999, to 8.5 per 1,000 live births in 2011. Washington has also experienced an increase in NAS rates, from 1.2 per 1,000 live births in 2000 to 3.3 per 1,000 live births in 2008. In Washington, prenatal exposure to opioids increased from 11.5 percent of all drug-exposed neonates in 2000 to 24.4 percent in 2008, and 41.7 percent of infants diagnosed with NAS were exclusively exposed to opioids.²²

²⁰ *Opioid Trends across Washington State*. April 2015. University of Washington Alcohol & Drug Abuse Institute. <http://adai.uw.edu/pubs/infobriefs/ADAI-IB-2015-01.pdf>

²¹ NAS refers to a constellation of behaviors and symptoms in newborns exposed in utero to addictive illegal or prescription drugs. Infants born with NAS typically have prolonged hospital stays, and experience serious medical complications.

²² Neonatal Abstinence Syndrome: How States Can Help Advance the Knowledge Base for Primary Prevention and Best Practices of Care, (2014) <http://www.astho.org/prevention/nas-neonatal-abstinence-report/>

From calendar year 2012 to 2015, OFCO identified **32 maltreatment related fatalities of children ages 0 to 3 years where a caregiver's opioid use was a known risk factor.**

Of these 32 fatalities, **65.6 percent (21) were related to unsafe sleep conditions.** Some examples include:

- A one-month old infant died when the mother fell asleep while breastfeeding and the child aspirated. The child was born premature at 33 weeks and showed signs of being drug affected. The mother was involved with methadone maintenance treatment at the time of death.
- A one-month old infant died and while the cause of death was determined to be SIDS, the infant had been sleeping on the mother's chest, on a couch. The child spent time in the NICU after birth for methadone withdrawal.
- A three-month old infant died while co-sleeping with the mother who placed the infant next to her in bed, surrounded by pillows. Both the mother and the infant tested positive at delivery for opiates.

Other examples of child fatalities involving opioid use include:

- A three-year old child died after accidentally ingesting a combination of the mother's methadone and alprazolam (a medication used to treat anxiety).
- An eighteen-month old child died after being left alone in a car for several hours. The family was experiencing homelessness and the mother had a history of using opiates and morphine. Drug paraphernalia was found in the car, and the child's three-year-old sibling tested positive for both these drugs immediately after the fatality, indicating direct exposure to the drugs. The mother had a history of neglecting her children's basic needs due to chemical dependency and had previously lost custody her older children.
- An infant was born premature after a high risk pregnancy during which the mother used methamphetamines, crack-cocaine, and opioids. The infant suffered life-threatening medical complications and remained in the hospital, dying months later.

Federal and State Laws and Policies Concerning Substance Abuse and Child Maltreatment

The federal Child Abuse and Prevention Treatment Act requires that states have policies and procedures in place to notify child protection agencies when an infant is affected by illicit substance abuse or withdrawal symptoms resulting from prenatal drug exposure. In response, the Washington State Department of Health in collaboration with DSHS published detailed guidelines for health care providers regarding maternal drug screening, testing and reporting of drug exposed newborns to CPS.²³

State laws concerning child abuse and neglect also emphasize responding to substance abuse and its co-occurrence with child maltreatment. For example, "when considering whether a clear and present danger exists [to a child suspected to be maltreated], a parent's substance abuse as a contributing factor to negligent treatment or maltreatment shall be given great weight."²⁴ Furthermore, during a CPS investigation the department must make a determination whether drug or alcohol abuse contributed to the child abuse or neglect, and if so, obtain a chemical dependency evaluation of the subject.²⁵

²³ Guidelines for Testing and Reporting Drug Exposed Newborns in Washington State, revised July 2015.

<http://here.doh.wa.gov/materials/guidelines-drug-exposed-newborns>

²⁴ RCW 26.44.020(16)

²⁵ RCW 26.44.170

When CPS is notified of a newborn that is substance affected, the investigator is required to complete a “Plan of Safe Care”, even if the substance is a prescription medication.²⁶ This plan of care is designed to ensure the protection of drug affected newborns, not to punish mothers battling addiction. The “Plan of Safe Care” typically includes the plan for medical care for the infant; safe housing for the family; child care if needed; emergency contacts for the parent to call; and referrals for necessary services and available resources such as substance abuse treatment, nutrition assistance through the federal WIC program, and parenting classes.

OFCO Recommendations

Recommendation: Expand services for expectant mothers, and mothers of newborns such as the Nurse-family Partnership

Nurse-Family Partnership® (NFP) is a community health program that serves vulnerable mothers pregnant with their first child. Each mother served by NFP is partnered with a registered nurse early in her pregnancy and receives ongoing nurse home visits that continue through her child’s second birthday. NFP improves family outcomes including: increased time between births and fewer children; more stable partner relationships; less engagement in risky behaviors, less substance abuse during pregnancy and reduced role impairment; mothers are less reliant on welfare; children are less likely to be maltreated or abused; and the program leads to reductions in emergency room visits, hospital days and reduced childhood mortality.²⁷

NFP currently serves clients in 14 of Washington’s 39 counties: Clark, Cowlitz, Franklin, Jefferson, Kitsap, King, Mason, Pierce, Skagit, Snohomish, Spokane, Thurston, Yakima and Whatcom.²⁸ However, these existing programs report demand for services far exceeds existing resources. One county program received 355 referrals for services in 2015, yet is only staffed to serve 150 clients.²⁹

²⁶ CA Practices & Procedures Manual, 2552. CPS Response to Newborns Identified by a Medical Practitioner as Substance Affected. The Child Abuse Prevention and Treatment Act (CAPTA) requires States to have policies and procedures in place to notify child protective services (CPS) agencies of substance-exposed newborns (SENs) and to establish a plan of safe care for newborns identified as being affected by illegal substance abuse or having withdrawal symptoms resulting from prenatal drug exposure. (42 U.S.C. § 5106a(b), as amended by the CAPTA Reauthorization Act of 2010 (P.L. 111-320).)

²⁷ Olds DL, Kitzman H, Hanks C, et al. *Effects of nurse home visiting on maternal and child functioning: Age-9 follow-up of a randomized trial.* *Pediatrics.* 2007;120(4):e832-45; Olds DL, Kitzman HJ, Cole RE, et al. *Enduring effects of prenatal and infancy home visiting by nurses on maternal life course and government spending: Follow-up of a randomized trial among children at age 12 years.* *Archives of Pediatrics & Adolescent Medicine.* 2010;164(5):419-24; Small SA, Reynolds AJ, O’Connor C, Cooney SM. *What works, Wisconsin: What science tells us about cost-effective programs for juvenile delinquency prevention: A report to the Wisconsin governor’s juvenile commission and the Wisconsin Office of Justice Assistance.* Madison: University of Wisconsin-Madison; 2005; and aroly LA, Kilburn MR, Cannon JS. *Early childhood interventions: Proven results, future promise.* Santa Monica: RAND Corporation; 2005: Monograph Report 341.

²⁸ Nurse-Family Partnership, State Profile 2014. http://www.nursefamilypartnership.org/assets/PDF/Communities/State-profiles/WA_State_Profile.aspx

²⁹ Hinton, C. phone interviews with NFP programs, April 2016.

NURSE-FAMILY PARTNERSHIP GOALS

1. Improve pregnancy outcomes by helping women engage in good preventive health practices, including prenatal care; improving their diets; and reducing their use of cigarettes, alcohol and illegal substances;
2. Improve child health and development by helping parents provide responsible and competent care; and
3. Improve the economic self-sufficiency of the family by helping parents develop a vision for their own future, plan future pregnancies, continue their education and find employment.

Recommendation: Provide DCFS caseworkers with additional training and support resources addressing substance abuse by parents, and assessing child safety.

Several child fatality and near fatality review recommendations have identified the need for additional training for caseworkers on issues related to parental chemical dependency, and in particular, opiate use, methadone treatment, and assessing child safety in these situations.³⁰ Related recommendations suggest that a chemical dependency professional should be located in DCFS offices to provide case consultation, guidance for client engagement, and information on community resources. The department should continue efforts to provide ongoing training to caseworkers and assure that professional case consultation regarding substance abuse is available, either located in the DCFS office, or through community partners.

Recommendation: Provide evidence based substance abuse education and prevention for children and youth in state care

Children and youth in foster care are at a heightened risk for substance abuse. Youth in foster care are also less likely than those living with their parents to talk with a parent about the dangers of drug and alcohol use.³¹ A history of maltreatment, trauma, poverty and parental substance abuse all increase adolescent substance abuse. Youth who have been in foster care report a higher rate of drug use, 34% compared to 21% of youth never in foster care.³² The department should develop and implement strategies to provide substance abuse prevention and education to children and youth in foster care. These efforts should partner with the child's schools, service providers, and caregivers.

³⁰ See Appendix C for the full text of these recommendations.

³¹ National Survey on Drug Use and Health, SAMHSA, (2014), <http://www.samhsa.gov/data/sites/default/files/spot141-teens-foster-care-2014.pdf>

³² Grant, Three Risk Factors for Foster Youth drug Abuse, Behavioral Health, Drug abuse, (March 25, 2014) <http://www.rehabs.com/3-risk-factors-for-foster-youth-drug-abuse/>

CHILD NEAR FATALITIES EXAMINED BY OFCO

State law requires DSHS to notify OFCO of the near fatality³³ of any child who has been in the department’s custody, or receiving services, within the last 12 months.³⁴ Near fatal incidents offer a learning opportunity for child welfare and other professionals to understand how interventions with families in the context of the child protection system can be more effective in preventing child maltreatment.

Regardless of whether a near fatality review is conducted, CPS frequently conducts an investigation of the incident to determine whether abuse or neglect occurred, and when necessary takes action to protect the child and any other children remaining in the home.

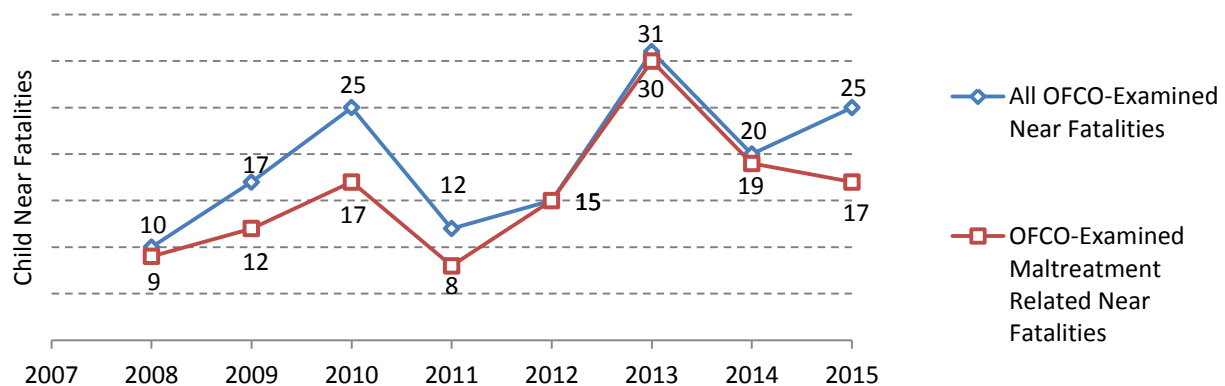
OFCO conducts an administrative review of all near fatalities involving child abuse or neglect when the family had an open case with CA at the time of the near fatality or within one year prior, even if the subject child was not the recipient of department services. OFCO examined **20 near fatalities in 2014** and **25 in 2015**.

OFCO examines these cases to:

- identify any safety issues regarding the child and any other children remaining in the home;
- determine whether the near fatality appears to have resulted from abuse or neglect, thus requiring a DSHS near fatality review, or whether ongoing child maltreatment concerns in the family may have contributed to the near fatality;
- identify any problematic casework practice or decisions by the agency to ensure more effective protection of the children in the family, as well as improve agency services in similar cases in the future; and
- assist policymakers in developing strategies to avoid these near fatalities.

Figure 7: **OFCO-Examined Near Fatalities by Year**

By Calendar Year (January 1st – December 31st)



³³ RCW 74.13.500 defines “near fatality” as “an act that, as certified by a physician, places the child in serious or critical condition.”

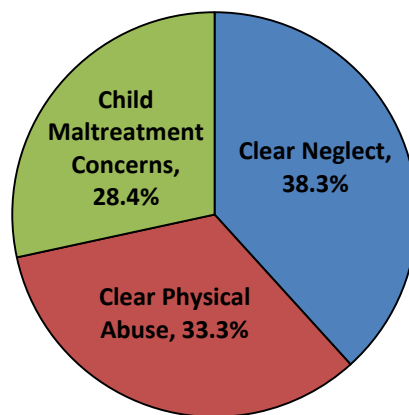
³⁴ RCW 74.13.640(2).

MALTREATMENT RELATED NEAR FATALITIES

OFCO identifies child near fatalities reported to CPS that were directly caused by child abuse or neglect, as well as those in which abuse or neglect concerns may have contributed to the incident, and the family had CA history in the last 12 months. Of the 45 near fatalities examined by OFCO in 2014 and 2015, 36 were determined to either be caused by abuse or neglect, or abuse or neglect concerns were present. **OFCO examined a total of 81 maltreatment related near fatalities from calendar year 2012-2015.** During this four-year period, child neglect caused slightly more near fatalities than physical abuse (38 percent and 33 percent respectively).

Figure 8: **Maltreatment Related Child Near Fatalities, 2012-2015**

(n = 81)

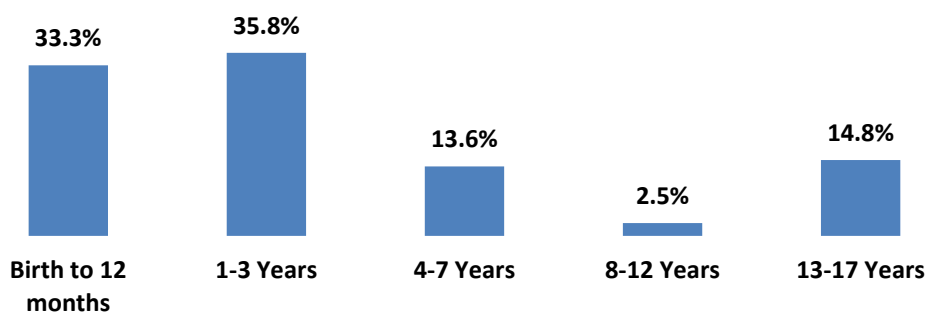


CHILD'S AGE AT TIME OF NEAR FATALITY

Over two-thirds of the 81 maltreatment related near fatalities examined by OFCO from 2012 to 2015 involved children under the age of three years old. Very few near fatality incidents involved children 8 to 12 years of age. In contrast to fatalities, where the majority of infant fatalities were related to unsafe sleep practices, only seven percent of near fatalities were. Forty percent of infant near fatalities resulted from neglect and 37 percent from physical abuse. Attempted suicide is the leading cause of near fatal incidents in teenagers: of the twelve near fatalities of children ages 13 – 17 years, half were suicide attempts.

Figure 9: **Child Age at Time of Near Fatality, 2012-2015**

(n = 81)



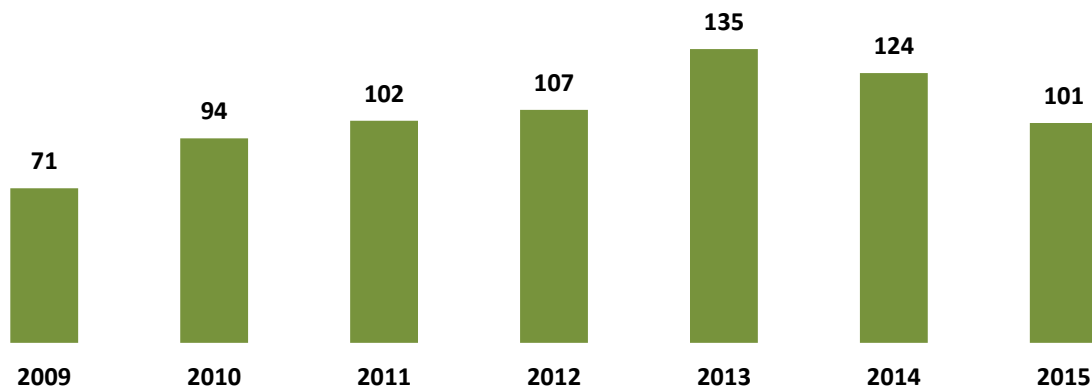
RECURRENT MALTREATMENT

CA is required to notify OFCO of all families or children who experience three or more founded reports³⁵ of abuse or neglect in the last twelve months.³⁶ This notification enables OFCO to review cases involving chronic child maltreatment and intervene as needed. A close review of cases of recurrent maltreatment can indicate whether Washington’s child welfare system is effectively reducing the recurrence of child maltreatment, and inform practice to further reduce this problem.³⁷

Governor Inslee’s *Results Washington* initiative brings increased attention to recurrent maltreatment. A leading indicator under Goal 4 of this initiative, to build “Healthy and Safe Communities”, is to decrease the percentage of children with a founded allegation of abuse or neglect who have a new founded allegation within twelve months, from 9.7% to 6% by July 31, 2017.³⁸ Although this is a slightly different measure than three or more founded reports within the last twelve months, the common goal is to reduce the number of children experiencing recurrent maltreatment in Washington.

OFCO began receiving these notifications in mid-2008. The number of cases meeting this criterion steadily increased from 2009 through 2013 but decreased in both 2014 and 2015. In the first couple years the department began sending notices, CA also transitioned to a new electronic records keeping system. The lower number of recurrent maltreatment notifications in the onset may have been due to notification process errors rather than a steady increase over the years in recurrent maltreatment cases.

Figure 10: **Number of Recurrent Maltreatment Notifications Made to OFCO, 2009-2015**
by Calendar Year (January 1st – December 31st)



³⁵ “Founded” means 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 - see RCW 26.44.020(8). In this context, “report” means a “referral” to Child Protective Services, which DSHS/CA calls an “intake.”

³⁶ RCW 26.44.030(13)

³⁷ “Repeat Maltreatment” was identified as an area needing improvement in the 2010 Washington State Child and Family Services Review (CFSR). The CFSR also noted that there has been a significant drop in re-victimization rates since 2005. *July 2010 State Assessment*.

³⁸ The initial goal was to decrease the percentage of children with founded allegations of abuse or neglect who have a new founded allegation within six months. It was recently changed to twelve months, excluding reports in the first 14 days. More information can be found at : <http://www.results.wa.gov/whatWeDo/measureResults/documents/communitiesGoalMap.pdf>

Neglect is by far the most common type of maltreatment recurrently experienced by children, comprising 84 percent of all founded reports reviewed by OFCO in 2015. Eleven percent of the founded reports were physical abuse allegations, and five percent were sexual abuse allegations. By the time OFCO received notice of the third founded report the department had taken legal action to ensure the safety of the children in 67 percent of cases.³⁹

While OFCO and CA's reporting periods are different, the **maltreatment recurrence rate as measured by CA** – a second “founded” allegation of abuse or neglect within 12 months, excluding the first 14 days – **also increased** from fiscal year 2010 – 2014 (July 1 – June 30).

It is difficult to identify the precise factors driving these increases and decreases in recurrent maltreatment, but there are some factors that might be expected to affect the recurrence rates. All else equal, if the number of intakes made to CPS or the number of opened investigations and assessments increase, the number of founded allegations of abuse or neglect would be expected to increase as well. The number of opened investigations and assessments matches the trend seen in OFCO's recurrent maltreatment reviews. Investigations increased from 2009 through 2013 and then dropped in 2014, the latest year data is available.⁴⁰

Some factors may inflate or deflate the number of founded findings and may not reflect the actual rate of abuse or neglect. For example, beginning in 2014, a differential response system, Family Assessment Response (FAR), was incrementally implemented in 29 offices across the state. In FAR cases, while CPS still conducts a comprehensive assessment of child safety, an administrative finding as to whether child abuse or neglect occurred is not made. Both OFCO and CA will continue to monitor the impact of FAR on recurrent maltreatment rates.

Other factors may be more reflective of actual changes in the rate of maltreatment, for example broad social factors such as the economic recession, unemployment, the availability of social services, and other factors thought to affect rates of child maltreatment in general.

While no single strategy can reduce such a complex phenomenon, the department has recently taken several steps to develop a multifaceted strategy for reducing repeat abuse and neglect.⁴¹ These actions include:

- **Safety Boot Camp:** The “Safety Boot Camp” is a specialized training curriculum designed for field caseworkers and supervisors focusing on thorough safety and risk assessments and providing effective intervention to protect children from further harm.
- **Case review of families with ten or more prior CPS reports:** The department implemented an internal case review process when a child has been reported as a victim of abuse or neglect for the tenth time within a three year period, and those reports have screened in for investigation. Cases that meet the review criteria now benefit from a practice consultation and case staffing,

³⁹ The legal status of the children involved in the recurrent maltreatment cases was either in shelter care status or dependency.

⁴⁰ Partners for Our Children, Data Portal. <http://partnersforourchildren.org/>

⁴¹ Children's Administration presentation and supplemental report by Assistant Secretary Jennifer Strus to the Results Washington Goal 4 Committee on December 21, 2015. Supplemental report can be found at: <https://data.results.wa.gov/reports/G4-2-1-a-Supplemental-Founded-Allegations>

with recommendations to increase the effectiveness of child welfare interventions and services.

- **Workload reduction:** The department completed a system-wide analysis of casework tools, forms and other processes to identify inefficiencies. By reducing duplication and redundancies, and replacing outdated or inefficient processes or tools with more innovative resources, caseworkers are expected to have more time to work directly and more intensively with families.
- **Shift to safety-centered practice:** The department believes safety-centered practice is superior to an incident-focused model of practice, and that this shift in focus will result in more accurate assessment of safety and risk.
- **Standardize case consultations:** CA will standardize case consultations to help caseworkers with case-related issues while remaining focused on child safety, service planning, tailoring services and engagement strategies.

SECTION II

IMPLEMENTATION STATUS OF FATALITY AND NEAR FATALITY RECOMMENDATIONS

INTRODUCTION

State law requires the Department of Social and Health Services (DSHS) Children’s Administration (CA) to conduct a child fatality review when the death of a child was suspected to be caused by child abuse or neglect, and the child was in the care of or receiving services from DSHS/CA at the time of death, or in the year prior.⁴² If it is not clear whether a child’s death was the result of abuse or neglect, the department must consult with OFCO to determine if a review should be conducted. State law also requires the department to review any **near fatality of a child**⁴³ who was in the care of or receiving services from the department at the time of the incident or in the preceding twelve months.⁴⁴ Even if these criteria are not met, DSHS may conduct a review of any fatality or near fatality at its discretion, or at the request of OFCO.⁴⁵

The purpose of reviewing child fatalities and near fatalities is to increase the agency’s understanding of the circumstances around the child’s injury or death and to evaluate practice, programs and systems to improve the health and safety of children.⁴⁶ These reviews of the department’s services and community response to concerns about child abuse and neglect help identify areas for increased education and training, as well as potential policy or legislative changes.

The committee reviewing a child fatality or near fatality is made up of individuals with no prior involvement with the case, and typically includes CA staff, OFCO staff, and community professionals selected from diverse disciplines with expertise relevant to the case, such as law enforcement, chemical dependency, domestic violence, mental health, child health, or social work practice. The review committee has full access to all records and files regarding the child or otherwise relevant to the review that have been produced or retained by the supervising agency.⁴⁷

⁴² See RCW 74.13.640. Prior to the passage of SHB 1105 in 2011, CA was required to review any unexpected deaths of children who were in the care of or receiving services from CA, or had received care or services in the last year. As amended, DSHS must only review those deaths that are “suspected to be caused by child abuse or neglect.” This eliminates fatality reviews of a child’s accidental or natural death, even if the child had been receiving child welfare services in the year prior to the fatality.

⁴³ RCW 74.13.500 defines “near fatality” as “an act that, as certified by a physician, places the child in serious or critical condition.”

⁴⁴ RCW 74.13.640(2). A review is also required if the child was receiving services from a supervising agency at the time of the incident or in the prior three months.

⁴⁵ Id. The department also conducts Internal fatality or near fatality reviews when a case does not meet the statutory requirements that mandate an executive review, but the department and/or OFCO believe a review could aid in evaluating the agency’s practice. Because these reviews do not meet the statutory requirements for public release, internal review reports remain confidential in order to protect the privacy of the child and family

⁴⁶ See DSHS CA Operations Manual, Section 5200 at http://www.dshs.wa.gov/ca/pubs/mnl_ops/chapter5.asp#5200

⁴⁷ RCW 74.23.640(3)

DSHS must issue a report on child fatality review results within 180 days following the fatality, unless granted an extension by the Governor.⁴⁸ These reports are subject to public disclosure and must be posted on the department's public website. The department is authorized to redact confidential information contained in these reports to protect the child's privacy.⁴⁹

In order to promote accountability and the consistent implementation of recommendations from fatality reviews, OFCO is required to issue an annual report to the Legislature on the implementation of recommendations issued by fatality review committees.⁵⁰ OFCO's previous reports included only fatality review recommendations. **This report also includes recommendations from near fatality reviews, given that the purpose of a near fatality review is identical to a fatality review.**

This section of the report describes the implementation status of recommendations made in child fatality and near fatality reviews conducted by CA between May 1, 2014 and July 31, 2015.⁵¹ During this period, CA conducted reviews in the deaths of **18 children**⁵², and the near-deaths of **8 children**.⁵³ **Eighteen** fatality reviews resulted in **49 recommendations**, while the 8 near-fatality reviews resulted in **13 recommendations**. Based on information provided by CA, OFCO found that **91.9 percent of the recommendations were either completely implemented or in the process of implementation**, while 4.8 percent were considered, but not implemented.⁵⁴ The vast majority of recommendations addressed either statewide issues (51.6 percent) or local office concerns (43.6 percent), while a much lower number were tailored to remedy regional concerns (4.8 percent).

⁴⁸ Id.

⁴⁹ Individual child fatality reports are available at: www.dshs.wa.gov/ca/pubs/fatalityreports.asp.

⁵⁰ RCW 43.06A.110. OFCO reports are available at: www.ofco.wa.gov

⁵¹ To allow the department sufficient time to consider and implement fatality recommendations, child fatality reviews that occurred August 1, 2015 – December 31, 2015 are not included in this report. The implementation status of recommendations from fatality reviews occurring before May 1, 2014 are included in past OFCO reports and can be found at: <http://ofco.wa.gov/reports/>

⁵² Fourteen of these reviews were executive child fatality reviews and four were internal reviews.

⁵³ All eight reviews were internal reviews.

⁵⁴ No implementation status was reported for one recommendation.

Table 3: 2014-2015 Child Fatality and Near Fatality Review Recommendations by Implementation Status and Targeted Organizational Level

(n=62)

	Number of Recommendations	Percent	Statewide (#)	Region (#)	Office (#)
Implemented	34	54.8%	16	1	17
In Process	23	37.1%	15	1	7
Partially Implemented	1	1.6%	--	1	--
Not Implemented	3	4.8%	1	--	2
Status Unknown	1	1.6%	--	--	1

As in past years, the most prominent topic areas identified by fatality recommendations were:

- **Training** for caseworkers, supervisors, or community professionals (41 percent of recommendations);
- **Casework practice**, including risk assessment and safety planning (49 percent of recommendations); and
- **Partnerships with community professionals** (8 percent of recommendations).

Part 1 of this report takes a closer look at recommendations concerning these three major themes.

Part 2 examines why certain recommendations were considered, but not implemented.

Part 3 discusses select recommendations worthy of further consideration and recommendations with notable implementation results.

1. MAJOR THEMES OF RECOMMENDATIONS

The majority of recommendations aimed to improve training, casework practice, or CA’s partnerships with community professionals. Training topics identified in recommendations include: safety assessment and planning; domestic violence; mental health; and chemical dependency. Recommendations regarding casework practice spanned a wide range of topic areas and appeared to be more challenging to implement. Recommendations addressing CA’s partnerships with community professionals identified the need to improve communication and clarify roles and responsibilities between CA and community partners such as law enforcement, medical facilities, and other state or private agencies. Most of these recommendations are reported to have been implemented or are in the process of implementation.

Table 4: **2014-15 Child Fatality and Near Fatality Review Recommendations by Topic**⁵⁵
(n=62)

Topic	Number	Percent
Provide Training <i>(Training on child safety)</i>	25 <i>(15)</i>	40.4%
Improve Casework Practice <i>(Safety planning and risk assessment)</i>	29 <i>(9)</i>	46.7%
Improve Partnerships with Community Professionals	6	9.7%
Other: Increase Agency Resources	2	3.2%

A. TRAINING FOR CASEWORKERS, SUPERVISORS OR COMMUNITY PROFESSIONALS

Twenty-five review recommendations (40.4%) address training issues for caseworkers, supervisors or other professionals involved with the child welfare system. Fourteen of these recommendations have been implemented and nine are in the process of implementation. One recommendation was considered but not implemented, and the implementation status was not listed for another recommendation. **The most prevalent training topics identified in these recommendations involved the assessment of risk and/or child safety (15 recommendations).** Other topics included domestic violence, chemical dependency, supervision skills, and investigative skills.

Child Safety – Fifteen recommendations identify the need for further training on assessment of child safety, and the development of plans to ensure the safety of children in the home. Safety planning is a collaborative process between the family and the department, as well as any other key extended family members, support persons, and community professionals involved with the family. All fifteen recommendations have been implemented or are in the process of implementation.

⁵⁵ Previous reports have organized recommendations according to ten common topics; in the current review period, all of the recommendations fell broadly within four topics.

Common themes in these child safety recommendations are:

- *Safety assessment and safety planning*: Five recommendations targeted this area of needed training for CA staff. – *In Process*
- Two recommendations addressed the need for staff to be proficient in completing *background checks* and doing searches on FamLink for individual’s *CPS history*, by recommending that specific training be included in Regional Core Training or provided by the Alliance for Child Welfare Excellence.⁵⁶ – *In Process*
- *Infant safe sleep training*: One recommendation identified a need for a local DCFS office to receive training on the appropriate approach to discuss safe sleep with clients. Another recommendation suggested reviewing the safe sleep information packet provided to foster parents. This same recommendation also said that the department should consider adding information for licensors and caseworkers on discussing safe sleep practices in foster homes. – *Completed*
- *Health and safety visits*: One recommendation addressed the need for local staff to review policy requirements for health and safety visits to children in state care. OFCO notes that in the last reporting period, there was a recommendation to strengthen policy regarding health and safety visits. In April 2015, a policy revision limited the number of health and safety visits that could be conducted by staff other than the assigned worker, and specified that children with cases open to CPS longer than 60 days must receive private, individual face-to-face visits every month.⁵⁷ – *Completed*
- *Suicide assessment and prevention*: One recommendation suggested making a web-based, non-mandatory training available to all staff, covering risk factors and warning signs for suicide. CA reports that the Alliance is now offering a training titled “*Youth Suicide Prevention: safeTALK*” which is provided by a contractor from the University of Washington. This is available statewide to all staff. – *Completed*

Domestic Violence – Because of the high co-occurrence of domestic violence and child maltreatment, the identification of domestic violence is critical when making case decisions intended to increase child safety. Recommendations for additional domestic violence training for CA staff have come from several fatality reviews over the years. During the current reporting period, one recommendation suggested training for the local CPS unit on the *Social Worker’s Practice Guide to Domestic Violence*,⁵⁸ as well as the use of “identified experts in the field of assessing domestic violence.” Similar recommendations targeting workers statewide were made during the last reporting period. – *In Process*

⁵⁶ The Alliance for Child Welfare Excellence provides training for CA staff and others working with vulnerable children and families, including caregivers. Described as “Washington’s first comprehensive statewide partnership” to provide professional training, the Alliance represents a partnership between CA, three state universities, and Partners for Our Children (a child welfare policy and analysis group). See <https://allianceforchildwelfare.org>

⁵⁷ See Practice and Procedures Guide, #4420 for other revisions to this policy.

⁵⁸ The *Social Worker’s Guide to Domestic Violence* is the agency’s practice guide that was issued in 2010 and revised in May, 2012 as a product of “a multi-agency, multi-year collaboration that has leveraged the knowledge and expertise of state and national experts in the fields of domestic violence and child welfare.” (see Introduction to Guide, at http://ca.dshs.wa.gov/intranet/pdf/manuals/DV_Guide_Intro.pdf)

Chemical Dependency – Two training recommendations related to chemical dependency issues.

- The fairly recent legalization of marijuana poses a challenge to workers trying to assess risk in homes where regular marijuana use is occurring. As marijuana use becomes more common, workers need training to better assess the impact and risks to children who live in homes where marijuana use is regular and frequent. [It is recommended for] CA to collaborate with Alliance for Child Welfare Excellence to develop, at minimum, a resource guide for staff [on this topic]. – *Considered, Not Implemented.*
- Staff statewide would benefit from ongoing training regarding alcohol abuse. Some CA staff may have a bias regarding alcohol abuse and lethality. – *Completed*

Casework Practice and Supervision Skills – Five training recommendations, made in three different fatality reviews, were related to social work practice skills and clinical supervision. Four recommendations targeted CPS specifically, and addressed the skills of either an individual caseworker or supervisor, or recommended training for the entire CPS unit. One recommendation was for cross-training of workers in a small rural office to help with effective case coverage in different units during times of staff shortages. Four of these five recommendations were *completed*. The fifth recommendation to review a policy regarding investigative standards was reported as *in process*.

B. CASEWORK PRACTICE

Twenty-nine fatality and near fatality review recommendations seek to improve casework policies, procedures or practices. All but four of these recommendations are reported to be implemented or in the process of implementation. Three recommendations have not been implemented and one recommendation was reported as “Not Applicable – No Recommendation.”⁵⁹ While these recommendations touch on a wide range of topics, several were clustered in the following areas of practice:

Safety Assessment and Planning – **Nine** recommendations addressed the need for thorough child safety assessments and effective safety plans for families.

- **Three** of these addressed **safe sleep environments for infants**, all emanating from one review of an infant death. These recommendations suggested amending existing policy to require workers to:
 - observe and discuss the sleep environment of any infants during each health and safety visit (and presumably, take action to address with caregiver if inappropriate); and
 - document this in the case record.All three of these recommendations are *in process* of being implemented. New guidelines are being added to existing policy to incorporate all of these activities as standard practice.
- **Two** recommendations were case-specific: the first recommended a higher level of supervision for a particular CPS caseworker, while the second requested that photos taken by law enforcement be secured and placed on file for possible future use. Both recommendations were *completed*.

⁵⁹ See Footnote 16 for discussion.

- Three recommendations requested that CA **reevaluate the use of Solution Based Casework, the child welfare practice model adopted by the agency in 2007.**⁶⁰ Similar recommendations were made in child fatality reviews in prior years. Additionally, the Washington State Racial Disproportionality Advisory Committee recommended that the department study this practice model to determine its impact on racial disproportionality in the child welfare system.⁶¹ While state law requires the use of a risk assessment process in child welfare services⁶², it does not specify which process or tool is to be used. CA is in the process of exploring other models. This change is expected to reduce a great deal of confusion, redundancy, and inaccuracies in the assessment of risk (and correspondingly, increase the safety of children) across all services provided by CA. – *In Process*

Multidisciplinary Collaboration -- **Six** recommendations related to improving collaboration with other service providers to CA clients.

- **One** recommendation addressed accountability of contracted providers, asking CA to remind staff and clarify how to proceed when they have concerns about a contracted provider’s services. CA reports that policy regarding contracts was updated to clarify roles and responsibilities of various parties and other details; an on-line feedback mechanism was also developed to facilitate reporting concerns. – *Completed*
- **Two** recommendations addressed the need for improved communication with service providers – one involved ensuring providers are given full information about prior services clients have received,⁶³ while the other urged stronger efforts to ensure that in “high risk” cases, current service providers for the family, as well as safety plan participants, are included in FTDMs. – *In Process*
- **Three** recommendations emanating from one fatality review addressed the need for identified experts to thoroughly and accurately assess parents with *domestic violence, mental health disorders, and/or chemical dependency.* – *Completed*

Internal Practice Consultation – **Six casework practice recommendations** addressed better use of the agency’s internal resources for consultation regarding case plans. CA was urged to remind staff about and provide contact information for key resources such as regional Practice Consultants and Policy and Program Managers, MedCon physicians⁶⁴, Assistants Attorney-General, and staff at the Alliance for Child Welfare Excellence. One recommendation addressed the need for more intensive clinical supervision of new or less experienced caseworkers. These recommendations were reported as *completed or in process.*⁶⁵

⁶⁰ Solution Based Casework is the family-centered child welfare practice model adopted by CA in 2007. Structured Decision Making is the actuarial risk assessment tool used within this model to assist workers in making informed decisions to keep children safe. In 2011, the Child Safety Framework was adopted to support and enhance the SBC practice model to assure child safety throughout the life of a case.

⁶¹ Racial Disproportionality and Disparity in Washington State Child Welfare - Remediation Plan, December 2, 2008.

<https://www.dshs.wa.gov/ca/advancing-child-welfare/racial-disproportionality>

⁶² RCW 26.44.030(18)

⁶³ CA notes that this recommendation represents “an ongoing activity for all cases.”

⁶⁴ The Washington State Child Abuse Consultation Network provides statewide consultation and training regarding medical findings in cases of alleged child abuse and neglect. Child Protection Medical Consultants provide quick access to a physician with expertise in the diagnosis of complex cases of child abuse and neglect to CA staff, physicians, prosecutors, attorneys-general, law enforcement, tribal social workers, and other professionals in child welfare.

⁶⁵ One recommendation was reported as “not implemented” as it was case-specific, and the case was already closed.

One of the more general recommendations related to casework practice addressed the need for greater uniformity in the agency’s practice when new children are born to parents with dependent children. The recommendation states, “[CA should} use Regional Program Consultants to promote consensus and clarity about who is responsible to call intake and how these intakes are assigned. In addition, the Committee recommended that the [local] office consider having shared planning meetings with families prior to the birth of new children on open CFWS cases.” – *In Process*

Effective Tools for Casework Practice

A recommendation that the department **provide case workers with mobile electronic equipment** is far-reaching in scope and will affect casework practice across the board, as it will assist and support staff in their day-to-day work. This recommendation emanated from a review which found an extraordinarily high level of staff turnover in the office handling the case, leading to a decision to utilize workers from other program units as well as other CA offices to close out a large number of open CPS investigations.

Recommendation: “CA should further evaluate providing, either through funding or donations, CPS investigators with mobile electronic equipment beyond what is currently available. Specifically the Committee noted a tablet or related item could be used to take photographs, access DSHS programs such as FAMLINK, ACES and other available databases which would help workers utilize their time in the field in a more cost effective manner and could aid in worker safety and investigations.”

CA Response: “A budget decision package has again been submitted by DSHS to the OCIO/OFM to support mobile computing for all CA field staff, not just CPS, and is pending approval by the Legislature in a future budget. It will include funding for devices, mobile data plans and mobile device management costs for approximately 1500 devices. Additionally the 2016 APDU was again approved in October 2015 by the Federal government and includes \$1.2 million in funding to support mobile computing technology.

Children’s Administration is in the process of rolling out 900 devices state wide as a mobile computing pilot for all field staff. This pilot includes a Dell 3 in 1 tablet as well as an iPhone, using Meraki Mobile Device Management software. CATS is taking the lead on this project providing required staff training on the new equipment, software and it’s [sic] uses. As we evolve this process and develop LMS training curriculum for new staff. We will be better prepared in the Spring [of 2016] to continue the mobile revolution and transform our workforce to be 21st Century Social Workers.”

C. PARTNERSHIPS WITH COMMUNITY PROFESSIONALS

In addition to the five recommendations described under “casework practice” involving day-to-day work with service providers on active cases, **six recommendations** more broadly addressed the need to **strengthen communication and partnerships with community professionals and other agencies**.

Three of the recommendations involved education or training. These recommendations aim to:

- Offer outreach and training to local law enforcement agencies regarding mandatory child abuse reporting requirements (*in process*) and trouble-shoot problems with law enforcement reports to CPS intake in a specific county (*completed*).
- Evaluate the need for cross-training with the Developmental Disabilities Administration to improve interagency collaboration and clarify expectations under the interagency Memorandum of Understanding. – *In Process*.
- Provide training for community providers working with infants on CA policy regarding safe sleep guidelines. This recommendation was targeted at a local DCFS office. – *Completed*

One recommendation addressed the need for a particular office to develop “working agreements with adjacent out-of-state counties to allow for the provision of services and monitoring on voluntary cases in nearby communities.” CA reports that it was able to develop working agreements with hospitals in those counties, but not with the counties themselves. – *Partially Completed*

2. REVIEW RECOMMENDATIONS CONSIDERED BUT NOT IMPLEMENTED

Few child fatality recommendations (n = 3, or just under five percent) were not implemented.⁶⁶ OFCO examined each of these three recommendations to determine why they were not, as described below. Interestingly, in previous years several fatality recommendations were not implemented due to workload, insufficient resources or lack of funding; this was not the case for any of the recommendations not implemented during this reporting period.

Two of the three recommendations emanated from one fatality review, in which the committee identified concerns in prior CPS investigations involving the family. These recommendations were therefore either case- or worker-specific:

1. Recommendation: *“The Committee recommended that the [local] CFWS unit consider reviewing this case with a practice consultant, CPS program manager or Alliance staff for consideration of ongoing services, re-assessment of safety and to determine if the correct safety threat is identified.”*

Agency Response: *“Case was closed prior to implementation of this recommendation.”*

Another recommendation resulting from this fatality review was categorized by CA as “not applicable” as CA did not believe the text of the recommendation advised any action on the part of the agency:

2. Recommendation: *“Insure that future service providers for this family are given an accurate summary of prior services that have been provided to this client.”*

OFCO notes that implementation of this recommendation is contingent upon this case being reopened in the future. Agency notes state that the recommended action is “an ongoing activity for all cases.” OFCO therefore considers this recommendation as not implemented as this particular case was not open at the time of writing.

The remaining recommendation that was not implemented emanated from a different fatality review:

3. Recommendation: *“The Committee believes that CA staff throughout the state would benefit from guidance about the system’s response to the legalization of marijuana and training specifically focused on understanding of marijuana as a drug. The Committee recognized that the fairly recent legalization of marijuana has posed a challenge to workers trying to assess risk in homes where regular marijuana use is occurring. As marijuana use becomes more common, workers need training to better assess the impact and risks to children who live in homes where marijuana use is regular and frequent. The Committee recommended that CA collaborate with Alliance for Child Welfare Excellence to develop, at minimum, a resource guide for staff that focuses on this issue.”*

⁶⁶ All near fatality recommendations were either implemented or were in process.

Agency Response: *“Marijuana use and its effects on safety for children in regards to the caregiver’s ability to safely parent or the safety of the child’s environment is covered under substance abuse training curriculum which is mandatory for all staff. Marijuana, alcohol or any prescribed drug should be ‘used responsibly’ or as prescribed and should not impair one’s ability to safely care for their children.”*

3. DISCUSSION OF SELECT REVIEW RECOMMENDATIONS

A. RECOMMENDATIONS RESULTING IN SUBSTANTIVE POLICY AND PRACTICE CHANGES

The implementation of several fatality review recommendations (and two near fatality review recommendations) resulted in tangible and significant changes in policy and practice. These recommendations were notable for their clarity and the department’s practical implementation.

1. Recommendation: “CA should consider adopting a change in intake policy that would require an emergent CPS investigative response to intakes where there is a serious allegation of physical abuse to children ages five and under.”

Implementation: “Intake screening tool [was] changed for children ages 0-3 [so that] allegations of physical abuse automatically default to an Investigation pathway [with an] emergent 24-hour response.” – *Completed*

2. Recommendation: “The committee recommended that all staff receive updated training on a regular basis regarding assessing safety throughout the life of a case and writing effective safety plans.”

Implementation: “P&P (sic) and the Alliance are developing ‘safety boot camp’ training that will cover these topics, the dynamics of child abuse and neglect, and a review of the Child Safety Framework. Health and Safety Visit Policy (4420) was updated in April 2015 and includes updated Health and Safety Visit requirements.” – *In Process*

3. Recommendation: “In order to improve accountability of contracted providers, CA should explore continued and improved ways to message out to CA staff the agency expectations and process for forwarding concerns about contracted provider service delivery.”

Implementation: “[Practices & Procedures] 6201 & 6202 – Developing and Monitoring Contracts – Policies were updated to clarify when a contract needs to be in place prior to starting contracted services. It also includes the roles and responsibilities of those involved in that process, and DSHS Administrative Policy 13.10 which contains many of the contract development requirements. Contracts developed an on-line feedback loop to report concerns.” – *Completed*

4. Recommendation: “CA should provide training to all staff regarding the utilization of the Medical Consultation Network, highlighting that the consultations can also include medically complex cases.”

Implementation: “This information is covered in the *Lessons Learned* training. This training was provided in 2015 statewide to almost every office and every unit.” – *Completed*

5. Recommendation: “CA should consider utilizing Quality Practice Specialists (QPS) for extra support and coaching for supervisors who may be unable to meet clinical supervision expectations. Without being designated in a “supervisory” capacity, the QPS could provide formal assistance to supervisors who may be overwhelmed.”

Implementation: “Regions 2 and 3 now have two Practice Specialists each on board and available to support offices, supervisors and staff with focused training and support to overall practice. Region 1 has posted for their initial position and anticipates filling the second by the end of this (2015) Fiscal Year. These positions are assigned to the Deputy Regional Administrators and are classed as non-supervising SHPC4's. Regions are also similarly supported by Alliance practice coaches who assist supervisors with focused training for new and/or struggling staff. As of [November 2015] all regions have a minimum of two Quality Practice Consultants hired and in place providing support to supervisors and staff.” – *Completed*

6. Recommendation: “CA should explore obtaining Superior Court Office Management Information System (SCOMIS) and DISCIS [District and Municipal Court Information System] access to aid in thorough CPS investigations. These two tools would allow workers to seek and obtain information related to criminal history that is not currently available to CA staff. The information obtained may assist in more appropriate completion of the Structured Decision Making tool as well as appropriately assessing safety within a family.”

Implementation: In 2015, CA created a criminal background check unit that processes all criminal background and criminal history checks for CA staff. This includes reviews of history in SCOMIS and DISCIS. – *Completed*

B. IMPROVED COLLABORATION AND CASEWORK PRACTICE AT THE LOCAL LEVEL

The following recommendations were implemented at the local or regional level and are good examples of specific, realistic recommendations that resulted in positive changes in local practice.

1. Recommendation: “The Committee recommended that the Area Administrator work with Regional CPS Program staff to identify a mentor for the supervisor to partner with to improve and reinforce clinical supervision skills and to develop a plan for continued staff development and training among staff. The Committee recognized the challenges faced by supervisors in smaller offices who are required to have expertise in all programs and recommended that the mentor be a staff member who is experienced with supervision and understands the challenges of supervising multiple programs.”

Implementation: “The Quality Practice consultant is scheduled to begin mentoring with the office supervisor on Oct. 23, 2015.” – *Completed*

2. Recommendation: “The local office [should] collaborate with the Alliance for Child Welfare Excellence to ensure that all staff are trained in the appropriate approach to discuss safe sleep with clients and with the local public health department on outreach and education.”

Implementation: “Safe Sleep training is scheduled for the [...] office on [date]. Training will be completed by the Alliance and the Inland Northwest SIDS Foundation.” – *Completed*

3. Recommendation: “The Committee recommended that the local office staff and Area Administrator consider cross training of staff to help with case coverage during times of staff shortages. The Committee recognized that the [...] Office currently has some relatively new staff and this may be a long range goal but the Committee saw a benefit to this for staff.”

Implementation: “Three of the [five] office staff have been trained in both CPS and CFWS. As the newer staff get more experience opportunities for cross training will be explored.” – *Completed*

C. RECOMMENDATIONS THAT LACK FOLLOW-THROUGH

Some recommendations made quite some time ago were reported by CA to be “in process” of implementation, yet no details were provided regarding their progress toward implementation. For example:

Recommendation: *[CA should] “use Regional Program Consultants to promote consensus and clarity about who is responsible to call intake and how these intakes are assigned. In addition, the Committee recommended that the [local] office consider having shared planning meetings with families prior to the birth of new children on open CFWS cases.”*

This recommendation was made one year ago in April 2015. The first part of this recommendation is very specific and it is unclear why implementation is still “in process.” The second part of the recommendation addresses the need for greater uniformity in the agency’s practice when new children are born to parents with dependent children. This is a substantive issue and while crafting a policy broad enough to apply to all such cases is complicated, the agency should report on its progress. This also applies to the below recommendation made in March 2015, reported to be in the process of implementation:

Recommendation: *“Clarification and guidance should be provided from CA leadership regarding informal and formal placements and third party custody to the field. The Committee also suggested that CA should consider providing field staff with a uniform position by CA regarding third party custody.”*

Another recommendation made in April 2015, shown below, is both specific and actionable, yet is reported to be “in process” and “under consideration” by CA, with no further information:

Recommendation: *“The Committee recommended that the [Name] office consider maintaining the case assignment with an existing assigned worker when a new child is expected, rather than re-assigning to an adolescent unit. This would reduce the number of workers assigned and may encourage the use of shared planning and early engagement to plan for the new child prior to delivery.”*

Finally, a recommendation made in August 2014 received a rather vague progress report, that “[a] briefing is being prepared as to why this is an issue”:

Recommendation: *“The Committee recommends that Children’s Administration explore the possibility of using this case as a discussion/cross-training opportunity during future statewide CA/Judicial collaborations. The key aspect of this recommendation is to provide a professional venue for the discussion of the risks associated with placement with an out-of-state parent when the ICPC does not apply that may result in the reduction of the frequency of critical incidents occurring to children in such cases.”*

This substantive and specific recommendation begs further information regarding CA’s plans to implement it (or not).

D. RECOMMENDATIONS REPORTED AS ADDRESSED BY EXISTING POLICY

As in previous reports, OFCO notes that a substantial number of recommendations (about one quarter) were reported to be either implemented or in the process of implementation, based on the agency’s conclusion that what was recommended is “already standard practice” or “existing policy.” The overarching purpose of child fatality and near fatality reviews is to improve the child welfare system and hold the agency accountable for its part in achieving those improvements. In that spirit, OFCO would like to see the agency take a step further in responding to such recommendations. OFCO believes that the intent of fatality and near fatality review recommendations is to have the agency *carefully examine why standard practice did NOT occur in the case under review, and what can be done to ensure that such errors do not occur in the future.* For example:

1. Including key people in Family Team Decision Meetings (FTDMs)

An infant died of “probable positional asphyxia” after the mother and child fell asleep together on a couch. The mother tested positive for marijuana. CPS had received several reports alleging maltreatment of the infant, related to the mother’s drug use and lack of prenatal care during pregnancy. An FTDM was held, at which it was decided to return the child to the mother with a new safety plan in place.

One of the recommendations made by the review committee was: *“when the office is dealing with a high risk case such as this one, every effort should be made to include community partners and safety plan participants in FTDMs.”* The agency reported that the implementation of this recommendation is “in process”, noting that “this is already the standard practice for FTDMs.”

In cases such as this one, best practice is for the agency to carefully examine the casework practice that led to the committee’s recommendation, and describe steps taken to assure future compliance with existing practice requirements.

2. Establishing a parenting plan prior to dependency dismissal

A child was killed from physical abuse by the father. The child has been previously dependent and the dependency was dismissed just a few months before the fatal incident. The dependency resulted from physical injuries to the child in early infancy, conclusive for physical abuse, which the parents were unable to explain. The perpetrator was never identified. The dependency was dismissed following the mother's completion of court-ordered services and stability during a trial return of the child to her care. The father had never participated in services to address parental deficiencies identified in the dependency, and the mother had reported not being in contact with the father. The dependency had been dismissed prior to the next scheduled dependency review hearing.

The fatality review committee "suggested that best practice would be to require the establishment of a parenting plan prior to dismissal of the case." The review committee apparently believed that a parenting plan could have restricted the father's contact with the child and may have afforded the child some level of protection. Entry of a parenting plan would also demonstrate the mother's ability to utilize the family court system to protect her child once the dependency case was dismissed.

In 2009, legislation was passed authorizing Juvenile Courts to enter parenting plans or modify existing parenting plans as part of the dependency disposition order or at dependency review hearings.⁶⁷ In order to ensure that this policy is considered in similar cases in future, CA reports that it will update and re-circulate to staff statewide a practice memo summarizing the requirements and procedures for entering or modifying parenting plans as part of a dependency case.

CONCLUSION

Recommendations made in child fatality and near fatality reviews have led to significant changes in state law and child welfare practices. For example, laws expanding the definition of "negligent treatment or maltreatment" to include the cumulative effects of chronic neglect, and requirements that the department identify and assess potential caregivers living in a parents home prior to returning a child to the parent, were made in response to issues identified and recommendations made in child fatality reviews.⁶⁸ As discussed in this and previous reports, many of the recommendations have strengthened training and improved collaboration between state and community partners within the child welfare system.

Over the past several years, changes have been made to improve and expand the child fatality and near fatality review process. In 2011 legislation was passed to allow for the release of autopsy reports to CA for the purposes of conducting child fatality reviews.⁶⁹ In 2012, CA established a centralized child fatality review process. In 2015 legislation was passed requiring the department to conduct near fatality reviews of children involved with the child welfare system, and that the Department of Early Learning also review child fatalities occurring at licensed child care facilities.⁷⁰

⁶⁷ Chapter 526, Laws of 2009.

⁶⁸ Justice and Raiden Robinson, 2004 and Sirta Sotelo, 2005 Fatality Reviews. <http://ofco.wa.gov>

⁶⁹ RCW 68.50.105

⁷⁰ RCW 74.13.640 and RCW 43.215.490

Conducting these reviews is critical to strengthening our child welfare system and protecting children. In March 2016 the National Commission to Eliminate Child Abuse and Neglect Fatalities, released its report, *“Within Our Reach: A National Strategy to Eliminate Child Abuse and Neglect Fatalities.”*⁷¹ A primary recommendation in this report is that states conduct a review of all child abuse and neglect fatalities, and using the knowledge gained in these reviews, develop and implement a fatality prevention plan. The report also notes that a prior report to CPS was the single strongest predictor of a child’s potential risk for death.⁷² This reinforces the critical importance of reviewing these cases, examining the family’s prior involvement with CPS, and developing and implementing strategies to prevent child abuse and neglect fatalities.

OFCO thanks the many professionals, both within CA and the broader child welfare community, for their participation in child fatality and near fatality reviews and their contributions to better protect children in Washington State.

⁷¹ <http://eliminatechildabusefatalities.sites.usa.gov/http://eliminatechildabusefatalities.sites.usa.gov/>

⁷² Id. page 44.

APPENDICES

APPENDIX A:

Maltreatment Related Child Fatality Data

APPENDIX B:

Maltreatment Related Child Near Fatality Data

APPENDIX C:

Child Fatality and Near Fatality Review Recommendations
2014-2015

APPENDIX D:

The Role of OFCO

APPENDIX A: MALTREATMENT RELATED CHILD FATALITY DATA

Table 5: Number of Maltreatment Related Child Fatalities per Year

(n = 158)

	# 2012	# 2013	# 2014	# 2015
Clear Physical Abuse	6	4	6	5
Clear Neglect	10	13	7	8
Child Maltreatment Concerns	18	33	28	20

Table 6: Manner of Death per Year

(n = 158)

	# 2012	# 2013	# 2014	# 2015
Homicide	8	4	5	5
Accidental	13	21	16	7
Natural / Medical	5	11	13	14
Suicide	0	5	0	2
Unknown / Undetermined	8	9	7	5

Table 7: Child Age at Time of Death per Year

(n = 158)

	# 2012	# 2013	# 2014	# 2015
12 Months or Less	18	32	30	24
1-3 Years	8	4	6	3
4-7 Years	4	4	4	2
8-12 Years	2	3	0	1
13-17 Years	2	7	1	3

Table 8: Manner of Death by Age Group

(n = 158)

Less than 12 months			1 - 3 Years		
	#	%		#	%
Accidental	40	38.5%	Accidental	8	38.1%
Homicide	7	6.7%	Homicide	8	38.1%
Natural/Medical	33	31.7%	Natural/Medical	0	0.0%
Suicide	0	0.0%	Suicide	0	0.0%
Unknown/Undetermined	24	23.1%	Unknown/Undetermined	5	23.8%

4 - 7 Years			8 - 12 Years		
	#	%		#	%
Accidental	4	28.6%	Accidental	3	50.0%
Homicide	5	35.7%	Homicide	0	0.0%
Natural/Medical	5	35.7%	Natural/Medical	3	50.0%
Suicide	0	0.0%	Suicide	0	0.0%
Unknown/Undetermined	0	0.0%	Unknown/Undetermined	0	0.0%

13 - 17 Years		
	#	%
Accidental	2	15%
Homicide	2	15%
Natural/Medical	2	15%
Suicide	7	54%
Unknown/Undetermined	0	0%

Table 9: Child Age at Time of Death per Year

(n = 158)

Race and Ethnicity	# 2012	# 2013	# 2014	# 2015
American Indian or Alaska Native	8	6	2	1
Asian or Pacific Islander	1	2	1	3
African American	0	5	6	3
Caucasian	20	28	22	20
Multi-Racial	4	8	5	6
Other or Unknown	1	1	5	0
Latino / Hispanic	0	6	6	2

APPENDIX B: MALTREATMENT RELATED CHILD NEAR FATALITY DATA

Table 10: Maltreatment Related Child Near Fatalities per Year

(n = 81)

	# 2012	# 2013	# 2014	# 2015
Clear Neglect	10	7	4	10
Clear Physical Abuse	3	14	5	5
Child Maltreatment Concerns	2	9	10	2

Table 11: Child Age at Time of Near Fatality per Year

(n = 81)

	# 2012	# 2013	# 2014	# 2015
12 Months or Less	6	12	6	3
1-3 Years	7	11	4	7
4-7 Years	0	3	4	4
8-12 Years	0	0	0	2
13-17 Years	2	4	5	1

APPENDIX C: CHILD FATALITY AND NEAR FATALITY REVIEW RECOMMENDATIONS 2014-2015

The recommendations made by representatives from the community, OFCO and CA participating in child fatality and near fatality reviews are forwarded to a CA administrator or CA’s Continuous Quality Improvement Committee for review and prioritization. At regular intervals, administrators are required to report on the progress of implementing a recommendation or provide a written response when a specific recommendation was not implemented.

Listed below, by topic are the 61 recommendations made in child fatality and near fatality reviews conducted from April 2014 through July 2015 and the implementation status for each recommendation. Recommendations that were considered and not implemented are also listed separately, with the department’s explanation why no further action was taken on the recommendation.

PROVIDE TRAINING	
<i>Safety</i> – The investigator assigned to the October investigation [should] receive training on child sexual assault protocols and additional training specific to investigating and understanding the dynamics of familial sexual abuse prior to being assigned to other sexual assault investigations.	Status: Completed Level: Local
<i>Safety</i> – The CPS supervisor [should] receive additional support and training about the supervisory review tool, or about using a format/template to insure that the reviews consistently reflect all performance measures and practice requirements, as well as providing clinical direction needed to guide the investigation and assure child safety.	Status: Completed Level: Local
<i>Supervision</i> – The Committee recommended that the Area Administrator work with Regional CPS Program staff to identify a mentor for the supervisor to partner with to improve and reinforce clinical supervision skills and to develop a plan for continued staff development and training among staff. The Committee recognized the challenges faced by supervisors in smaller offices who are required to have expertise in all programs and recommended that the mentor be a staff member who is experienced with supervision and understands the challenges of supervising multiple programs.	Status: Completed Level: Local
<i>Safe Sleep</i> – The Committee recommended the local office collaborate with the Alliance for Child Welfare Excellence to ensure that all staff are trained in the appropriate approach to discuss safe sleep with clients and with the local public health department on outreach and education.	Status: Completed Level: Local

PROVIDE TRAINING

<p><i>Cross-train DCFS Staff</i> – The Committee recommended that the local office staff and Area Administrator consider cross training staff to help with case coverage during times of staff shortages. The Committee recognized that the [local] office currently has some relatively new staff and this may be a long range goal but still saw a benefit to this for staff.</p>	<p>Status: Completed Level: Local</p>
<p><i>Safety Planning and Risk Assessment</i> – The local office should consider additional training through the Alliance specific to safety planning and safety plan analysis.</p>	<p>Status: Completed Level: Local</p>
<p><i>Safety Planning and Risk Assessment</i> – The Committee recommended that all staff receive updated training on a regular basis regarding assessing safety throughout the life of a case and writing effective safety plans. The Committee stated the best method to meet this recommendation would be to utilize infield mentoring by the Alliance for Child Welfare Excellence. The Committee also acknowledged that small group work such as in unit meetings versus large classroom education would be a second, less preferred option.</p>	<p>Status: In process Level: Statewide</p>
<p><i>Suicide</i> – CA should consider making available to any CA staff a (non-mandatory) presentation (e.g., web-based) that provides basic information regarding both risk factors and warning signs for suicide.</p>	<p>Status: In process Level: Statewide</p>
<p><i>Researching History</i> – Regional Core Training through the Alliance for Child Welfare Excellence should include specific training on searching for history on individuals named in intakes.</p>	<p>Status: Completed Level: Statewide</p>
<p><i>Safety Planning and Risk Assessment</i> – The Committee believed that additional information and history would have led to a more thorough assessment of the home situation and a more comprehensive response to the gathering questions, resulting in more specific and focused service delivery and increased child safety. Therefore, the Committee recommended reviewing Policy 2331, Investigative standards.</p>	<p>Status: In process Level: Local</p>
<p><i>Domestic Violence</i> – The parents were referred to couples counseling and allowed to work with the same provider, both of which are contra-indicated in domestic violence cases. The Committee recommended the use of identified experts in the field of assessing domestic violence. In addition, the Committee recommended that the unit complete training through the Alliance focused on the domestic violence practice guide.</p>	<p>Status: In process Level: Local</p>

PROVIDE TRAINING

<p><i>Health and Safety Visits</i> – The Committee noted that there was not a health and safety check done within seven days of the child’s placement in the parent’s care. Therefore, the Committee recommends reviewing Policy 4420, which addresses the requirements for health and safety contacts.</p>	<p>Status: Completed Level: Local</p>
<p><i>Substance Abuse</i> – The Committee believes that CA staff throughout the state would benefit from guidance about the system’s response to the legalization of marijuana and training specifically focused on understanding of marijuana as a drug. The Committee recognized that the fairly recent legalization of marijuana has posed a challenge to workers trying to assess risk in homes where regular marijuana use is occurring. As marijuana use becomes more common, workers need training to better assess the impact and risks to children who live in homes where marijuana use is regular and frequent. The Committee recommended that CA collaborate with Alliance for Child Welfare Excellence to develop, at minimum, a resource guide for staff that focuses on this issue.</p>	<p>Status: Considered but not implemented Level: Statewide</p>
<p><i>Safety Planning and Risk Assessment</i> – The Committee believes that CA should provide regular, ongoing training about the use and application of the safety framework, specifically in the development of safety plans.</p>	<p>Status: In process Level: Statewide</p>
<p><i>Safety Planning and Risk Assessment</i> – CA should have regular, ongoing safety assessment training for all staff.</p>	<p>Status: In process Level: Statewide</p>
<p><i>Substance Abuse</i> – The Committee believes that staff statewide would benefit from ongoing training regarding alcohol abuse. The Committee expressed concern that some CA staff may have a bias regarding alcohol abuse and lethality.</p>	<p>Status: In process Level: Statewide</p>
<p><i>Safety Planning and Risk Assessment</i> – The Committee recommended that the department collaborate with the Alliance for Child Welfare to provide training on the Child Safety Framework that is specific to CFWS cases. It is recommended that the training focus the following: Global assessment and gathering of information throughout the case in order to identify parental deficiencies and correctly identify tasks and services that can address those deficiencies and measure progress in addition to compliance; safety assessment at key decision points; and safety planning, including understanding key elements of strong safety plans, and implementing safety plans when children are returned home.</p>	<p>Status: Completed Level: Statewide</p>

PROVIDE TRAINING	
<i>Foster Parent Education</i> – CA should consider reviewing what is contained in packets given to foster caregivers for when infants are placed and evaluate if additional or modified materials regarding safe sleep could be incorporated. This might include suggestions for licensors and DCFS workers to explain to caregivers why safe sleep is important and suggest ways of offering help to foster parents if needed.	Status: Completed Level: Statewide
<i>MedCon</i> – CA should provide training to all staff regarding the utilization of the Medical Consultation Network, highlighting that the consultations can also include medically complex cases.	Status: Completed Level: Statewide
<i>Background Checks</i> – The Committee recommended that the local office staff work with the Alliance for Child Welfare Excellence to complete training on the application and use of the background check policy, to include the use of shared decision-making and critical thinking to evaluate history, recognize patterns of behavior, and assess a potential caregiver for suitability and reliability.	Status: In process Level: Local

CASEWORK PRACTICE	
<i>Safety Planning and Risk Assessment</i> – The CPS supervisor should provide a higher level of supervision to this worker on high risk cases to insure that investigations are comprehensive and thoroughly assess child safety and risk.	Status: Considered but not implemented Level: Local
<i>Practice Consultation</i> – The Committee recommended that the CFWS unit consider reviewing this case with a practice consultant, CPS program manager or Alliance staff for consideration of ongoing services, re-assessment of safety and to determine if the correct safety threat is identified.	Status: Considered but not implemented Level: Local
<i>Safety Assessment (Case Specific)</i> – The assigned staff should obtain the photos of the home taken by the police on the day of the fatality and ensure they are in the parent’s file for future reference and help with assessing safety and risk.	Status: Completed Level: Local
<i>Collaboration with Service Providers</i> – Insure that future service providers for this family are given an accurate summary of prior services that have been provided to this client.	N/A – no recommendation

CASEWORK PRACTICE

<p><i>Safety Planning and Risk Assessment</i> – The Committee recommended that CA reevaluate the tools used in the Safety Framework as they are currently designed in order to make the assessment process more cohesive.</p>	<p>Status: In process Level: Statewide</p>
<p><i>FTDMs / Partnerships with Community Professionals</i> – The committee felt that when the office is dealing with a high risk case such as this one, every effort should be made to include community partners and safety plan participants in FTDMs.</p>	<p>Status: In process Level: Local</p>
<p><i>Safety Planning and Risk Assessment</i> – The CPS staff of this office should consider developing practice of using the SDM at the same time as the safety assessment to better inform case planning and assess risk.</p>	<p>Status: In process Level: Local</p>
<p><i>Practice Consultation</i> – When dealing with a high risk case where the safety plan is not being followed, the SW and supervisor should consider staffing with the AAG, CPS program Manager or Practice Consultant for shared decision-making.</p>	<p>Status: Completed Level: Statewide</p>
<p><i>Practice Consultation</i> – The Committee recommended that CA remind staff about practice consultation resources available through CA Quality Improvement or Policy Divisions. The names and contact information for the Practice Consultants and Policy Program Managers should be provided to all staff on a regular basis.</p>	<p>Status: Completed Level: Statewide</p>
<p><i>Contracted Providers</i> – In order to improve accountability of contracted providers, CA should explore continued and improved ways to message out to CA staff the agency expectations and process for forwarding concerns about contracted provider service delivery. This would include clear reminders to workers, supervisors, and administrators on how to proceed with concerns about contracted providers.</p>	<p>Status: Completed Level: Statewide</p>
<p><i>Third Party Custody</i> – Clarification and guidance should be provided from CA leadership regarding informal and formal placements and third party custody to the field. The Committee also suggested that CA should consider providing field staff with a uniform position by CA regarding third party custody.</p>	<p>Status: In process Level: Statewide</p>
<p><i>Use of Chemical Dependency Providers</i> - The Committee believed that the alleged substance abuse by the parents was not adequately assessed. The Committee recommended the use of identified experts in chemical dependency to assess the parents use, and possible abuse, of both legal and illegal substances.</p>	<p>Status: Completed Level: Local</p>

CASEWORK PRACTICE

<p><i>Use of Mental Health Providers</i> – The Committee questioned whether or not the family therapist fully assessed the impact of the mother’s depression on her ability to parent. The Committee recommended the use of mental health expert when there is credible information that a parent is suffering from mental illness.</p>	<p>Status: Completed Level: Local</p>
<p><i>Case Assignment</i> – The local office should reassess their practice of not reassigning CPS intakes to the previously assigned social worker. The Committee believes it can be positive for a worker to have the personal history of a family when assessing a new intake, but acknowledged that practice must be balanced with keeping an open mind during each investigation. The Committee discussed the pitfalls of reassigning a case to the previous worker as the investigator may not recognize safety threats and risk when becoming too familiar with a family. It is the hope of the Committee that the assigned supervisor can provide objective oversight to make sure an appropriate assessment is completed.</p>	<p>Status: In process Level: Region</p>
<p><i>Safety Planning and Risk Assessment</i> – CA should discuss the value of continued utilization of the SDM. During the Committee discussion, this issue was identified as statewide and not specific to the local office. The Committee questions the benefit that continued use of the SDM provides. If CA continues use of the SDM, the Committee strongly suggested ongoing refresher trainings for all CPS staff. After the review was completed, the Area Administrator informed this writer that the office held a training for all CPS workers on the SDM recently because she was aware of the challenges of accurate completion of this tool.</p>	<p>Status: In process Level: Statewide</p>
<p><i>Intakes</i> – The Committee noted that there seem to be variations in practice regarding the department’s response when new children are born to families who have dependent children. The Committee recommended that the department use Regional Program Consultants to promote consensus and clarity about who is responsible to call intake and how these intakes are assigned. In addition, the Committee recommended that the local office consider having shared planning meetings with families prior to the birth of new children on open CFWS cases.</p>	<p>Status: In process Level: Local</p>
<p><i>Practice Consultation</i> – The Committee recommended that challenging cases like this where there are unexplained injuries to a child, that supervisors and line staff consider seeking assistance from the CPS Regional Practice Consultant or CPS Program Manager to help articulate their case to the court and to clearly frame services so that they are targeted to address parental deficiencies.</p>	<p>Status: In process Level: Statewide</p>

CASEWORK PRACTICE	
<i>Parenting Plan</i> – The Committee suggested that best practice would be to require the establishment of a parenting plan prior to dismissal of the case.	Status: In process Level: Statewide
<i>Safe Sleep</i> – Consider changing CA policy which currently does not require workers to observe sleep environments (rooms, beds, cribs, bedding materials) during all health and safety visits in both in-home and out-of-home placements. Minimally such change in policy would require such activity for any child under age one.	Status: Completed Level: Statewide
<i>Safe Sleep</i> – Consider expanding the recently revised “CA Worker Health & Safety Visits with Child - Required Information for Documentation (04-09-15)” guidelines to include, in the section on observations of non-verbal children, specific documentation of infant sleep environment during monthly health and safety visits.	Status: Completed Level: Statewide
<i>Safe Sleep</i> – Consider expanding the recently revised “CA Worker Monthly Visit with Caregiver - Required Information for Documentation (04-09-15)” guidelines to include suggestions for specific conversations with caregivers as to infant safe sleep environment.	Status: In process Level: Statewide
<i>Family Evaluation</i> – In order to ensure that relevant information about parental capacity gathered during the investigation of the child’s death is included in the parent’s case history, the Committee recommends that the current worker review the investigation and incorporate this in the current Comprehensive Family Evaluation.	Status: In process Level: Local
<i>Case Assignment</i> – The Committee recommended that the office consider maintaining the case assignment with an existing assigned worker when a new child is expected, rather than re-assigning to an adolescent unit. This would reduce the number of workers assigned and may encourage the use of shared planning and early engagement to plan for the new child prior to delivery.	Status: In process Level: Local

PARTNERSHIPS WITH COMMUNITY PROFESSIONALS	
<i>Law Enforcement</i> – The Committee recommended that the CPS program manager or practice consultant coordinate with staff from the local CA offices to conduct outreach and training with area law enforcement agencies regarding the reporting requirements in RCW 26.44.250.	Status: In process Level: Region

PARTNERSHIPS WITH COMMUNITY PROFESSIONALS

<p><i>Law Enforcement</i> – An administrative representative from the local office will speak with the law enforcement agency regarding the decision to mail the April 26, 2014, report rather than calling CA intake. The Committee believed the report should have been called in to intake rather than mailed. An administrative representative from the local office should also speak with the medical facility that did not report the February 7, 2012 incident involving the child accessing and ingesting methadone.</p>	<p>Status: Completed Level: Region</p>
<p><i>DDA</i> – CA should evaluate the need and/or benefit of cross-training opportunities with DDA that would include information as to the agency collaboration and the current interagency Memorandum of Understanding.</p>	<p>Status: In process Level: Statewide</p>
<p><i>Service Providers</i> – The local office staff coordinate with community providers who work with infants, to share information about safe sleep guidelines, so that they are aware of the Department’s policy about the issue.</p>	<p>Status: Completed Level: Office</p>

OTHER

<p><i>Tools and Resources Available to Caseworkers</i> – Children's Administration should further evaluate providing, either through funding or donations, CPS investigators with mobile electronic equipment beyond what is currently available. Specifically the Committee noted a tablet or related item could be used to take photographs, access DSHS programs such as FAMLINK, ACES and other available databases which would help workers utilize their time in the field in a more cost effective manner and could aid in worker safety and investigations.</p>	<p>Status: Completed Level: Statewide</p>
<p><i>Resources</i> – CA should explore obtaining Superior Court Office Management Information System (SCOMIS) and DISCIS access to aid in thorough CPS investigations. These two tools would allow workers to seek and obtain information related to criminal history that is not currently available to CA staff. The information obtained may assist in more appropriate completion of the Structured Decision Making tool as well as appropriately assessing safety within a family.</p>	<p>Status: Completed Level: Statewide</p>

APPENDIX D: THE ROLE OF OFCO

The Washington State Legislature created the Office of the Family and Children’s Ombuds⁷³ (OFCO) in 1996 in response to two high profile incidents that indicated a need for oversight of the child welfare system.⁷⁴ OFCO provides citizens an avenue to obtain an independent and impartial review of Department of Social and Health Services (DSHS) decisions. OFCO is also empowered to intervene to induce DSHS to change problematic decisions that are in violation of the law or that have placed a child or family at risk of harm, and to recommend system-wide improvements to the Legislature and the Governor.

- **Independence.** One of OFCO’s most important features is independence. OFCO’s ability to review and analyze complaints in an independent manner allows the office to maintain its reputation for integrity and objectivity. Although OFCO is organizationally located within the Office of the Governor, it conducts its operations independently of the Governor’s Office in Olympia. OFCO is a separate agency from DSHS.
- **Impartiality.** The Ombuds acts as a *neutral investigator* and not as an advocate for individuals who file complaints, or for the government agencies investigated. This neutrality reinforces OFCO’s credibility.
- **Confidentiality.** OFCO must maintain the confidentiality of complainants and information obtained during investigations. This protection makes citizens, including DSHS professionals, more likely to contact OFCO and speak candidly about their concerns.
- **Credible review process.** OFCO has a credible review process that promotes respect and confidence in OFCO’s oversight of DSHS. Ombuds are qualified to analyze issues and conduct investigations into matters of child welfare law, administration, policy, and practice. OFCO’s staff has a wealth of collective experience and expertise in child welfare law, social work, mediation, and clinical practice and is trained in the United States Ombudsman Association Governmental Ombudsman Standards. OFCO and DSHS operate under an inter-agency agreement that guides communication between the two agencies and promotes accountability.⁷⁵

AUTHORITY

Under chapter RCW 43.06A, the Legislature enhanced OFCO’s investigative powers by providing it with broad access to confidential DSHS records and the agency’s computerized case-management system. It

⁷³ State law requires that all statutes must be written in gender-neutral terms unless a specification of gender is intended. Pursuant to Chapter 23 Laws of 2013, the term “ombudsman” was replaced by “ombuds”. <http://apps.leg.wa.gov/documents/billdocs/2013-14/Pdf/Bills/Session%20Laws/Senate/5077-S.SL.pdf>

⁷⁴ The death of three year old Lauria Grace, who was killed by her mother while under the supervision of the Department of Social and Health Services (DSHS), and the discovery of years of sexual abuse between youths at the DSHS-licensed OK Boys Ranch. The establishment of the office also coincided with growing concerns about DSHS’ role and practices in the Wenatchee child sexual abuse investigations.

⁷⁵ The inter-agency agreement is available online at http://ofco.wa.gov/documents/interagency_ofco_dshs.pdf

also authorizes OFCO to receive confidential information from other agencies and service providers, including mental health professionals, guardians ad litem, and assistant attorneys general.⁷⁶ OFCO operates under a shield law which protects the confidentiality of OFCO's investigative records and the identities of individuals who contact the office. This encourages individuals to come forward with information and concerns without fear of possible retaliation. Additional duties have been assigned to OFCO by the Legislature over the years regarding the reporting and review of child fatalities, near fatalities, and cases of children experiencing recurrent maltreatment.⁷⁷

OFCO derives influence from its close proximity to the Governor and the Legislature. The Director is appointed by and reports directly to the Governor. The appointment is subject to confirmation by the Washington State Senate. The Director-Ombuds serves a three-year term and continues to serve in this role until a successor is appointed. OFCO's budget, general operations, and system improvement recommendations are reviewed by the Legislative Children's Oversight Committee.

WORK ACTIVITIES

OFCO performs its statutory duties through its work in four areas, currently conducted by *6.8 full time employees*:

- **Listening to Families and Citizens.** Individuals who contact OFCO with an inquiry or complaint often feel that DSHS or another agency is not listening to their concerns. By listening carefully, the Ombuds can effectively assess and respond to individual concerns as well as identify recurring problems faced by families and children throughout the system.
- **Responding to Complaints.** The Ombuds impartially investigates and analyzes complaints against DSHS and other agencies. OFCO spends more time on this activity than any other. This enables OFCO to intervene on citizens' behalf when necessary, and accurately identify problematic policy and practice issues that warrant further examination. Impartial investigations also enable OFCO to support actions of the agency when it is unfairly criticized for properly carrying out its duties.
- **Taking Action on Behalf of Children and Families.** The Ombuds intervenes when necessary to avert or correct a harmful oversight or mistake by DSHS or another agency. Typical interventions include: prompting the agency to take a "closer look" at a concern, facilitating information sharing, mediating professional disagreements, and sharing OFCO's investigative findings and analyses with the agency to correct a problematic decision. These interventions are often successful in resolving legitimate concerns.
- **Improving the System.** Through complaint investigations and reviews of critical incidents (including child fatalities, near fatalities, and cases of children experiencing recurrent maltreatment), OFCO works to identify and investigate system-wide problems, and publishes its findings and recommendations in public reports to the Governor and the Legislature. This is an effective tool for educating state policymakers and agency officials about the need to create, change or set aside, laws, policies or agency practices so that children are better protected and cared for and families are better served by the child welfare system.

⁷⁶ See also RCW 13.50.100(6).

⁷⁷ See RCW 74.13.640(1) (b); 74.13.640(2); and 26.44.030(15).