Office of the Family and Children's Ombuds

Child Fatalities and Near Fatalities in Washington State

A report on data and reviews

2018

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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. OFCO also participates in executive child fatality and near fatality reviews and reports on the implementation status of recommendations produced from these executive reviews. Through this process, OFCO identifies issues related to these critical incidents, and facilitates systemic improvements.

OFCO CRITICAL INCIDENT REVIEWS

Section I of this report describes OFCO's critical incident review activities from January 1, 2017 to December 31, 2017. The critical incidents discussed in this report include:

- **Child Fatalities:** When there is an open case on the family at the time of the fatality or any Department of Children, Youth, and Families (DCYF) history with the family within twelve months of the fatality, including "information only" referrals; or when the fatality occurred in a DCYF licensed, certified, or state operated facility.

- **Child Near Fatalities:** When the near fatality is a result of alleged child abuse and/or neglect and there is an open case or a case with DCYF history within twelve months, including "information only" referrals; or the near fatality occurred in a DCYF 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 examines all child fatalities and near fatalities, both involving child abuse or neglect and cases unrelated to child maltreatment, when the child's family had DCYF history within one year prior to the incident. In 2017, OFCO examined a total of **65 child fatality cases** and **24 near fatality cases**. Through this process 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 **African American or Black children are disproportionally high** relative to their representation in the state population.
- Major risk factors include: **substance abuse** by; and/or **mental health** problems of a caregiver; and/or a history of **domestic violence** in the family.
- **Suicide among youth** is a rising problem across the nation. OFCO reviewed critical incidents from 2014-2017 and observed the **deaths and near deaths by suicide of 26 youth**.

OFCO also reviewed **98 cases of recurrent maltreatment in 2017**. 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 DCYF 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 DCYF 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 DCYF between June 30, 2016 and September 30, 2017. During this time period, DCYF conducted reviews in twenty child fatalities and eight near-fatal incidents.

These reviews produced **44 recommendations**. Based on information provided by DCYF, OFCO found that nine recommendations (20.5 percent) had been fully implemented, and 33 were either still in the process of implementation or under consideration by the Department. The majority of recommendations addressed statewide issues (61.4 percent).

DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES

Beginning July 1, 2018 the former DSHS Children's Administration joined with the Department of Early Learning to form the Department of Children, Youth, and Families (DCYF). The fatalities, near fatalities, and reviews discussed in this report all occurred prior to the creation of DCYF, however this report refers to the state's child welfare agency by its current name, DCYF.

SECTION I
OFCO CRITICAL INCIDENT REVIEWS

BACKGROUND

The Department notifies OFCO when a critical incident, such as a child fatality or near fatality, occurs.[1] OFCO then immediately begins an independent preliminary review of the circumstances surrounding the incident and the Department's involvement. Critical incidents include:

- **Child Fatalities:** When the family was involved in the child welfare system within the preceding twelve months of the child's death, including "information only" referrals; or when the fatality occurred in a DCYF licensed, certified, or state operated facility.[2]

- **Child Near Fatalities:**[3] When the near fatality is a result of alleged child abuse and/or neglect and the family was involved in the child welfare system within the preceding twelve months, including "information only" referrals; or the near fatality occurred in a DCYF 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.[4]

- **Recurrent Maltreatment:**[5] When children in the same family experience three founded reports of alleged abuse or neglect within the preceding 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 DCYF clients (such as dangerous behavior by foster youth), or incidents affecting DCYF 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, 2017 to December 31, 2017. Over this one year period, OFCO conducted:

- **65** administrative examinations of child fatalities involving both child abuse or neglect and cases unrelated to child maltreatment;
- **24** examinations of child near fatalities; and
- **98** reviews of cases of recurrent maltreatment.

[1] OFCO receives notice through DCYF's Administrative Incident Reporting System (AIRS).
[2] 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 DCYF database.
[3] 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.
[4] RCW 74.13.500.
[5] RCW 26.44.030(15).

CHILD FATALITIES EXAMINED BY OFCO

OFCO conducts a preliminary review of all fatalities in which the child's family was involved with the child welfare system 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.[6]

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 DCYF 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, DCYF conducts a similar administrative review of all critical incidents and in some cases convenes an executive child fatality review committee.[7] Because OFCO uses slightly broader criteria to determine whether further examination of a fatality is warranted, fatality data compiled by DCYF and OFCO may vary.

OFCO examined **65 child fatalities in 2017**.[8] 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.

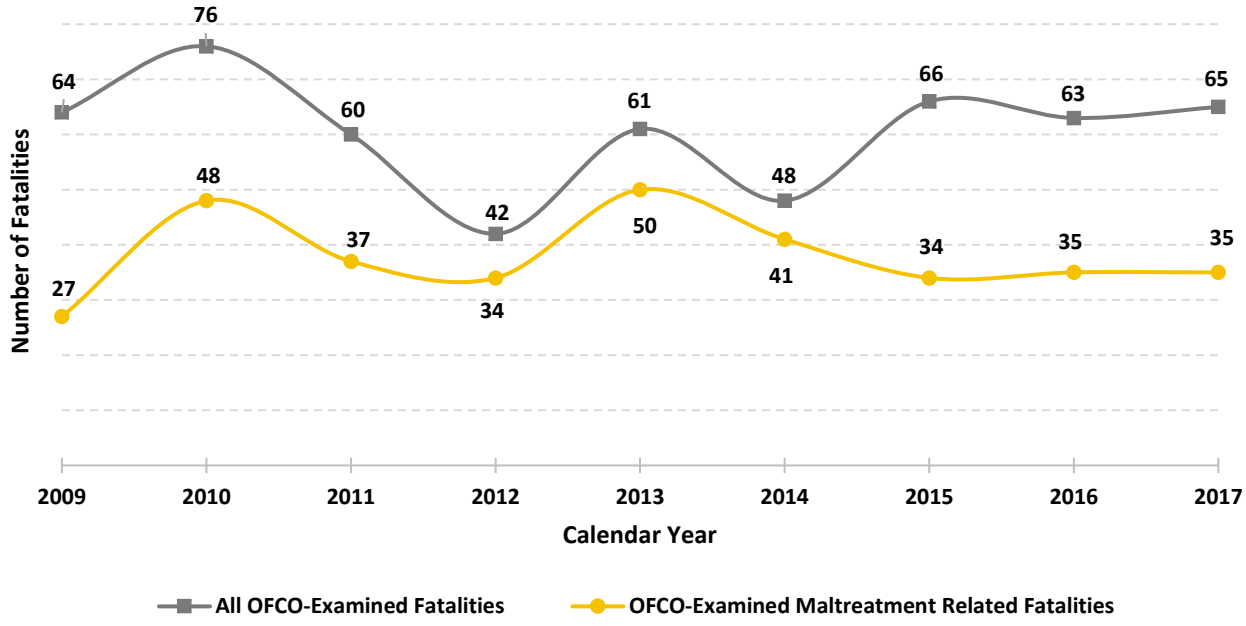
OFCO defines **maltreatment related fatalities** to be those in which:

- 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.

Of the 65 child fatalities examined by OFCO in 2017, OFCO considered 35 to be related in some way to child maltreatment. The following data describes the profile of these 35 maltreatment related child fatalities. While this report primarily focuses on incidents that occurred in 2017, four years of demographic data is available in Appendix A in order to contextualize these incidents and show year-to-year differences.

[6] "DCYF history" may include reports to CPS that were not screened in for investigation.
[7] State law requires DCYF 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 twelve months before the death.
[8] Calendar year.

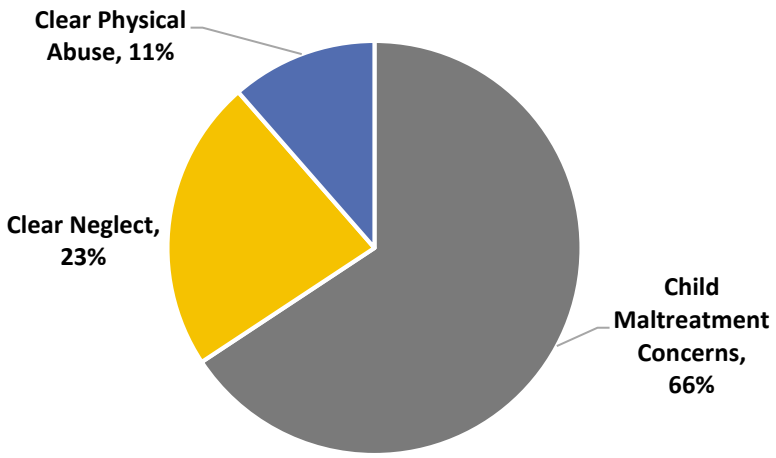
Figure 1: **OFCO-Examined Child Fatalities by Year**



MALTREATMENT RELATED CHILD FATALITIES

Of the 65 child fatalities examined by OFCO in 2017, OFCO considered 35 to be related to child maltreatment. Eight children died as a direct result of neglect and four died from physical abuse. OFCO found that child abuse or neglect concerns were present and may have contributed to the child's death in another 23 cases.[9]

Figure 2: **Type of Maltreatment in Child Fatalities, 2017**
(n = 35)



OFCO CHILD MALTREATMENT DEFINITIONS

Clear Physical Abuse: A CPS investigation concluded that 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 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] 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 12 of the 35 maltreatment related deaths examined during this period resulted in a "founded" finding for neglect and/or physical abuse. Investigations into 12 of the deaths were "unfounded". In the remaining 11 deaths no findings were made.

Fatality Case Examples by Maltreatment Type

Example 1: Clear Physical Abuse

An infant died as a result of physical injuries inflicted by the father. The child was admitted to the hospital with serious head injuries and multiple fractures. An exam also revealed the child had trauma that was consistent with sexual abuse. The child later passed away from the injuries. A CPS risk only investigation had been active since the child's birth. The hospital contacted CPS when the mother and infant tested positive for opiates and marijuana at birth. The caseworker saw the child and met with the mother while they were still in the hospital, though the father was not present at the time. After the family was discharged the caseworker made attempts to meet with the family again and see the home but was unable to locate the family before the assault occurred.

The CPS investigation into the fatality resulted in founded findings of physical abuse, sexual abuse, and neglect for the father. The child's father was arrested and charged in the child's death.

Example 2: Clear Neglect

A five-month-old infant was found unresponsive on a bed the baby was sharing with the father. The father admitted to using heroin within twelve hours of the child's death and the mother reported using methamphetamine within 24 hours. The toxicology screen completed by the Medical Examiner's office revealed methamphetamines in the baby's system, at levels consistent with second hand methamphetamine smoke but not high enough to be the cause of death. The death was determined to be Sudden Unexpected Infant Death with an unsafe sleep environment and adult overlay (adult rolling over onto child) as contributing factors. The CPS investigation conducted into the fatality resulted in a founded finding of neglect for both parents.

Example 3: Child Maltreatment Concerns

A one-year-old died after being hit by a car the child's father was backing out of the driveway of the mother's home. Though the father did not visibly appear under the influence, he refused to complete a toxicology screen following the accident. The father had a previous conviction for vehicular homicide while he was driving under the influence. In the weeks following the child's death, the father was admitted to the hospital for suicidal ideations and drug withdrawal.

The family had a Family Voluntary Services (FVS) case that closed six months prior to the child's death. This case resulted from allegations of domestic violence between the parents and an alleged suicide threat by the father. At the time the FVS case was closed, a protection order prohibited contact between the parents. The father had a history of alcohol abuse and reportedly continued to drink. The CPS investigation conducted into the fatality resulted in an unfounded finding for neglect for the father.

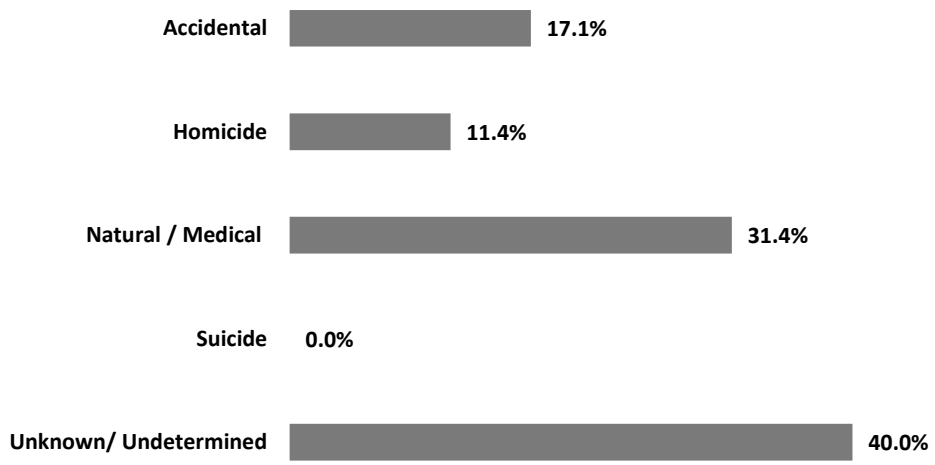
MANNER OF DEATH

The manner and cause of death is determined by a medical examiner or coroner.[10] 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 or 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, 2017**
(n = 35)



Sudden Unexpected Infant Death (SUID) is a broad category of infant death (birth to twelve 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 or undetermined.

[10] This section discusses the manners of death for only maltreatment related fatalities. While there were no suicides related to maltreatment in 2017 there were two deaths by suicide in 2017 that OFCO examined but were not related to maltreatment. See "Youth Suicide" on page 24 for additional information on deaths by suicide.
[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.

Figure 3A: Examples of **Child Fatalities by Manner of Death**

Manner of Death	Summary of Fatality	Summary of Case Status
Accidental	A one-month-old infant died when placed to sleep on an adult bed propped up with a wedge pillow by the relative care provider. The Medical Examiner determined the manner of death to be accidental most likely caused by an adult rolling over onto the infant.	• **Case History:** Case open for Child and Family Welfare Services in shelter care status. • **Placement:** Child placed in out-of-home care with a relative. • **Fatality CPS Investigation:** Unfounded finding.
Homicide	A two-year-old child died after being physically abused by the mother's boyfriend. The boyfriend was criminally charged in the death.	• **Case History:** Family had an open Child Protective Services (CPS) investigation relating to earlier suspicious injuries. • **Placement:** Child in parent's care. • **Fatality CPS Investigation:** Resulted in a founded finding of physical abuse by the boyfriend and neglect by the mother.
Natural or Medical	A seven-year-old medically fragile child was found deceased in a home with no heat or electricity. Temperatures outside were below freezing and the child required a feeding tube and other medical equipment. The medical examiner determined the manner of death to be natural/medical with the cause due to pneumonia and other complications.	• **Case History:** Family had an open CPS case relating to the mother not getting the child appropriate medical services. • **Placement:** Child in mother's care. • **Fatality CPS Investigation:** Resulted in a founded finding of neglect by the mother.
Suicide[12]	A fourteen-year-old died by suicide while in the care of the mother and step-father. A recent CPS report alleged the parents were failing to access needed mental health services for their children.	• **Case History: CPS?** Case closed three months before fatality. Family recently involved with Family Assessment Response (FAR) but the case transferred to CPS investigations after the parents did not cooperate with FAR. • **Placement:** Child in parents' care. • **Fatality CPS Investigation:** Mother and step-father each received a founded finding of neglect.
Unknown or Undetermined	A one-month-old infant was found deceased in a bed with the mother, who had been consuming alcohol that night.	• **Case History**: Recent history with Department was an "information only" referral that did not meet the criteria for a CPS or FAR response. • **Placement:** Child in parent's care. • **Fatality CPS Investigation:** The mother was not cooperative so a full investigation could not be completed.

[12] There were no suicides among the OFCO examined maltreatment related fatalities in 2017. This example is from 2016.

CHILD FATALITIES AND RACIAL DISPROPORTIONALITY

As in previous years, maltreatment related child fatalities continue to be disproportionally higher for children of color. While African American children make up 4.4 percent of Washington children, **14.3 percent of maltreatment related child fatalities examined by OFCO in 2017 were those of African American or Black children.** Children identified as multiracial comprised 17.1 percent of fatalities yet are 8.3 percent of Washington's child population. 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.[13]

Table 1: **Child Race and Ethnicity, 2017**
(n = 35)

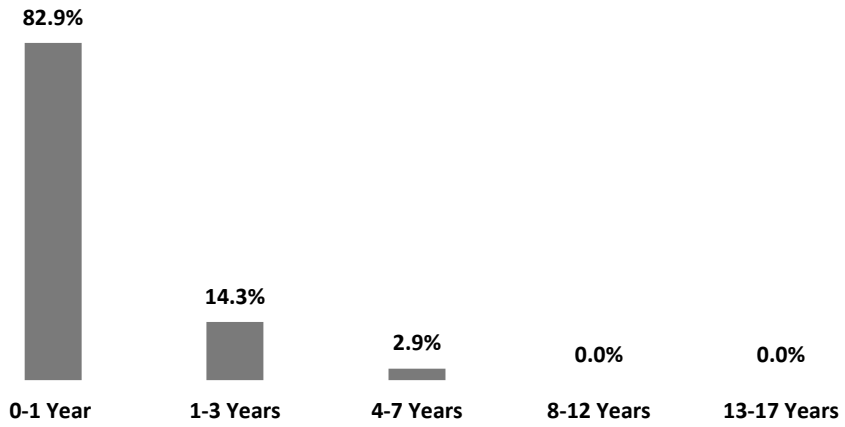
	OFCO-Examined Maltreatment Related Child Fatalities		WA Children in Out of Home Care[14]	WA State Children[15]
	#	%		
African American or Black	5	14.3%	8.8%	4.4%
American Indian or Alaska Native	2	5.7%	4.5%	2.4%
Asian or Pacific Islander	2	5.7%	2.3%	7.8%
Caucasian	18	51.4%	64.7%	77.0%
Other	2	5.7%	0.0%	-
Multi-Racial	6	17.1%	18.5%	8.3%
Latino / Hispanic	2	5.7%	19.0%	18.5%

[13] "Within our Reach: A National Strategy to Eliminate Child Abuse and Neglect Fatalities". Commission to Eliminate Child Abuse and Neglect Fatalities. 2016. https://www.acf.hhs.gov/sites/default/files/cb/cecanf_final_report.pdf.
[14] Number of children in care on January 1, 2018 was 9058. Information from: Partners for Our Children Data Portal Team. (2018). [Graph representation of Washington state child welfare data 6/18/2018]. Children in Out-of-Home Care (Count). Retrieved from http://www.vis.pocdata.org/graphs/ooh-counts.
[15] Ages 0-19. Office of Financial Management. Population estimates by age, sex, race and Hispanic origin. 2010-2017. http://www.ofm.wa.gov/pop/asr/default.asp.

CHILD'S AGE AT TIME OF DEATH

An overwhelming majority of maltreatment related fatalities (97.2 percent) involved children under the age of three. Infants (birth to twelve months) accounted for 82.9 percent of the fatalities. Infants are the most vulnerable to risk of fatal harm from their caregivers. This year there were no maltreatment related deaths of children ages eight to seventeen years.

Figure 4: **Age of Child at Time of Death, 2017**
(n = 35)

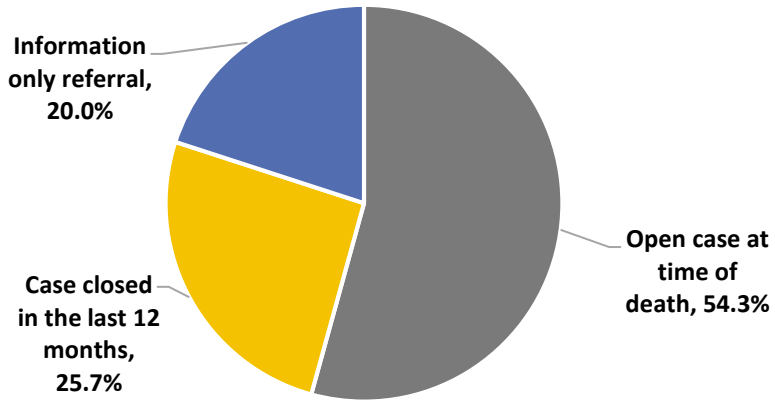


FAMILY CONTACT WITH THE DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES

OFCO examines child fatalities when there is an open case with the family at the time of death or any DCYF history or contact in the preceding twelve months. This includes referrals made to DCYF that were screened as "information only" and did not meet the criteria for investigation or services. OFCO also examines fatalities that occur in a DCYF licensed, certified, or state operated facility.

Over half of the families involved in the maltreatment related fatalities examined by OFCO had an open case with DCYF at the time of death. Twenty-six percent of families had cases that closed in the previous twelve months.

Figure 5: **DCYF Case Status within 12 Months of Fatality, 2017**
(n = 35)



Of the nineteen fatalities with open cases at the time of death, fourteen (73.7 percent) were open for CPS investigation; three families were receiving Child and Family Welfare Services; and two families were participating in Family Voluntary Services.

Table 2: **Program Type for DCYF Cases Open at Time of Death, 2017**

Program Type (Open at Time of Death)	Program Description[16]	Number of Fatalities (n=19)	Percent
Child Protective Services (CPS) – Investigation Pathway	Investigates screened in reports of child maltreatment.	14	73.7%
Child and Family Welfare Services (CFWS)	Case management and permanency planning for children and youth in out of home placement.	3	15.8%
Family Voluntary Services (FVS)	Cases transfer to FVS after a CPS investigation, AND the parent requests services OR the family was determined to be at moderately high or high risk for abuse or neglect. Participation is voluntary.	2	10.5%
Family Assessment Response (FAR)	A CPS alternative pathway to investigate low to moderate risk screened in reports of child maltreatment, and offer any needed services	0	0%

[16] "Reference Guide 2018: Performance, Governance, Programs and Services." Children's Administration, Department of Social and Health Services. 2017. https://www.dshs.wa.gov/sites/default/files/CA/pub/documents/SSBG2018.pdf.

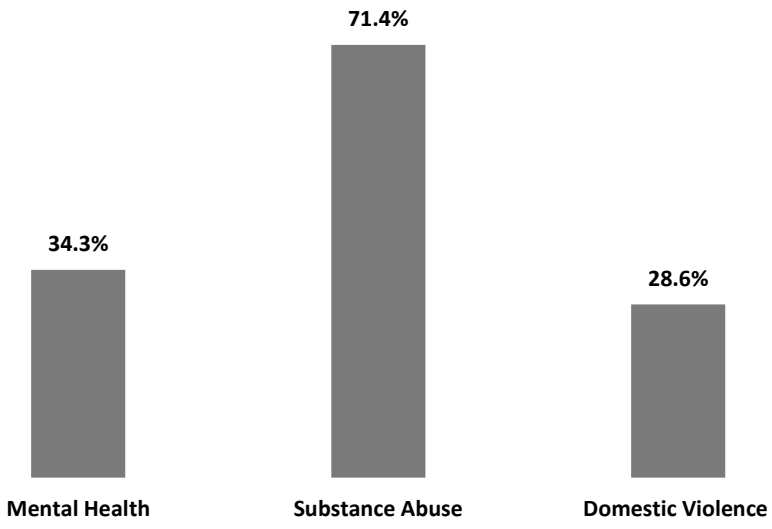
SUBSTANCE ABUSE, DOMESTIC VIOLENCE AND MENTAL HEALTH ARE RISK FACTORS FOR CHILD FATALITIES

Parental substance abuse is a major risk factor for child fatalities, maltreatment and involvement with the child welfare system. Children removed from their home as a result of parental substance abuse are likely to remain in foster care longer and have significantly higher rates of adoption than those in foster care for other reasons.[17]

The majority of children who died came from families with a history of drug or alcohol abuse (71.4 percent). Of the families with known drug or alcohol abuse, 56 percent (fourteen families), had documented histories of prenatal drug use and in many cases this was what led to a referral to CPS at the time of a child's birth. Fifty-two percent of these families had a history of opiate use (thirteen families); 37 percent had documented methamphetamine use (eleven families); and 76 percent of families were noted to use some "other substance", most commonly alcohol or marijuana.

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 88.6 percent of the fatalities examined by OFCO.

Figure 6: **Family Risk Factors in Child Maltreatment Related Fatalities, 2017**
(n = 35)



[17] "Family-Based Recovery: An Innovative In-Home Substance Abuse Treatment Model for Families with Young Children": Hanson, Karen E.; Saul, Dale H.; Vanderploeg, Jeffrey J.; Painter, Mary; & Adnopoz, Jean. *Child Welfare*: July 2015, Vol. 94, No. 4.

OFCO Recommendation: Expand Home Visiting Programs

Expand services for expectant mothers, and mothers of newborns such as the Nurse-Family Partnership (NFP) or similar programs. 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. The Governor's proposed 2019-2021 budget provides funding for a universal home visiting and newborn assessment program.[18] Specialized nurses would conduct in-home assessments to requesting parents with newborns and provide up to six home visits and determine if additional resources and supports are needed. Families could receive additional intensive home visiting services for one to three years.

MAJORITY OF INFANT DEATHS ARE RELATED TO UNSAFE SLEEP ENVIRONMENTS

Approximately 3,500 infants in the United States die each year from sleep-related deaths.[19] To reduce the risk of infant deaths the American Academy of Pediatrics recommends several infant care strategies, including:

- Place baby to sleep on their back;
- Baby should be placed on a firm sleep surface such as a crib, bassinet or play yard;
- Keep soft objects and loose bedding out of the crib; and
- Share a room with baby but do not co-sleep or share a bed.

Bed-sharing or co-sleeping is particularly dangerous for babies born prematurely or with a low birth weight; if a caregiver is a smoker or the mother smoked during pregnancy; an adult has used any medications that make it harder to wake up; an adult has consumed any alcohol or drugs; or the surface has soft bedding on it or is soft like an armchair or couch.[20] One study found the chance of a baby dying of SIDS while bed-sharing is substantially higher when the baby is of low birth weight, the parent(s) smoke and the mother consumes more than two alcoholic drinks regularly than for families who have none of those risk factors.[21]

In 2017, OFCO examined the deaths of 22 infants that occurred when the child was in an unsafe sleep environment. These deaths comprise the vast majority of infant fatalities examined by OFCO (75.9 percent). Most of these infants were under the age of four months.

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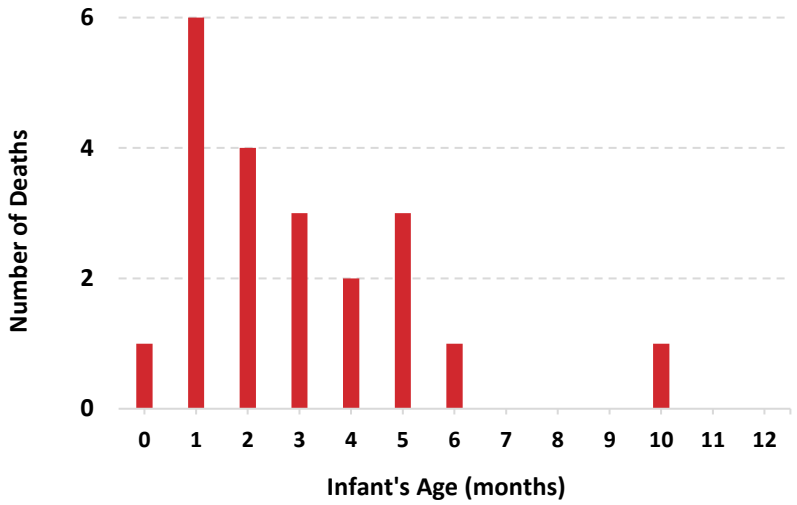
[18] Governor Inslee's Proposed 2019-2021 Budgets. https://ofm.wa.gov/budget/state-budgets/gov-inslees-proposed-2019-21-budgets.

[19] "SIDS and Other Sleep-Related Infant Deaths: Updated 2016 Recommendations for a Safe Infant Sleeping Environment". Moon, Rachel Y. *Pediatrics*. November 2016, Volume 138, Issue 5. http://pediatrics.aappublications.org/content/pediatrics/138/5/e20162938.full.pdf.

[20] "How to Keep Your Sleeping Baby Safe: AAP Policy Explained". Rachel Y. Moon, MD. FAAP. *HealthyChildren.org.* 2016. https://www.healthychildren.org/English/ages-stages/baby/sleep/Pages/A-Parents-Guide-to-Safe-Sleep.aspx.

[21] "Is Sleeping With Your Baby As Dangerous As Doctors Say?" Michaeleen Doucleff. *National Public Radio*. May 21, 2018. https://www.npr.org/sections/goatsandsoda/2018/05/21/601289695/is-sleeping-with-your-baby-as-dangerous-as-doctors-say.

Figure 7: **Infant's Age at Time of Sleep Related Death, 2017**
(n = 22)



DCYF Policies Addressing "Safe Sleep"

DCYF staff must conduct a safe sleep assessment when placing a child under one year in a new placement setting and when completing a CPS intervention with a family that has a child under one. When licensing or approving home studies with families that accept infants for placement, the home study worker must assess the sleeping environment and educate the family on safe sleep practices.[22] Assessing and discussing safe sleep is particularly important for children and families with the risk factors of substance abuse, alcohol use, smoking, premature births or low birth weights, and babies with medical complications.

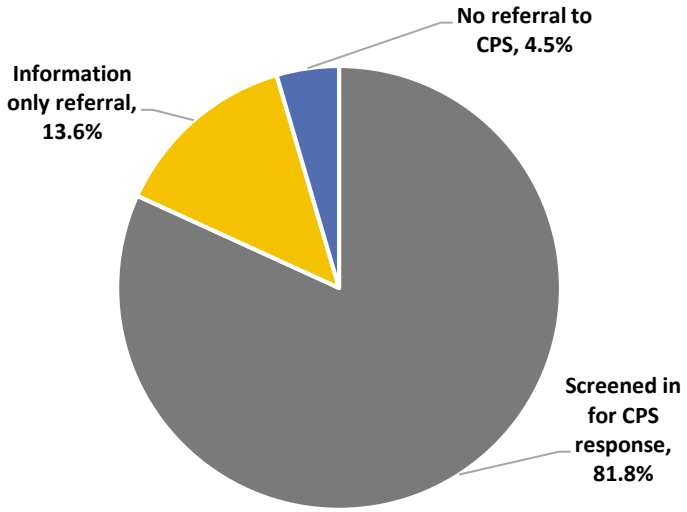
Are Unsafe Sleep Environments Neglectful?

There is a wide range of CPS responses and outcomes to an infant death that occurs while co-sleeping or in another unsafe sleep environment. This variance is expected based on differing family histories, circumstances, and results from the autopsy or death investigation. Though a baby may have died while co-sleeping or while in another unsafe environment, it is not always clear if the sleeping environment was a causal factor in the death.

Of the twenty-two infant fatalities examined by OFCO that occurred in an unsafe sleep environment, eighteen of them (81.2 percent) screened in for some type of CPS response and three of them did not meet the criteria for a CPS response and screened out ("information only").[23] Of the reports that were accepted for a CPS response, seven were founded for negligent treatment or maltreatment, eight were unfounded, and there were no findings made in three.

[22] DCYF Practices and Procedures Guide. 1135. Infant Safety Education and Intervention.
[23] In one fatality examined by OFCO no CPS referral was made.

Figure 8: **CPS Response to Referrals of Infant Deaths in Alleged Unsafe Sleep Environments, 2017**
(n = 22)



In examining these fatalities, OFCO observed differences in whether placing a child in an unsafe sleep environment was considered neglectful, even if it was determined to be the cause or a contributing factor in the death.

OFCO Recommendation: Establish a Consistent Response to CPS Investigations Regarding Unsafe Sleep Environments

While each incident, case history and family are unique and must be assessed individually, the examples below highlight the need for greater clarity and guidance on if or when co-sleeping or placing a baby in an unsafe sleep environment is considered negligent and how to respond when a death occurs. The Department should develop policies addressing CPS screening decisions, investigations and investigative findings of neglect related to co-sleeping and unsafe sleep environments.

A two-month-old infant was found deceased after the child was placed face down on the mother's bed which was covered with clothes and blankets. **This referral screened in for a CPS investigation**. The manner of death was ruled natural and the cause of death was attributed to SIDS.

- The mother was involved in a recent CPS investigation relating to allegations of physical abuse of an older child. This investigation was unfounded and at the time the case closed the older child and the infant were not with the mother and were residing with a relative. During this investigation safe sleep was reviewed with the mother and the relative caregiver. The infant's sleep environment in the relative's home was observed and the family was utilizing a bassinet for sleep. It is unclear if the mother took the bassinet with her or had another safe sleep area for the child when she removed her child from the relative's home.

- The **CPS investigation into the fatality resulted in a founded finding of neglect** by the mother. The CPS Investigative Assessment noted that the mother intentionally placed the child to sleep on their stomach despite knowing that safe sleep is for an infant to be placed on the back. The CPS investigation was completed before the autopsy and toxicology report was finalized.

A CPS referral stated a ten-month-old infant died while co-sleeping with the mother in a bed with numerous blankets. The referent noted concerns about the mother's changing explanation for the death, a lack of cooperation by the family, and that the mother had another small child in the home. **This referral screened in for a CPS investigation**.

- The mother previously participated in Family Voluntary Services and was given portable cribs for her children, yet she continued to co-sleep with her infant.

- The **CPS investigation into the fatality resulted in a founded finding of neglect**. The CPS Investigative Assessment noted that the finding was based upon **the Department's previous efforts to prevent further co-sleeping** and that although the final autopsy report was not yet complete, **it appeared the death was due to co-sleeping**. The Department also filed a dependency to protect the mother's older child. The final autopsy report noted the manner of death to be natural/medical with the cause of death as SIDS, and co-sleeping as a contributing factor.

A two-week-old infant died while sleeping with the mother. **This CPS referral screened in for investigation.** The Medical Examiner ruled the manner of death accidental and the cause "suffocation, respiratory arrest, and positional asphyxiation" stemming from the baby sleeping on the mother's chest.

- The mother had an open dependency case with her older child and at the time of death was involved in a methadone maintenance program while residing in a shelter. Case notes document that the mother was told about the importance of safe sleep and the risks of co-sleeping, though she later said she did not know about these risks.

- **The CPS investigation into the death resulted in an unfounded finding**. The Investigative Assessment noted that the mother was "recommended" not to co-sleep and that a **death due to co-sleeping is not enough to result in a founded finding**.

A CPS referral was made when a three-month-old infant was found deceased face down on an air mattress that the mother was sharing with the child. This referral **screened in for CPS investigation**. The mother had prior CPS history with most of the concerns relating to lack of supervision of her children and drug use. This included ten intakes, six of which screened in for further CPS response, though all resulted in unfounded findings. Most of these intakes alleged concerns about the mother's lack of supervision of her children.

- At the time of death the **case was open for CPS investigation**. The family's most recent referral alleged that the mother left her three children, all under the age of three, alone. Staff where the mother was residing found the baby asleep face down on the mother's bed unsupervised. During this investigation a caseworker met with the mother and discussed safe sleep environments, but could not observe the family's sleeping environment due to policies of where the mother was living. The mother stated she was aware of safe sleep policies and that she places the child to sleep on their stomach because the infant can roll over.

- There was a bassinet set up next to the air mattress though it was not used the evening the child died. An autopsy was completed though the full report was not made available by the time the case closed. Notes from law enforcement indicate that they suspect the child died of SIDS. **The outcome of the CPS investigation was unfounded**.

A Medical Examiner reported to CPS that a two-month-old child died while co-sleeping with the mother and a three-year-old sibling. The baby was on one side of the mother and the sibling was on the other. The mother woke up and the child was not breathing. The report from the Medical Examiner was determined by intake staff to **not meet the criteria for a CPS response, so it "screened out"** and there was no further involvement or CPS investigation into the death.

Three months prior to the infant's death, CPS closed an investigation of allegations that the parents were not following up on medical care for an older sibling. The investigation resulted in an unfounded finding.

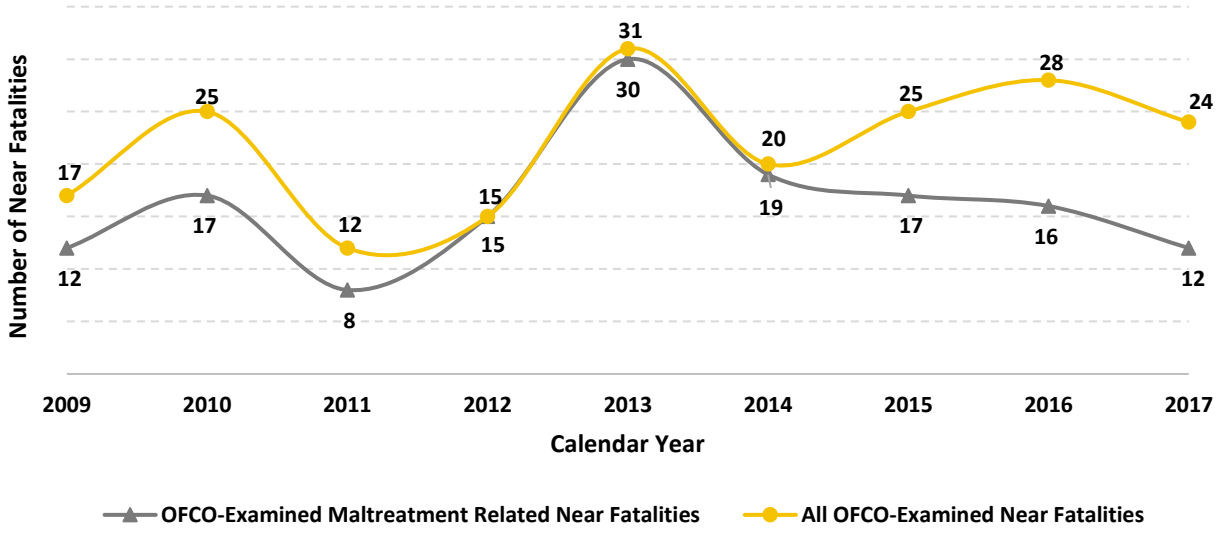
CHILD NEAR FATALITIES EXAMINED BY OFCO

State law requires DCYF to notify OFCO of the near fatality[24] of any child who has been in the Department's custody, or receiving services, within the last twelve months.[25] OFCO conducts a preliminary review of all near fatalities involving alleged child abuse or neglect when the family had an open case with DCYF at the time of the near fatality or in the preceding twelve months, even if the subject child was not the recipient of Department services and including "information only" referrals. OFCO examined **24 near fatalities in 2017**.

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 DCYF 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 near fatalities.

Figure 9: **OFCO-Examined Near Fatalities by Year**

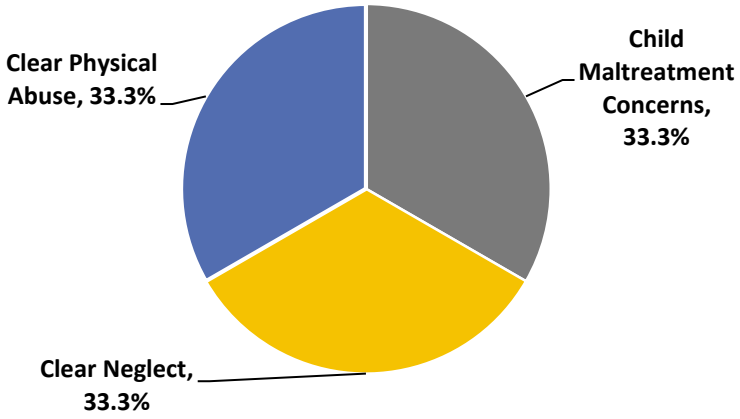


[24] RCW 74.13.500 defines "near fatality" as "an act that, as certified by a physician, places the child in serious or critical condition."
[25] RCW 74.13.640(2).

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 DCYF history in the preceding twelve months. Of the **24 near fatalities examined by OFCO in 2017**, **twelve** were determined to either be caused by **abuse or neglect**, or abuse or neglect concerns were present. **Child neglect and physical abuse** each caused **one-third of the near fatalities**.

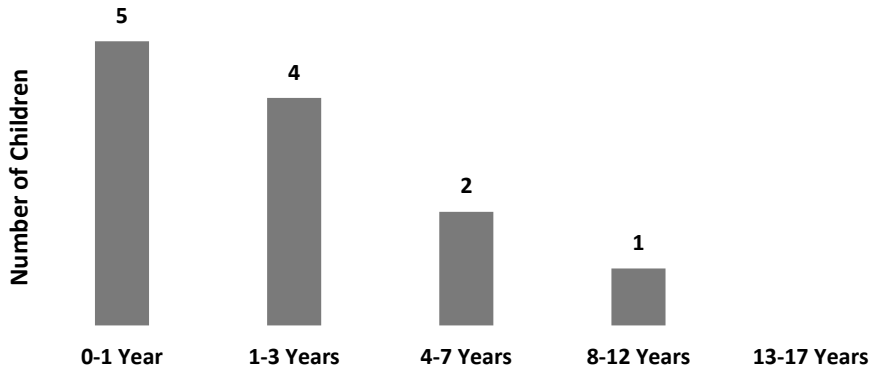
Figure 10: **Maltreatment Related Child Near Fatalities, 2017**
(n = 12)



CHILD'S AGE AT TIME OF NEAR FATALITY

Three-quarters of the maltreatment related near fatalities in 2017 involved children under the age of three years. There was only one maltreatment related near fatality of a child eight years or older in 2017.

Figure 11: **Child Age at Time of Near Fatality, 2017**
(n = 12)



EXAMPLES OF MALTREATMENT RELATED NEAR FATALITIES

Abusive Head Trauma

A dependent infant presented to the hospital with new and old head injuries. The relative caregiver reported having accidentally dropped the child. Medical providers found the injuries did not match this explanation and were consistent with non-accidental trauma. The child was diagnosed with bilateral retinal hemorrhage likely caused by shaking. The child survived this incident but may suffer long term effects. This near fatal incident was referred to CPS and accepted for investigation. Based on medical evidence, CPS concluded the injuries did not match what would be expected if the infant was dropped accidentally and the relative caregiver received a founded finding for physical abuse.

Medication Ingestion

A nine-year-old child was brought to the hospital after ingesting their mother's prescription medication which was loose in the back seat of the family car. The child had developmental delays, was nonverbal and had a history of trying to eat medications, believing they were candy. The referral from the hospital was accepted for CPS investigation. The CPS investigator noted the mother knew the child had previously ingested medications and required a high level of supervision, yet left medication accessible to the child. Further, the mother admitted knowing the child had possibly ingested the medication, but did not inform medical personnel, delaying appropriate medical care. The mother received a founded finding of neglect.

Near Drowning in Bathtub

A ten-month-old child was brought to the hospital following a near drowning. The mother placed the ten-month child and a sibling in the bathtub together and left the room. When she returned the child was face down in the water. This incident was referred to and accepted for CPS investigation. The CPS investigation determined that the allegation of neglect by the mother was unfounded, though cited concerns about the lack of supervision of the children.

YOUTH SUICIDE

Suicide among youth is a serious and rising problem. Intentional self-harm was the second leading cause of death for Washington youth ages fifteen to nineteen in 2015.[26] Suicide rates among teens nationally have grown dramatically from 2006 to 2016, increasing 70 percent among white youth ages ten to seventeen and 77 percent among black youth.[27] Recent survey data found that 20 percent of tenth graders in Washington seriously considered suicide in the past year.[28] Suicide attempts are often associated with feelings of sadness, stress, anger, uncertainty and loss, among others.[29] These feelings are quite common among youth involved in the child welfare system, who have often experienced significant traumas and are at greater risk of mental and physical health problems.[30]

A twelve-year-old child died by suicide in a relative caregiver's home. The relatives knew the child was previously hospitalized for suicidal ideation and was struggling with self-harming behaviors. Despite being aware of these risk factors, they did not take the necessary steps to minimize risk to the child, such as securing firearms or locking up medications. The CPS investigation into this death resulted in a founded finding of neglect for the relative caregivers.

Youth Suicides and Suicide Attempts Examined by OFCO, 2014-2017

OFCO reviewed four years of fatality and near fatality data to identify the number of youth suicides. Of all critical incidents examined by OFCO from 2014 to 2017, there were fifteen deaths by suicide and eleven suicide attempts that were considered nearly fatal.[31] While only seven of these 26 cases were considered by OFCO to be related to child maltreatment, they are all included in this section for further analysis. The average age of youth involved is 14.9 years. Seventeen youth (65.4 percent) are female and nine are male. Just over 60 percent (61.5 percent) of the youth are Caucasian.

[26] "Leading Causes of Death by Age Group and Sex for Residents". Washington State Department of Health. https://www.doh.wa.gov/DataandStatisticalReports/HealthStatistics/Death/DeathTablesbyTopic.
[27] "National Suicide Statistics". Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/suicide/statistics/index.html.
[28] Looking Glass Analytics. Healthy Youth Survey 2014 Report of Results: Statewide Results, Grade 10. 2015. http://www.askhys.net/library/2014/StateGr10.pdf.
[29] "Suicide in Children and Teens." The American Academy of Child and Adolescent Psychiatry. October 2017. https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Teen-Suicide-010.aspx.
[30] "Foster care children at much greater risk of physical, mental health problems." University of California Irvine. October 2016. https://news.uci.edu/2016/10/17/foster-care-children-at-much-greater-risk-of-physical-mental-health-problems/.
[31] This includes all fatalities and near fatalities from calendar year 2014-2017, including related to maltreatment and unrelated to child maltreatment.

Table 3: **Race and Ethnicity in Youth Suicides (Fatalities and Near Fatalities), 2014-2017**

(n = 26)

	#	%
African American or Black	2	7.7%
American Indian or Alaska Native	3	11.5%
Asian or Pacific Islander	5	19.2%
Caucasian	16	61.5%
Latino / Hispanic	4	15.4%

Of the 26 fatalities and near fatalities examined by OFCO, fifteen youth (71 percent) had at least one prior suicide attempt that was documented in FamLink case records. Nine youth (35 percent) were previously hospitalized following suicidal actions, either for medical or psychiatric care. Twelve of the youth were noted to have a history of being victimized by sexual abuse. This aligns with research showing that children who were sexually abused are more likely to have made at least one suicide attempt.[32]

Youth Suicide Prevention Efforts in Washington State

Suicide is a public health problem affecting youth across Washington. In 2014, the Washington Department of Health, in collaboration with other agencies and community partners, was tasked with creating a statewide suicide prevention plan for people of all ages. This plan makes it clear that everyone has a role in suicide prevention. Preventing suicide by children in state care cannot be achieved by the child welfare system alone. Following the Washington State Suicide Prevention Plan released in 2016, some of the current local and statewide efforts to prevent youth suicide include:

- Governor Inslee's proposed 2019-2021 budget includes funding to create a regional crisis center network answering Washington calls to the National Suicide Prevention Lifeline.[33] The proposal consists of adding call centers serving Eastern Washington and more call center staff to assist with rising call volumes.
- Promoting the Crisis Text Line, a free 24/7 confidential service connecting trained counselors with people in crisis who prefer texting rather than reaching out by phone or in person. Data shows that 75 percent of users of this service are under twenty-five years old, and that almost twenty percent of these text conversations involve the issue of suicide.[34]
- Suicide prevention training opportunities for foster parents, such as those offered by Coordinated Care, the Washington Chapter of the American Foundation for Suicide Prevention, and the Alliance for Child Welfare Excellence.
- Community-based activities co-led by state agencies and other community organizations, such as the Safer Homes Coalition and the Washington Firearm Tragedy Prevention Network, to educate and promote safe storage of prescription medications and firearms in homes.

[32] "Suicidal Thoughts and Behaviours in Former Sexual Abuse Victims." Briere, J & Runtz, M. *Canadian Journal of Behavioural Science*, 18(4), 413-423.

[33] https://ofm.wa.gov/budget/state-budgets/gov-inslees-proposed-2019-21-budgets.

[34] See https://crisistrends.org/.

- A Substance Abuse and Mental Health Services Administration (SAMHSA)[35] grant awarded to the Department of Health funded work in three rural coast counties to launch a youth suicide prevention media campaign, a campus suicide prevention conference, a youth leadership conference, and efforts to address suicide prevention in higher education through 2019. This SAMHSA grant also funded a Tribal Youth Suicide Prevention Summit, initially with tribes in three counties but will now expand to a statewide event.
- The Office of the Superintendent of Public Instruction oversees and promotes multiple suicide prevention efforts, as well as resources to help those affected by youth suicide, within K-12 public schools.[36]

OFCO Recommendation: Conduct Reviews of Suicide Attempts

OFCO believes there would be value in conducting further reviews of youth suicide deaths and near-deaths when the child or family was involved with the Department in the preceding past twelve months, and in particular when the child was in out-of-home care. These deaths have generally not received executive child fatality reviews because they are often not directly attributed to abuse or neglect by the parent or caregiver. However, reviewing these fatalities and understanding the circumstances, risk factors and events leading up to the suicide can guide intervention and prevention efforts.

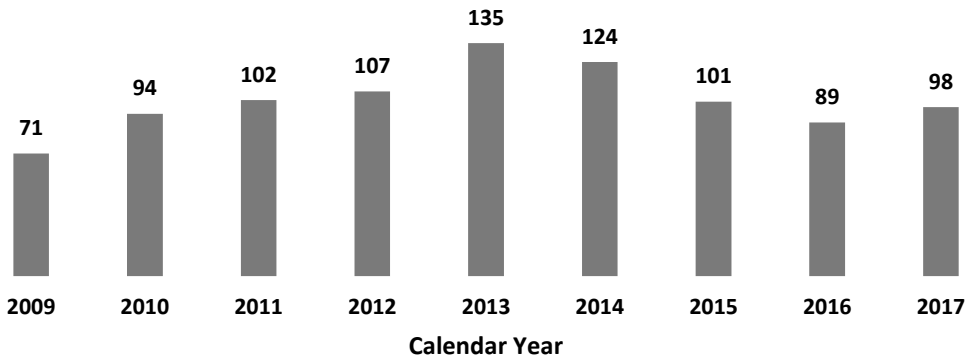
In one case, for example, a teen was hospitalized following a suicide attempt. The youth was residing with the mother under an in-home dependency and the family, including another dependent child, was participating in the Wraparound with Intensive Services (WISe) program to address the youth's mental health needs. The DCYF caseworker and mother expressed concerns about a delay in securing counseling services for the teen. The mother was dealing with her own mental health issues and sobriety. The youth had prior suicide attempts and multiple hospitalizations for psychiatric care. After the most recent near fatal suicide attempt, the mother and Department sought in-patient treatment for the youth but struggled to find a placement as the waitlists for these programs were long. This case did not receive an executive review because the near death was not found to be related to abuse or neglect. However, a further review of this, and similar cases could identify where additional resources are needed and strategies for collaborating with other providers to meet the needs of dependent children who have significant mental health issues.

[35] This Administration is a branch of the US Department of Health and Human Services.
[36] See http://www.k12.wa.us/safetycenter/YouthSuicide/SuicidePrevention.aspx.

RECURRENT MALTREATMENT

DCYF is required to notify OFCO of all families or children who experience three or more founded reports[37] of abuse or neglect in the last twelve months.[38] This notification enables OFCO to review cases involving chronic child maltreatment and intervene as needed. A close review of recurrent maltreatment cases can indicate whether Washington's child welfare system is effectively reducing the recurrence of child maltreatment, and inform practice to further reduce this problem.[39]

Figure 12: **Number of Recurrent Maltreatment Notifications Made to OFCO, 2009-2017**



Neglect is by far the most common type of recurrent maltreatment experienced by children, comprising 73.5 percent of all founded reports reviewed by OFCO in 2017. Nineteen percent of the founded reports were physical abuse allegations, and 4.6 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 77.5 percent of cases.[40]

It is difficult to identify the precise factors driving these annual 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. As shown in Figure 12, the number of opened investigations and assessments matches the trend seen in OFCO's recurrent maltreatment reviews. Investigations and assessments increased from 2009 through 2013, dropped from 2014 to 2016, and spiked in 2017.[41]

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[37] "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 DCYF calls an "intake."

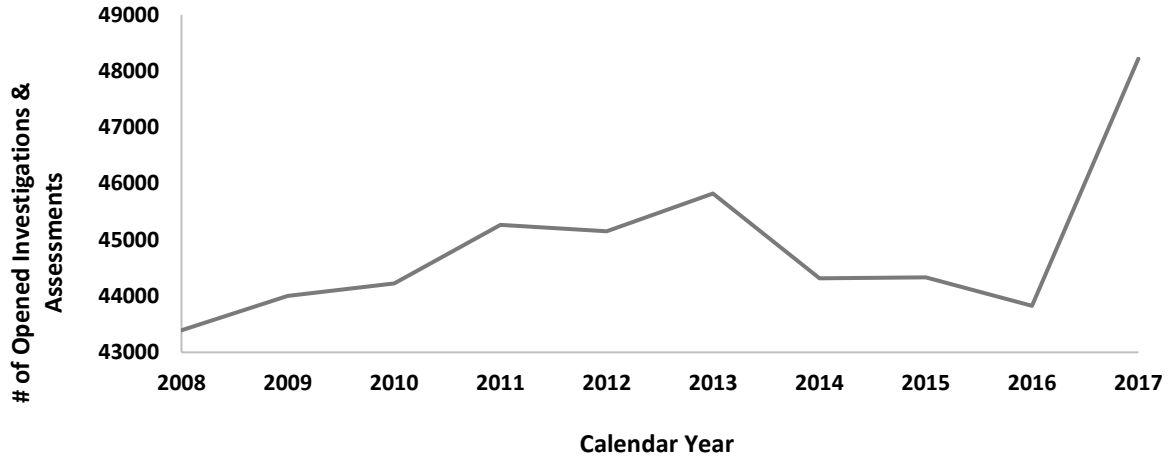
[38] RCW 26.44.030(13)

[39] "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.*

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

[41] Partners for Our Children Data Portal Team. (2018). [Graph representation of Washington state child welfare data 6/19/2018]. Investigations & Assessments (Count). Retrieved from http://www.vis.pocdata.org/graphs/ia-counts.

Figure 13: **Number of Opened Investigations and Assessments, Department of Children, Youth, and Families**[42]



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 across the state. As of June 2017, all offices have implemented FAR. 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. With the full implementation of FAR, all else being equal, the number of cases screening in for a CPS investigation resulting in a finding of child maltreatment would be expected to decrease.

[42] Partners for Our Children Data Portal Team. (2018). [Graph representation of Washington state child welfare data 6/19/2018]. Investigations & Assessments (Count). Retrieved from http://www.vis.pocdata.org/graphs/ia-counts.

OFCO received notice of a third founded finding involving a family comprised of the mother, her two-year-old and four-year-old children, and the father of the two-year-old. The father of the two-year-old child initially received a founded finding for physical abuse and neglect of the four-year-old. He was arrested for the abuse and a protection order was entered prohibiting him from being in the home or having any contact with the four-year-old child. The mother subsequently received multiple founded findings for neglect for continuing to allow him around her child.

Throughout all of these investigations there were concerns about the mother's drug use. During the last CPS investigation the Department requested the mother complete a UA and she refused. The CPS case was ultimately closed. After receiving the third founded notice, OFCO contacted the Area Administrator to request that the case be staffed with their Assistant Attorney General to determine whether more aggressive protective action by CPS was possible. A few days later OFCO noted that a new CPS intake was screened in alleging physical abuse by the mother towards the four-year-old child. OFCO notified the Area Administrator of this new referral and asked for a Family Team Decision Meeting (FTDM) to be held. The Department held an FTDM, resulting in a plan for the four-year-old child to be placed with their father and a dependency be filed on the two-year-old child, with placement in relative care.

SECTION II

IMPLEMENTATION STATUS OF FATALITY AND NEAR FATALITY RECOMMENDATIONS

INTRODUCTION

The Department of Children, Youth, and Families (DCYF) conducts a child fatality review when the death of a child was suspected to be caused by abuse or neglect, and the child was in the care of or receiving services from DCYF at the time of death, or in the preceding twelve months.[43] 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. The Department must also review any near fatality of a child[44] who was in the care of or receiving services from the Department at the time of the incident or in the preceding twelve months.[45] Even if these criteria are not met, DCYF may conduct a review of any fatality or near fatality at its discretion, or at the request of OFCO.[46]

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.[47] 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 DCYF staff, OFCO staff, and community professionals 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 relevant records and files regarding the child and family that have been produced or retained by the supervising agency.[48]

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[43] See RCW 74.13.640. Prior to the passage of SHB 1105 in 2011, DCYF 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, DCYF 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.

[44] RCW 74.13.500 defines "near fatality" as "an act that, as certified by a physician, places the child in serious or critical condition."

[45] 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.

[46] 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.

[47] See DCYF Practices and Procedures Guide Section 6301, Child Fatality/Near-Fatality Reviews.

[48] RCW 74.13.640(3).

DCYF must issue a report on child fatality review results within 180 days following the fatality, unless granted an extension by the Governor.[49] These reports are subject to public disclosure and must be posted on the Department's public website. The Department is required to redact confidential information contained in these reports to protect the child's privacy, as well as the privacy of siblings and any other information protected by law (e.g., HIPPA protected information).[50]

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.[51] This report also includes recommendations from near fatality reviews.

This section of the report describes the implementation status of recommendations made in child fatality and near fatality reviews conducted by DCYF between June 30, 2016 and September 30, 2017.[52] During this period, DYCF conducted reviews in the **deaths of twenty children and eight near fatalities**. These reviews produced **44 recommendations**. OFCO reviewed information provided by DCYF, and found that nine recommendations (20.5 percent) were already completed and 33 were either still in the process of implementation or still under consideration by the Department (75 percent). The majority of recommendations addressed statewide issues (61.4 percent). Thirty two percent addressed local office concerns while three recommendations were tailored to remedy regional concerns.

Table 4: **Child Fatality and Near Fatality Review Recommendations by Implementation Status and Targeted Organizational Level, 2016–2017**
(n=44)

	Number of Recommendations	Percent	Statewide (#)	Region (#)	Office (#)
Implemented	9	20.5%	5	1	3
In Process	33	75.0%	20	2	11
Status Unknown	2	4.5%	2	--	--

The most prominent topic areas identified by fatality recommendations were:

- **Training** for caseworkers, supervisors, or community professionals (50 percent of recommendations);
- **Casework practice**, including risk assessment and safety planning (43.2 percent of recommendations); and
- **Partnering with community professionals** (6.8 percent of recommendations).

[49] Id.
[50] Individual child fatality reports are available at: www.dshs.wa.gov/ca/pubs/fatalityreports.asp.
[51] RCW 43.06A.110. OFCO reports are available at: www.ofco.wa.gov.
[52] The implementation status of recommendations from fatality reviews occurring before June 30, 2016 are included in past OFCO reports and can be found at: http://ofco.wa.gov/reports/.

MAJOR THEMES OF RECOMMENDATIONS

The majority of recommendations aimed to improve training and casework practice. Recommended training topics include: chemical dependency, safety assessment and planning, and domestic violence. Recommendations regarding casework practice spanned a wide range of topic areas from supervision skills, assessing safety and collaborating with service providers. Recommendations addressing partnerships with community professionals recognize the need for the Department to partner with other service providers to best serve families.

Table 5: **Child Fatality and Near Fatality Review Recommendations by Topic, 2016-2017**
(n=44)

Topic	Number	Percent	Percent of Topic Completed	Percent of Topic in Process or Under Consideration
Provide Training	**22**	**50.0%**	**22.7%**	**72.7%**
Training on chemical dependency	(7)			
Training on child safety	(5)			
Training on domestic violence	(4)			
All other training recommendations	(6)			
Improve Casework Practice	**19**	**43.2%**	**15.8%**	**78.9%**
Safety assessment and planning	(11)			
Supervision skills and/or internal practice consultation	(3)			
All other casework practice recommendations	(5)			
Partnerships with Community Professionals	**3**	**6.8%**	**0%**	**100%**

A. TRAINING FOR CASEWORKERS, SUPERVISORS OR COMMUNITY PROFESSIONALS

Twenty-two review recommendations address training issues for caseworkers, supervisors or other professionals involved in the child welfare system. Five recommendations were already implemented and sixteen are in process or still under consideration by the Department.[53] The most prevalent training areas involved chemical dependency (seven recommendations) and child safety (five recommendations). Other topics included social work practice and supervision skills, domestic violence, investigating child fatalities, and working with families and/or children with disabilities.

Chemical Dependency – Seven training recommendations related to chemical dependency issues. While training on assessing families with chemical dependency is already provided to all caseworkers, the review committees identified a need for further trainings on how illegal and legal (e.g. marijuana,

[53] The implementation status for one training recommendation is unknown.

Opiate Replacement Therapy) substance use may influence a caregiver's ability to safely care for a child and how to identify certain behavior patterns.

- Recommendations from two separate reviews called for additional training on how marijuana use may impact a parent's ability to safely care for a child, how use during pregnancy may affect a fetus, and how to interview parents about marijuana use. In response to these recommendations, the Alliance for Child Welfare Excellence developed a training for caseworkers entitled *Parents' Marijuana Use and its Impact on Child Safety*.
  – Recommendations are complete.
- One review committee concluded that all offices should receive training on how to understand, interpret and utilize urinalysis reports.
  – Recommendation is in process.
- One recommendation was marked complete because a training on harm reduction and safety planning with substance abusing parents is already offered. One recommendation still in process recommends that current substance abuse training for caseworkers be expanded to discuss typical behavior patterns displayed by users of specific types of drugs.

***Child Safety* –** Five recommendations identified the need for further training on assessing child safety and developing 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.

- In response to concerns that the Department's contacts with a family prior to the fatality were limited in scope to the specific incidents described in the intake, one committee recommended that the Department develop a training on global assessment of families. Specifically this training should emphasize assessing all adults in a home, incorporating and analyzing historical records into current assessments and using clinical supervision at the 30-day case review to identify gaps. This recommendation was completed after the supervisor core training was updated in 2016 to teach supervisors how to work with line staff to distinguish what information is critical to obtain a comprehensive assessment of a family.
  – Recommendation is complete.
- Another recommendation called for enhancing safety trainings to include tactics for gathering and analyzing family member information and child welfare history, as well as utilizing LICWAC recommendations and when to re-staff cases with LICWAC.[54] Trainings to cover these topics were scheduled throughout 2017.
  – Recommendation is complete.
- Two recommendations call for caseworkers, supervisors and Family Team Decision Meeting facilitators in two specific offices to attend the existing Safety Boot Camp training if they had not completed it in the last two years. This was scheduled to be accomplished by January 2018.
  – Recommendations are in process.
- The Department is still in the process of working with the Alliance to cover a recommendation to provide training on the assessment of risk and when and how to intervene with a family.
  – Recommendation is in process.

[54] Local Indian Child Welfare Act Committee.

Domestic Violence – Because of the high co-occurrence of domestic violence and child maltreatment, identifying domestic violence is critical when making case decisions intended to increase child safety. Recommendations for additional domestic violence training for caseworkers have come from several reviews over the years. Four recommendations for domestic violence training came from three separate fatality reviews. The review committees recommended that caseworkers and supervisors in the local offices involved in the fatalities attend an existing two-day domestic violence training. One recommendation was made to add a section to this training to address how to speak with perpetrators of domestic violence during CPS investigations.
– Recommendations are all in process.

Other Trainings – A range of additional training recommendations were made, including:

- Provide a death investigation training for CPS investigative staff **(in process)**;
- Make a training available about interviewing and assessing the safety of children with disabilities and partnering with the Developmental Disabilities Administration **(in process)**;
- Continue the evaluation of a formal mentoring program for new caseworkers beyond the Regional Core Training **(in process)**;
- Two recommendations call for training in searching databases, Department of Health records, and open source information on the Internet **(in process)**; and
- Units taking on overflow case responsibilities should be cross-trained in the program they will be working with **(unknown status)**.

B. CASEWORK PRACTICE

Nineteen fatality and near fatality review recommendations sought to improve casework policies, procedures or practices. While these recommendations touch on a wide range of topics, several were clustered in the following areas of practice:

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

- A handful of recommendations addressed safety planning and casework when a family has a newborn baby.
    - One suggested the Department require a home visit to be conducted within a short period of time after an intake involving an infant is accepted. This would be separate from the policy requiring an initial face-to-face contact which may occur while a baby is still in the hospital. This recommendation is reported to be still in the process of implementation. OFCO requested further information, and additional background on this recommendation is provided in the highlighted text box titled “Immediate Home Visits for Newborns” **(in process)**.
    - Another recommendation, directed at a local office, suggested the office hold a Family Team Decision-Making meeting immediately when an infant has been exposed to drugs in utero and the parent denies drug use **(in process)**.

- A third recommendation calls for the Department to evaluate the use of shared planning meetings to expedite referrals to community resources on cases that require Plans of Safe Care for newborns **(in process)**.[55]

- A fatality review involving an infant death on an air mattress produced a recommendation to send out a "Quick Tip" (or policy reminder) to discuss the risks of bed-sharing with children on air mattresses.
  – This recommendation is complete.
- Two different reviews recommended that the Department examine current policies regarding cases where a parent has both dependent and non-dependent children in their care. The committees identified the need for further clarification on how to assess children who are not part of the dependency case. Both reviews involved parents who had older dependent children in out-of-home care and a newborn baby who was not dependent and in the care of the parent(s) when the fatality occurred.
  – Recommendations are in process.
- Two recommendations focused on assessing the safety of placements, caregivers, and others who have frequent access to the child.
  – Recommendations are in process.
- Two recommendations addressed documentation of casework. One called for improvements to the 30-day case review to address child permanency, safety and well-being with updated information and/or plans. The other recommended that instead of supervisors just noting that children are safe, they should document *why* they are safe in relation to certain risks. In this instance a discussion was held with local supervisors who started implementing this practice immediately.
  – One recommendation is in process and one was completed.

[55] A plan of safe care is a plan to address the safety needs of a newborn who is considered to be substance affected or when a child is born to a dependent youth. DCYF Practices and Procedures Guide 1135. Infant Safety Education and Intervention.

Families With Dependent and Non-Dependent Children

Recommendations:

- *DCYF should review the current policies regarding situations involving dependent and non-dependent children with the same parent, as occurred in this case, and consider any revision or clarification. The revision or clarification could possibly allow for the assigned social worker and supervisor to have a clearer indication of how to proceed with the responsibility of DCYF to complete a comprehensive, ongoing assessment of children who are not a part of an open case yet are under the care of their parent who has other dependent children.*

- *DCYF should review the current policies regarding active CFWS cases involving dependent and non-dependent children as occurred in this case. Consideration should be given to improving guidance to workers and supervisors on how to proceed with completing a comprehensive, ongoing assessment of children who are not a part of an open case yet are under the care of a parent who has other dependent children. This could include guidance on cases that involve multiple offices.*

Fatality Background:

In both cases a mother with older dependent children gave birth to another child and referrals were made by the hospital. The Department initiated a risk only investigation in both cases but did not file a dependency. The mothers were engaged in chemical dependency treatment at the time of the birth and death of the infants. The Committees recognized that there was not a clear understanding on the part of the CFWS caseworkers who were providing services for the family relating to the dependency, regarding their responsibility to assess the continued safety of the non-dependent children. One Committee recognized a possible conflict in the assigned CFWS worker's role in both encouraging the parent's progress in their services and promoting healthy bonding between the parent and newborn, while at the same time thoroughly scrutinizing and ensuring safety of the infant.

Recommendation Status:

In process – OFCO has requested additional information on the implementation of this recommendation.

Immediate Home Visits for Newborns

Recommendation:

DCYF should consider requiring a home visit to be conducted within some short period of time after an accepted intake involving a newborn. The Committee discussed various time periods including within three days of the intake, within one day of discharge from a hospital or within a week. This requirement would be separate from current policy requirements for initial face-to-face contact that may occur outside the home (e.g., hospital). This recommendation would require an immediate assessment of the home and infant sleep environment within a specified time frame not currently set in policy.

Fatality Background:

An infant died from injuries inflicted by the parent. At the time of death the Department had an open CPS case with the family, which was initiated when the hospital made a referral shortly after the child's birth. The caseworker made timely in-person contact with the parents and child while they were still in the hospital. After discharge from the hospital the caseworker attempted to reach the parents to arrange a home visit but was unsuccessful. No one from the Department was able to assess the infant's home and sleep environment prior to the death. The Committee recognized the caseworker's efforts to reach out to the family by phone but felt the worker could have been more aggressive in locating and meeting with the parents at home.

Recommendation Status:

In process – OFCO has requested additional information on the implementation of this recommendation.

Chemical Dependency Professional Liaison Program – A frequent recommendation over the years is for the Department to re-initiate the Chemical Dependency Professional (CDP) liaison program which provided DCYF field offices with in-house chemical dependency experts available to consult on cases, improve client engagement, and connect families with community resources. This program was cut due to budget constraints and the continued lack of funding poses a barrier to implementing this recommendation. This year three different reviews recommended re-initiating the CDP program.

Chemical Dependency Professionals

Recommendation (made in three separate reviews):

The Committee recommends that DCYF explore the possibility of re-initiating the Chemical Dependency Professional (CDP) liaison program which provided DCYF field offices with "in house CDPs" that were available for substance abuse related consultation, informational resources, guidance for client engagement and community resources. The Committee is aware that current state budget constraints may pose a barrier to this recommendation.

Fatality Background:

In all three of these cases (two fatalities and one near fatality), the caregivers had a history of chemical dependency use. The Committees discussed that substance abuse by a caregiver likely played some role in the fatality/near fatality and that a designated "in house" chemical dependency professional could provide guidance to caseworkers trying to engage these families and assess child safety.

This is a frequent recommendation over the years. This program used to be offered in Department offices but due to budget restrictions the program was eliminated.

Recommendation Status:

In process – due to budget constraints it is unlikely that this recommendation will be implemented at this time.

Administration and Documentation – Five recommendations focused on the administrative tasks of field work and casework documentation.

- One review committee recommended that the supervisor work with regional practice consultants to address clinical supervision and documentation practices. The supervisor met with the practice consultant and an examination of documented supervisor reviews show this being put into practice.
  – Recommendation is complete.
- One recommendation was made to reassess where Office of Indian Child Welfare caseworkers are located and move them closer to areas they routinely serve.
  – This recommendation is in process.
- Two recommendations focused on the transfer of cases from CPS to Family Voluntary Services. One called for a more specific method of transfer that details the roles and responsibilities of each caseworker, while the other recommends the supervisor be more involved in the transfer process.
  – Recommendations are in process.
- One recommendation addressed dissemination of information from the area administrator to field office staff.
  – This recommendation is in process.

C. PARTNERSHIPS WITH COMMUNITY PROFESSIONALS

Three recommendations addressed the need to strengthen communication and partnerships with community professionals and other agencies. One recommended that the area administrator reach out to the local hospital to discuss the importance of clear and timely communication between the hospital and the Department. In this case the mother reportedly engaged in heavy alcohol consumption during pregnancy. The child was born premature and expected to remain in the hospital at least a couple of weeks. The hospital initially agreed to notify the CPS caseworker when the baby would be discharged but this did not happen. Another review recommended that the area administrators meet with the director of a local domestic violence shelter to discuss ensuring safe sleep practices by parents of newborns living in the shelter. Both of these were reported to be in process. The third recommendation was that either the area administrator or a medical consultant communicate with local professionals who investigate child deaths and abuse (e.g. medical examiners, law enforcement) how SIDS findings, information sharing and autopsy reports impact the ability to assess the surviving children in the home.

CONCLUSION

The work of the child fatality and near fatality review committees advance our understanding of the circumstances contributing to these tragedies and develop strategies to improve child health and safety, and to prevent deaths and injuries in the future. For example, the fatality and near fatality review process has provided valuable information regarding the connection between unsafe sleep environments and infant fatalities, which has significantly changed child welfare practices and procedures and greatly increased public awareness about this issue.

OFCO thanks the many professionals, both within DCYF 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.

APPENDICES

APPENDIX A:

2014-2017 Maltreatment Related Child Fatality and Near Fatality Data

APPENDIX B:

Child Fatality and Near Fatality Review Recommendations

APPENDIX C:

The Role of OFCO

APPENDIX A: 2014-2017 MALTREATMENT RELATED CHILD FATALITY AND NEAR FATALITY DATA

This appendix includes additional data regarding maltreatment related fatalities and near fatalities examined by OFCO each year from 2014 to 2017. During this four year period OFCO examined 145 maltreatment related fatalities and 65 maltreatment related near fatalities.

Table 6: **Number of Maltreatment Related Child Fatalities per Year**

(n = 145)

	2014	2015	2016	2017
Clear Physical Abuse	6	5	3	4
Clear Neglect	7	8	10	8
Child Maltreatment Concerns	28	21	22	23

Table 7: **Manner of Death per Year**

(n = 145)

	2014	2015	2016	2017
Accidental	16	8	11	6
Homicide	5	5	4	4
Natural / Medical	13	14	7	11
Suicide	0	2	3	0
Unknown / Undetermined	7	5	10	14

Table 8: **Child Age at Time of Death per Year**

(n = 145)

	2014	2015	2016	2017
12 Months or Less	30	24	21	29
1-3 Years	6	3	7	5
4-7 Years	4	3	0	1
8-12 Years	0	1	1	0
13-17 Years	1	3	6	0

Table 9: **Child Race and Ethnicity in Maltreatment Related Fatalities per Year**

(n = 145)

Race and Ethnicity	2014	2015	2016	2017
African American or Black	6	3	2	5
American Indian or Alaska Native	2	1	7	2
Asian or Pacific Islander	1	3	1	2
Caucasian	22	21	23	18
Multi-Racial	5	6	2	6
Other or Unknown	5	0	0	2
Latino / Hispanic	**6**	**3**	**2**	**2**

Table 10: **Maltreatment Related Child Near Fatalities per Year**

(n = 65)

	2014	2015	2016	2017
Clear Neglect	4	11	9	4
Clear Physical Abuse	5	5	3	4
Child Maltreatment Concerns	10	2	4	4

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

(n = 65)

	2014	2015	2016	2017
12 Months or Less	6	3	8	5
1-3 Years	4	7	6	4
4-7 Years	4	4	0	2
8-12 Years	0	2	1	1
13-17 Years	5	2	1	0

Table 12: **Child Race and Ethnicity in Maltreatment Related Near Fatalities per Year**

(n = 65)

Race and Ethnicity	2014	2015	2016	2017
African American or Black	2	1	3	0
American Indian or Alaska Native	1	2	1	2
Asian or Pacific Islander	1	0	0	0
Caucasian	12	12	10	9
Multi-Racial	3	3	2	0
Other or Unknown	0	0	0	1
Latino / Hispanic	**4**	**5**	**5**	**2**

APPENDIX B: CHILD FATALITY AND NEAR FATALITY REVIEW RECOMMENDATIONS

The recommendations made by representatives from the community, OFCO and DCYF participating in child fatality and near fatality reviews are forwarded to a DCYF administrator or DCYF'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 44 recommendations made in child fatality and near fatality reviews conducted from June 2016 through September 2017 and the implementation status for each recommendation.

TOPIC A: PROVIDE TRAINING	
Chemical Dependency – DCYF should provide training to staff on how marijuana impacts a fetus in utero (to better understand possible impacts post birth), what to expect when mothers who are using marijuana are also breast feeding and how the use of marijuana may influence parents while they provide care for their children.	Status: Completed Level: Statewide
Chemical Dependency – Based on the fact that opioid use, morbidity and mortality have increased nationally and across Washington, DCYF should consider providing specific training for all case-carrying staff and supervisors regarding opioids and Opiate Replacement Therapy (ORT) including MMT. The training should address assessing child safety in cases involving a parent in MMT or other types of Opiate Replacement Therapy.	Status: In process Level: Statewide
Chemical Dependency – The Committee recommends that DCYF provide yearly training to all DCYF staff on the assessment of legal and illegal substances and their impact on a person's ability to safely care for a child.	Status: Completed Level: Statewide
Chemical Dependency – DCYF should consider expanding current substance abuse training to include information and discussion regarding typical behavior patterns displayed by users of specific types of drugs (e.g., heroin, methamphetamine, heavy marijuana use). This training would provide workers with the potential to better assess the caregiver's situation as it relates to child safety.	Status: In process Level: Statewide

TOPIC A: PROVIDE TRAINING	
Chemical Dependency – Trainings should regularly be available to all DCYF staff on the assessment of marijuana use and the impact it has on a person's ability to safely parent his/her child. DCYF should provide or procure training for staff on effectively interviewing subjects with substance use or abuse issues.	Status: Completed Level: Statewide
Chemical Dependency – DCYF shall develop or obtain a training for staff regarding the behavioral indicators of persons using and abusing Opiate Replacement Therapies (ORT) and Opiates. This training should provide staff with tools on how to assess the risk to child safety for parents using or abusing opiates and/or ORT's as well as provide guidance on what to do with that information after it was been received.	Status: In process Level: Statewide
Chemical Dependency – All DCYF offices should obtain training from Sterling Reference Laboratories regarding understanding, interpreting and utilization of urinalysis reports.	Status: In process Level: Statewide
Domestic Violence – The Committee recommends that the local DCFS office social workers and supervisory staff attend the two-day domestic violence training available in their region.	Status: In process Level: Local
Domestic Violence – The Committee recommends that all social workers and supervisors in the local office attend the available two-day domestic violence training or domestic violence trainings by June 2018.	Status: In process Level: Local
Domestic Violence – DCYF should consider collaborating with the Alliance on creating a one-page resource for staff that they would receive during the two-day DV training and attach that tip sheet to a "Quick Tip" for DCYF staff.	Status: In process Level: Statewide
Domestic Violence – The DCYF Domestic Violence program manager will contact the Alliance about adding a training section to the two-day Domestic Violence training and specifically address how to speak with perpetrators of DV during CPS investigations.	Status: In process Level: Statewide

TOPIC A: PROVIDE TRAINING	
Safety – In response to concerns that the 2015-2016 contacts were overly incident-focused at times, DCYF should develop or enhance currently available training for social workers and supervisors statewide on global assessment of families involved with CA. This training should emphasize and focus on the following: • Assessing other adults in the home, interviewing clients and verifying statements, obtaining consultation or interpretation of records (specifically medical, mental health and chemical dependency) and how to incorporate and analyze historical DCYF records into current assessments; and • Use of clinical supervision at the 30-day case review to identify and address gaps in information gathering and assessment, assess for bias, and include development of case plan and the social workers next steps.	Status: Completed Level: Statewide
Safety – DCYF should obtain or provide training on the assessment of risk as it pertains to child safety and when or how DCYF should intervene.	Status: In process Level: Statewide
Safety – DCYF in Region 1 should consider creating, offering more frequently, or enhance currently available training on assessing safety that captures the below topics: • Tactics for gathering and analyzing information on family members, DCYF history and criminal history; • Clinical supervisions of staff to assist in the information gathering process to include analysis of gathered information; and • Utilizing LICWAC recommendations, when to re-staff with LICWAC and make more informed placement decisions that align with DCYF practice and procedures policy.	Status: Completed Level: Regional
Safety – The Committee recommends that the local office supervisors, social workers and FTDM facilitators who assess for child safety and placement attend the available Safety Boot Camp trainings or a unit in-service training on safety assessment and planning by January 2018 if they have not completed a safety assessment training in 2016.	Status: In process Level: Local
Safety – The Committee recommends that all supervisors and social workers in the local office, who assess for child safety and placement, attend the available Safety Boot Camp trainings or a unit in-service training on global safety assessment and planning by January 2018 if they have not completed any safety assessment training in the last year.	Status: In process Level: Local

TOPIC A: PROVIDE TRAINING	
Casework Practice & Supervision – The Committee recommends that DCYF make training regularly available to all DCYF staff on navigating and using Department of Health records and the Community Service Office databases.	Status: In process Level: Statewide
Casework Practice & Supervision – Any unit taking on overflow case assignment responsibilities should be crossed-trained in the program from which that unit is receiving overflow cases if those responsibilities are not their primary program function.	Status: Unknown Level: Statewide
Casework Practice & Supervision – DCYF should consider having all case carrying staff attend training related to open source searching. These trainings aid investigators who are searching for people through free sources on the internet. While it is particularly pertinent in this case, it would be beneficial in other cases where children may be on the run or missing from care.	Status: In process Level: Statewide
Other – The Committee recommends that DCYF make training available to all DCYF staff on interviewing children with disabilities, safety assessment of children with disabilities, and partnering with the community for assessment and services of children with disabilities to include working with Developmental Disabilities Administration.	Status: In process Level: Statewide
Other – DCYF is encouraged to continue ongoing evaluation of formal mentoring of new child welfare workers beyond Regional Core Training (RCT). This would include looking to replicate formalized mentoring programs from other disciplines (such as law enforcement) that have sought to increase in-field competency.	Status: In process Level: Statewide
Other – DCYF should consider providing a death investigation training for seasoned CPS staff so they are aware of what to look for, correct terminology, and how to professionally challenge law enforcement to discuss investigative details during a death investigation.	Status: In process Level: Statewide

TOPIC B: CASEWORK PRACTICE	
Safety Assessment & Planning – DCYF should provide a reminder statewide to all case carrying staff that they have a responsibility to assess placements made by law enforcement.	Status: Unknown Level: Statewide
Safety Assessment & Planning – DCYF should review the current policies regarding active CFWS cases involving dependent and non-dependent children as occurred in this case. Consideration should be given to improving guidance to workers and supervisors on how to proceed with completing a comprehensive, ongoing assessment of children who are not a part of an open case yet are under the care of a parent who has other dependent children. This could include guidance on cases that involve multiple offices.	Status: In process Level: Statewide
Safety Assessment & Planning – Improve 30-day case review documentation to specifically address safety, permanency, wellbeing with updated case information or case plans.	Status: In process Level: Statewide
Safety Assessment & Planning – The local office CPS/FVS supervisor should verify that DCYF history on all caregivers and intimate partners or others who have frequent access to the child has been gathered, assessed and documented.	Status: In process Level: Local
Safety Assessment & Planning – The Committee recommends that the local office consider holding a Family Team Decision-Making meeting immediately at the local office or hospital when an infant has been exposed to drugs in utero and the parent denies use of drugs or the impact of such drugs on the infant.	Status: In process Level: Local
Safety Assessment & Planning – The Committee recommends that DCYF consider requiring a safety plan to be developed immediately at the time of an FTDM if a safety threat has been identified and the FTDM plan calls for a safety plan to be developed.	Status: In process Level: Statewide
Safety Assessment & Planning – DCYF should consider requiring a home visit to be conducted within some short period of time after an accepted intake involving a newborn. The Committee discussed various time periods including three days of the intake, within one day of discharge from a hospital or within a week. This requirement would be separate from current policy requirements for initial face-to-face contact that may occur outside the home (e.g., hospital). This recommendation would require an immediate assessment of the home and infant sleep environment within a specified time frame not currently set in policy.	Status: In process Level: Local

TOPIC B: CASEWORK PRACTICE	
Safety Assessment & Planning – The Committee recommends that DCYF evaluate the potential of using shared planning meetings, such as an FTDM or CPT, on cases involving Plans of Safe Care for newborns. While the Plan of Safe Care form (DSHS 15-491/December 2016) includes a section documenting any referrals to resources such as Public Health Nurse and Maternity Support Services, shared planning around such resources may beneficially expedite and streamline the process.	Status: In process Level: Statewide
Safety Assessment & Planning – In order to articulate mitigating factors to child safety, the Committee believes the local office supervisors involved in this case should document mitigating factors explaining why children are "safe" in relation to specific risks when completing case reviews and when the case is closing.	Status: Completed Level: Statewide
Safety Assessment & Planning – DCYF should review the current policies regarding situations involving dependent and non-dependent children with the same parent, as occurred in this case, and consider any revision or clarification. The revision or clarification could possibly allow for the assigned social worker and supervisor to have a clearer indication of how to proceed with the responsibility of DCYF to complete a comprehensive, ongoing assessment of children who are not a part of an open case yet are under the care of their parent who has other dependent children.	Status: In process Level: Statewide
Supervision and Practice Consultation – Monthly supervisory reviews were documented as having occurred regularly and timely. However, such reviews could have included clinical direction to provide guidance, critical thinking and feedback. The Committee recommends that the local office supervisor work with the regional program consultants to address clinical supervision and documentation practices.	Status: Office Level: Local
Supervision and Practice Consultation – The CPS/FVS supervisor should take a more active role in the transfer process by facilitating a formal transfer staffing and complete case file documentation of the concerns and dynamics of the case.	Status: In process Level: Local

TOPIC B: CASEWORK PRACTICE	
Supervision and Practice Consultation – To assist in information gathering and assessment, the local DCYF office Area Administrator, in conjunction with the CPS and FVS supervisors in the office, should devise a more specific method for case transfer that details the roles and responsibilities of the sending and receiving social workers. The receiving unit should ensure that there is sufficient information gathered from the sending party to proceed in ongoing safety assessment and case planning. If the sending party has not investigated other persons caring for the children or frequenting the home, obtained medical records and criminal histories and verified information given by the subjects and victims, the roles and responsibilities at transfer should outline who will follow up to gather the necessary information to complete comprehensive assessments (if the case is transferred without these items completed).	Status: In process Level: Local
Multidisciplinary Collaboration – The Committee recommends that DCYF explore the possibility of re-initiating the Chemical Dependency Professional (CDP) liaison program, which provided DCYF field offices with "in house CDPs" that were available for substance abuse related consultation, informational resources, guidance for client engagement and community resources. The Committee is aware that current state budget constraints may pose a barrier to this recommendation.	Status: In process Level: Statewide
Multidisciplinary Collaboration – The Committee recommends that DCYF explore the possibility of re-initiating the Chemical Dependency Professional (CDP) liaison program, which provided DCYF field offices with "in-house CDPs" that were available for substance abuse related consultation, informational resources, guidance for client engagement and community resources. The Committee is aware that current state budget constraints may pose a barrier to this recommendation.	Status: In process Level: Statewide
Multidisciplinary Collaboration – While the substance abuse issues of T.K.'s mother and father were not alleged during the most recent investigations, there was a longstanding history regarding this struggle and no corroborated, documented change. The Committee participants have identified that the loss of chemical dependency professionals stationed within DCFS offices may have decreased staff's engagement with families regarding chemical dependency issues. The Committee recommends that DCYF reconsider this partnership.	Status: In process Level: Statewide
Other – Region 2 should consider reassessing the location for Office of Indian Child Welfare CPS workers to possibly outstation them or move them to offices located closer to areas they routinely respond to.	Status: In process Level: Regional

TOPIC B: CASEWORK PRACTICE	
Other – The Committee recommended that Region 2 administration review their current expectations of the area administrators as to how they disseminate information to field office staff when the roving unit is assigned to their office. This recommendation is based on the discussion that the receiving office staff may not understand the role and purpose of the roving unit.	Status: In process Level: Regional
Other – DCYF should consider a "Quick Tip" to remind staff to discuss the risks associated with bed-sharing with children on air mattresses.	Status: Completed Level: Statewide

TOPIC C: PARTNERSHIPS WITH COMMUNITY PROFESSIONALS	
In an attempt to reduce possible ambiguity in CA's role in child death investigations, the Committee recommends that the local DCFS area administrator and/or a DCYF medical consultant communicate with the local professionals who investigate child death and child abuse (including the local medical examiner and local law enforcement), possibly at a multidisciplinary meeting, how SIDS findings, autopsy reports, and information sharing impacts CA's ability to assess the safety of the surviving children in the home and complete investigations more accurately.	Status: In process Level: Local
The area administrator should reach out to the hospital where P.S. was born to discuss communication between the hospital and CA. Specific to this case was the issue of notification to DCYF prior to the discharge of P.S.	Status: In process Level: Local
The area administrators should meet with the director of the Dawn Shelter to discuss collaboration and cooperation for cases involving families residing at the shelter. It is also recommended that a discussion occur with the domestic violence shelter about safe sleep practices within the shelter and the use of air mattresses and bed-sharing.	Status: In process Level: Local

APPENDIX C: THE ROLE OF OFCO

The Washington State Legislature created the Office of the Family and Children's Ombuds[56] (OFCO) in 1996 in response to two high profile incidents that indicated a need for oversight of the child welfare system.[57] OFCO provides citizens an avenue to obtain an independent and impartial review of Department of Children, Youth, and Families (DCYF) 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 DCYF.

- **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 DCYF. 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 DCYF operate under an inter-agency agreement that guides communication between the two agencies and promotes accountability.[58]

AUTHORITY

Under chapter RCW 43.06A, the Legislature enhanced OFCO's investigative powers by providing it with broad access to confidential DCYF records and the agency's computerized case-management system. It also authorizes OFCO to receive confidential information from other agencies and service providers,

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[56] 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.

[57] The death of the three year old Lauria Grace, who was killed by her mother under the supervision of 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 the growing concerns about DSHS's role and practices in the Wenatchee child sexual abuse investigations.

[5858] The inter-agency agreement is available online at http://ofco.wa.gov/documents/interagency_ofco_dshs.pdf.

including mental health professionals, guardians ad litem, and assistant attorneys general.[59] 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.[60]

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 general operations and system improvement recommendations are reviewed by the DCYF Oversight Board.

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 DCYF 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 DCYF 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 DCYF 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.

[59] See also RCW 13.50.100(6).
[60] See RCW 74.13.640(1) (b); 74.13.640(2); and 26.44.030(15).