WASHINGTON STATE

OFFICE OF THE FAMILY AND CHILDREN'S OMBUDS

CHILD FATALITIES AND NEAR FATALITIES IN WASHINGTON STATE

JULY 2024

Contents

EXECUTIVE SUMMARY 2

SECTION I: OFCO-EXAMINED CRITICAL INCIDENTS 4

CHILD FATALITIES EXAMINED BY OFCO 4

CHILD NEAR FATALITIES EXAMINED BY OFCO 12

ACCIDENTAL INGESTION OF DRUGS AND DRUG OVERDOSES 14

CHILD RACE AND ETHNICITY 18

SECTION II: IMPLEMENTATION STATUS OF FATALITY AND NEAR FATALITY REVIEW RECOMMENDATIONS 19

IMPLEMENTATION STATUS OF RECOMMENDATIONS 19

APPENDIX: CHILD FATALITY AND NEAR FATALITY REVIEW RECOMMENDATIONS 22

Contact Information:
Patrick Dowd, Director Ombuds
Elizabeth Bokan, Deputy Director Ombuds
Washington State Office of the Family and Children's Ombuds
6840 Fort Dent Way, Suite 125, Tukwila, WA 98188
(800)571-7321 ofcoinfo@ofco.wa.gov

This report was prepared by Sherry Saeteurn

EXECUTIVE SUMMARY

The Office of the Family and Children's Ombuds (OFCO) was established to ensure that government agencies respond appropriately to concerns related 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 critical incidents, such as child fatalities and near fatalities. 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.

The Department of Children, Youth and Families (DCYF) notifies OFCO when a critical incident occurs.[1] OFCO then conducts 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 12 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 12 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]

- **Other Critical Incidents:** The Department notifies OFCO of other critical incidents including child abuse allegations in licensed foster homes or residential facilities, incidents involving DCYF clients (such as dangerous behavior by foster youth), incidents affecting DCYF staff safety, or high-profile circumstances that may generate significant media interest. 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.

Section I of this report describes OFCO's critical incident review activities from January 1, 2023, to December 31, 2023. The critical incidents discussed in this report include child fatalities and child near fatalities. It is important to note that OFCO is not notified of all child fatalities or near fatalities, only those that are recorded in the DCYF reporting system.

From January 1, 2023, to December 31, 2023, OFCO conducted 79 administrative examinations of child fatalities involving both child abuse or neglect cases and fatality cases unrelated to child maltreatment, and 70 examinations of child near fatalities. Of these, OFCO considered 49 child fatalities and 53 child near fatalities to be related to child maltreatment. Through this process,

[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 74.13.640(2)(c).

OFCO identifies common factors and systemic issues regarding these critical incidents. As discussed in this report, systemic issues identified include sleep-related child fatalities and critical incidents resulting from a child's accidental ingestion of fentanyl.

Despite efforts to educate families about infant safe sleep practices, sleep-related infant fatalities persist and impact Black and American Indian/Alaska Native families at a higher rate compared to White families. Of the 79 child fatalities OFCO reviewed in 2023, nearly one-third (26 fatalities) were sleep-related infant deaths. Ninety-two percent (24 cases) of these sleep-related fatalities occurred while the parent was co-sleeping or surface sharing with the child at the time of the incident. In many of these cases, the parent was surface sharing with the infant due to lack of adequate housing. Efforts to prevent sleep-related infant fatalities should also address housing instability and economic disparities.

In 2023, OFCO continued to see a significant increase in critical incidents involving a child's accidental ingestion of drugs and drug overdoses. Accidental ingestions and overdoses accounted for 20% of the fatalities (16 fatalities) and nearly 73% of the near fatalities (51 fatalities) OFCO reviewed. Eighty-five percent of critical incidents from accidental ingestion of drugs or drug overdose involved fentanyl. Child fatalities and near fatalities involving fentanyl increased from 38 in 2022 to 57 in 2023. Young children are particularly at risk for accidental ingestion of drugs. Of the 67 incidents involving accidental ingestions, 45 incidents involved accidental ingestion by children 11 years of age or younger.

DCYF conducts an Executive Child Fatality Review when the death of a child was suspected to be caused by abuse or neglect, and the child or child's family was receiving services from DCYF at the time of death, or in the preceding 12 months.[5] The review committee consists 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 officials, chemical dependency treatment providers, domestic violence treatment providers, mental health treatment providers, child health providers, or social work practice specialists. The purpose of reviewing child fatalities and near fatalities is to increase understanding of the circumstances around the child's injury or death, evaluate practice and programs, make recommendations to prevent future child fatalities or near fatalities, and improve the health and safety of children. OFCO is required to issue an annual report on the implementation of recommendations issued by fatality review committees.

Section II of this report describes the implementation status of recommendations made in child fatality and near fatality reviews conducted between January 1, 2023, and December 31, 2023. During this period, DCYF conducted 17 child fatality reviews and 32 near fatality reviews.

[5] RCW 74.13.640.

SECTION I: OFCO-EXAMINED CRITICAL INCIDENTS

CHILD FATALITIES EXAMINED BY OFCO

OFCO conducts a preliminary review of all fatalities in which the child's family was involved with Washington's child welfare system within 12 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.

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 made by DCYF, 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.

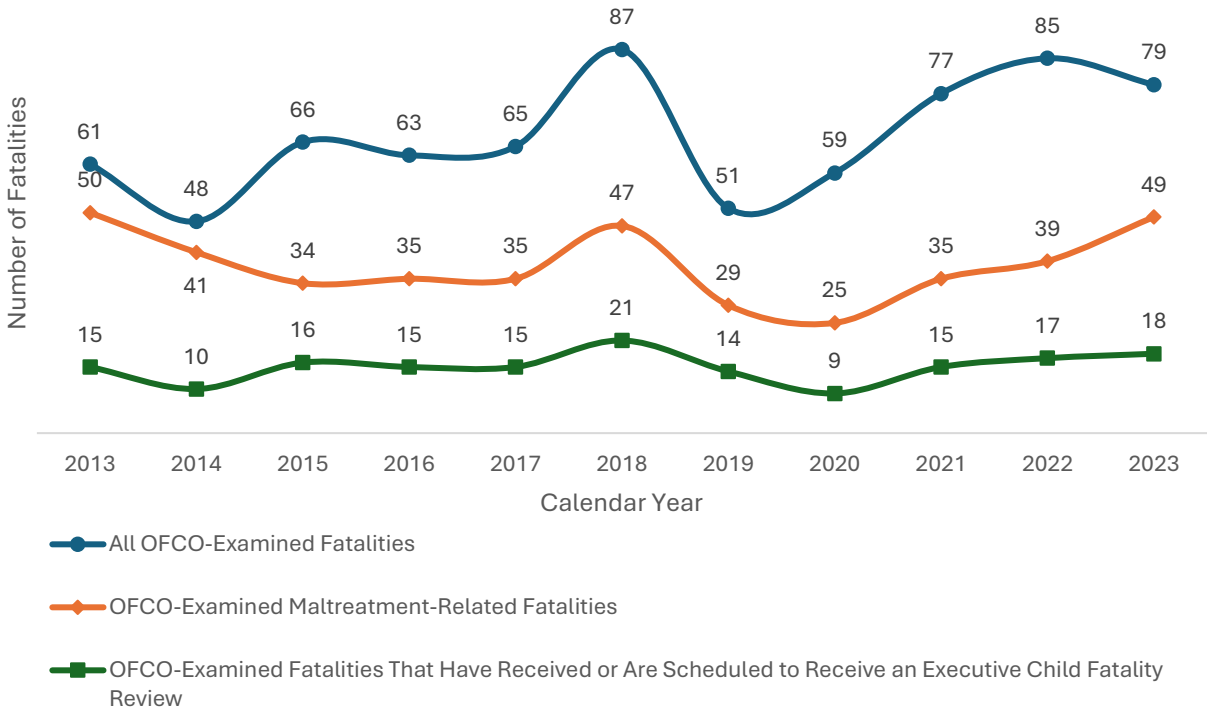
OFCO examined 79 child fatalities between January 1, 2023, and December 31, 2023. Not all fatalities of which OFCO receives notice are related to maltreatment. For example, OFCO may receive notice of an expected medical death of a child whose family has had contact with the Department in the past 12 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 79 child fatalities examined between January 1, 2023, and December 31, 2023, OFCO considered 49 to be related to child maltreatment. The following data describes the profile of these 49 maltreatment-related child fatalities.

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



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.

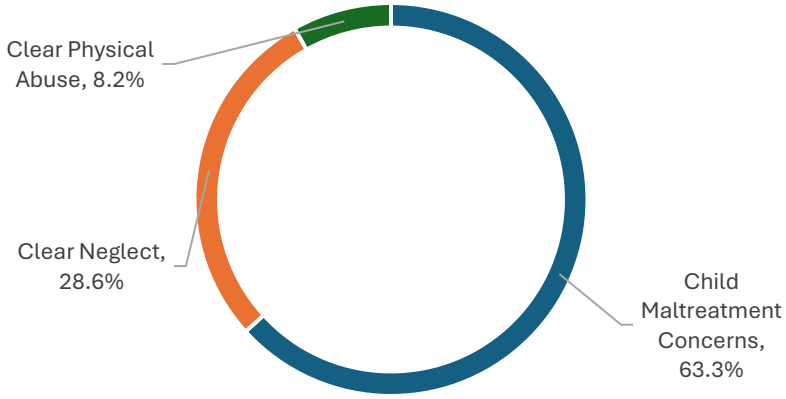
Clear Neglect
A CPS investigation concluded that neglect by a caregiver (e.g. an infant or toddler left unattended) caused the child's death. Law enforcement reports, medical records, and/or an autopsy report may also have concluded that negligent treatment/maltreatment caused the child's death.

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 could 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.

MALTREATMENT-RELATED CHILD FATALITIES

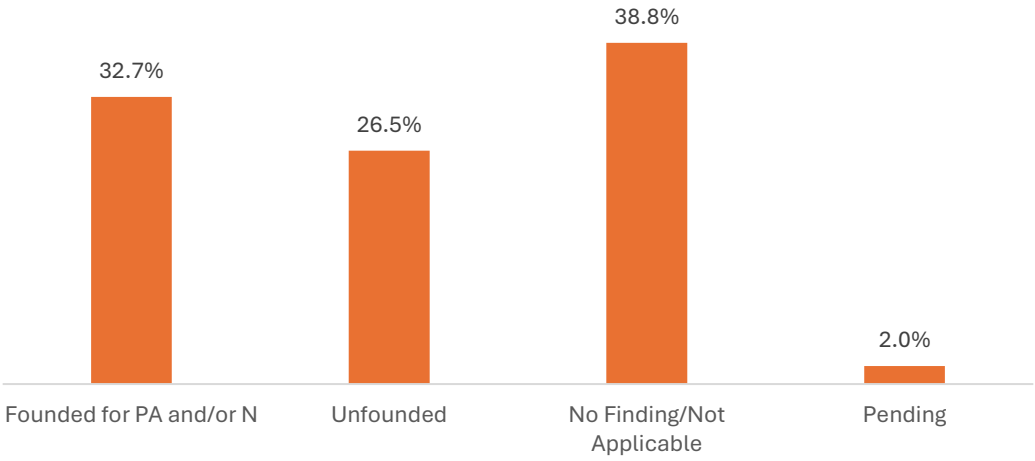
Of the 49 child fatalities related to child maltreatment, 4 children died due to physical abuse and 14 as a direct result of neglect. OFCO found maltreatment concerns in 31 additional cases.

Figure 2: **Type of Maltreatment in Fatalities, 2023**



Investigations into 16 of the 49 fatalities resulted in a "founded" finding of neglect and/or physical abuse. Investigations into 13 deaths were "unfounded." No findings were made in 19 deaths.[6] At the time of this report, one investigation remains pending.

Figure 3: **Findings in Maltreatment-Related Fatalities, 2023**



[6] Findings may not have been made for many reasons, including no intake being made regarding the death, the intake screened in for a risk only investigation, or the intake screened out.

MANNER OF DEATH

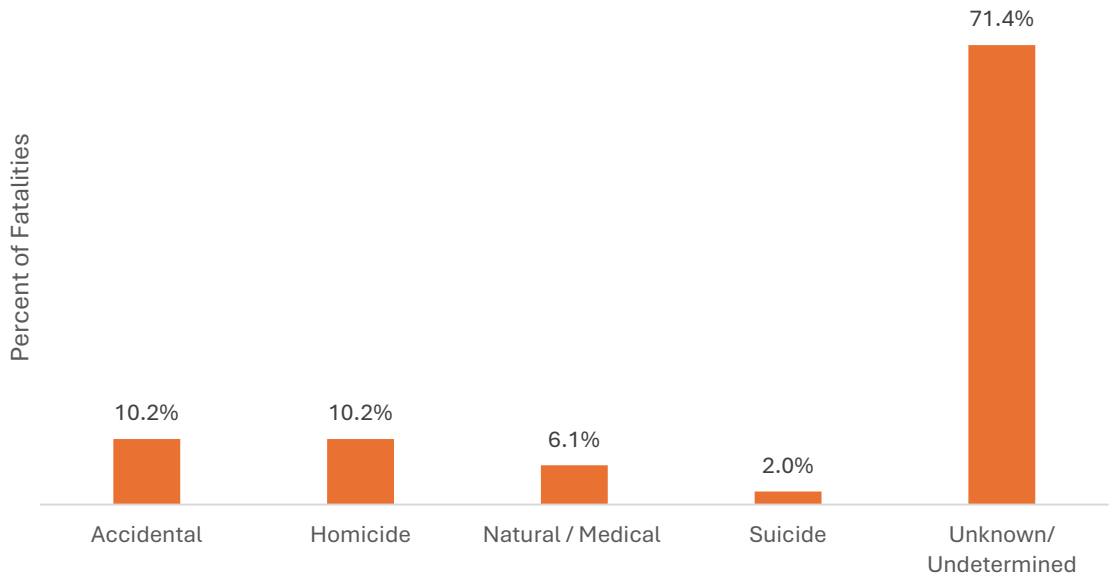
The manner and cause of death is determined by a medical examiner or coroner. The manner of death describes the context or circumstances of the death and is assigned to one of five categories:

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

The cause of death details how the death occurred. For example, the manner of death is determined as natural 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 motor vehicle accident. SIDS is generally considered a subset of natural or medical death, however, if significant risk factors were present during the scene investigation, such as an unsafe sleep environment or inappropriate bedding, the manner of death may be classified as unknown or undetermined. The manner of death may also be classified as unknown or undetermined for drug overdoses as there may not be enough information to establish whether the overdose was accidental or intentional.

Of the 49 maltreatment-related fatalities, the manner of death for 35 fatalities were unknown or undetermined, 5 were homicide, and 5 were accidental.[7] Three fatalities were ruled as natural or medical and one as suicide.

Figure 4: **Manner of Death, 2023**

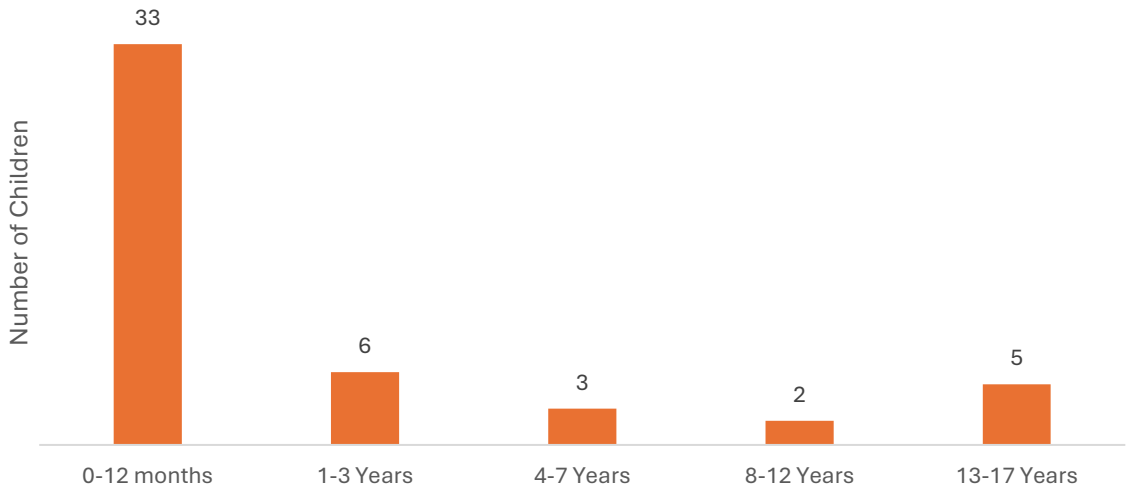


[7] Unknown/Undetermined category includes fatalities with limited case information and the manner of death was not reported.

CHILD AGE AT TIME OF DEATH

The majority of the maltreatment-related fatalities involved infants (birth to 12 months) who accounted for over 67% of the fatalities (33 fatalities).

Figure 5: **Child Age at Time of Death, 2023**



INFANT DEATHS INVOLVING UNSAFE SLEEP

Despite efforts to educate families and improve safe sleep practices, sudden unexpected infant deaths (SUID)[8] persist. SUID rates in the U.S. are higher among Black and American Indian/Alaska Native infants compared to White and Asian/Pacific Islander infants. Factors associated with a higher risk of sleep-related infant fatalities such as low socioeconomic status, unemployment, and housing instability are also highly correlated with race/ethnicity.[9]

Of the 79 child fatalities OFCO reviewed in 2023, nearly one-third (26 fatalities) were sleep-related infant deaths. A sleep-related infant death is defined as a sudden, unexpected infant death that occurs during an observed or unobserved sleep period, or in a sleep environment. Five of the sleep-related fatalities qualified for an executive review, as the child's death was attributed to abuse or neglect.

Ninety-two percent (24 cases) of these sleep-related fatalities occurred while the parent was co-sleeping or surface sharing with the child at the time of the incident. Sharing a sleep surface with an infant increases the risk of sleep-related sudden unexpected infant death, accidental suffocation, and strangulation. Surface sharing, especially on a couch or armchair, increases risk of suffocation by soft bedding, wedging or entrapment, and overlay. Surface sharing in combination with parental substance use greatly increases SUIDS risk.[10] Substance use was identified as a possible

[8] Sudden unexpected infant death (SUID) describes any sudden and unexpected death, whether explained or unexplained during infancy. Sudden infant death syndrome [SIDS]) is a subcategory of SUID and is a cause assigned to infant deaths that cannot be explained after a thorough case investigation. *Moon RY, Carlin RF, Hand I; AAP Task Force on Sudden Infant Death Syndrome; AAP Committee on Fetus and Newborn. Sleep-Related Infant Deaths: Updated 2022 Recommendations for Reducing Infant Deaths in the Sleep Environment. Pediatrics. 2022;150(1):e2022057990.*

[9] Id.

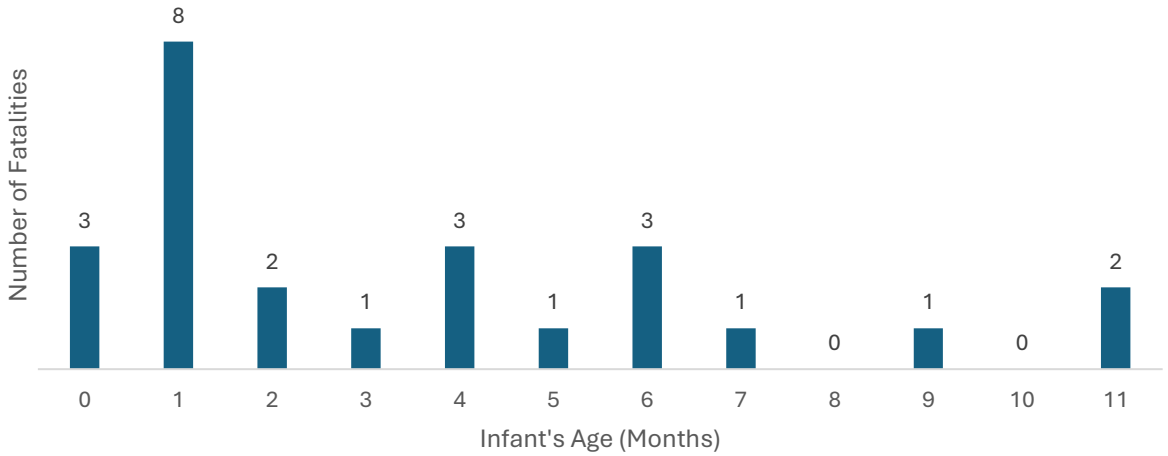
[10] Erck Lambert AB, Shapiro-Mendoza CK, Parks SE, et al. *Characteristics of Sudden Unexpected Infant Deaths on Shared and Nonshared Sleep Surfaces. Pediatrics. 2024; 153(3):e2023061984.*

contributing factor in six of these infant fatalities. In many of these 24 cases, the parent was surface sharing with the infant at least partially out of necessity because of limited sleeping space in the family's residence. In one case, a homeless parent was sleeping with the child in a car. Several cases involved cramped or inadequate living conditions with no heat, power, or running water.

RECOMMENDATION:

In addition to current efforts to prevent sleep-related infant fatalities, greater efforts are needed to address housing instability and economic disparities. Families involved with our child welfare system should have increased access to housing support and assistance as well as concrete goods necessary to ensure a safe living environment for the child.

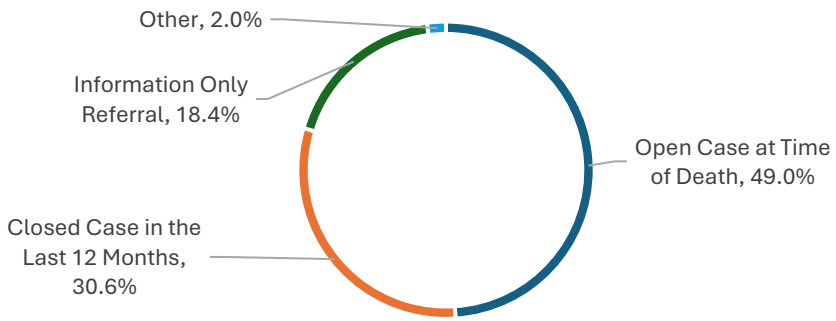
Figure 6: **Infant's Age at Time of Sleep-Related Fatality, 2023**



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

Of the 49 maltreatment-related fatalities examined by OFCO between January 1, 2023, and December 31, 2023, 24 families had an open case with DCYF: 21 fatalities occurred while the children were in the parents' care and 3 fatalities occurred while the children were placed in a licensed foster home. One child passed away while in the care of a grandparent who ran a Department of Early Learning (DEL) licensed daycare in their home. Fifteen families had a Child Protective Services (CPS), Family Assessment Response (FAR), or Family Voluntary Services (FVS) case closed within the previous year.

Figure 7: **DCYF Case Status Within 12 Months of Fatality, 2023**



Of the 24 families with an open case at the time of death, eight were open for a CPS investigation, eight had an open CFWS case, six were open to the FAR program, and two were participating in FVS.

Table 1: **Program Type for DCYF Open Cases at Time of Death, 2023**

Program Type	Number of Fatalities
Child Protective Services (CPS) Investigation Pathway *Investigates screened in reports of child maltreatment.*	8 fatalities
Child and Family Welfare Services (CFWS) *Case management and permanency planning for children and youth in out-of-home placement.*	8 fatalities[11]
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.*	6 fatalities
Family Voluntary Services (FVS) *Cases transfer to FVS after a CPS investigation AND the parent refuses services OR the family was determined to be at moderately high or high risk for abuse or neglect. Participation is voluntary.*	2 fatalities

FATALITIES OCCURRING AFTER FAMILY REUNIFICATION

The safe reunification of families is the primary goal of a dependency proceeding and the Department is required to offer or provide services to address concerns that led to a child's removal from the home.[12]

Of the 49 maltreatment-related fatalities, two fatalities occurred after family reunification; a three-year-old died of physical abuse during an open dependency within five months of returning to the parent on a trial return home, and a 17-year-old died of a fentanyl overdose three years after reunification.

Nine families had open or prior dependencies that did not involve the child that died.

[11] Three of the eight fatalities also involved DCYF's Licensing Division as the fatalities occurred in licensed foster homes.
[12] RCW 13.34.

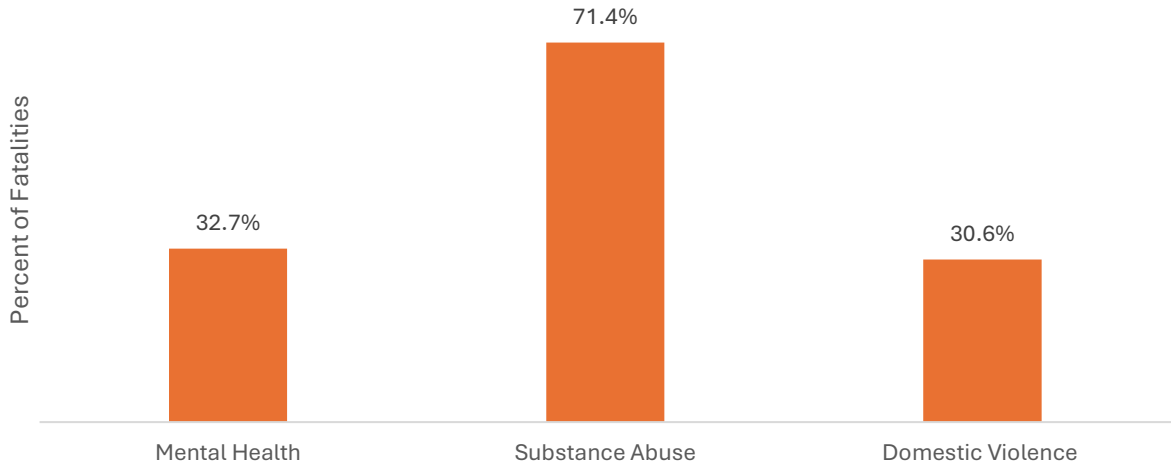
RISK FACTORS FOR CHILD FATALITIES: SUBSTANCE ABUSE, DOMESTIC VIOLENCE, AND MENTAL HEALTH

Parental substance abuse is a major risk factor for child fatalities, maltreatment, and involvement with the child welfare system. Of the 49 maltreatment-related fatalities, over 71% of the children came from families with a reported history of substance abuse (35 families). Of these 35 families with known substance abuse history, 24 families had documented history of methamphetamine and/or fentanyl use.

Domestic violence and mental health disorders were also identified as significant risk factors in many of these fatalities.

At least one of three risk factors were present in 80% of maltreatment-related fatalities.

Figure 8: **Family Risk Factors in Maltreatment-Related Fatalities, 2023**



CHILD NEAR FATALITIES EXAMINED BY OFCO

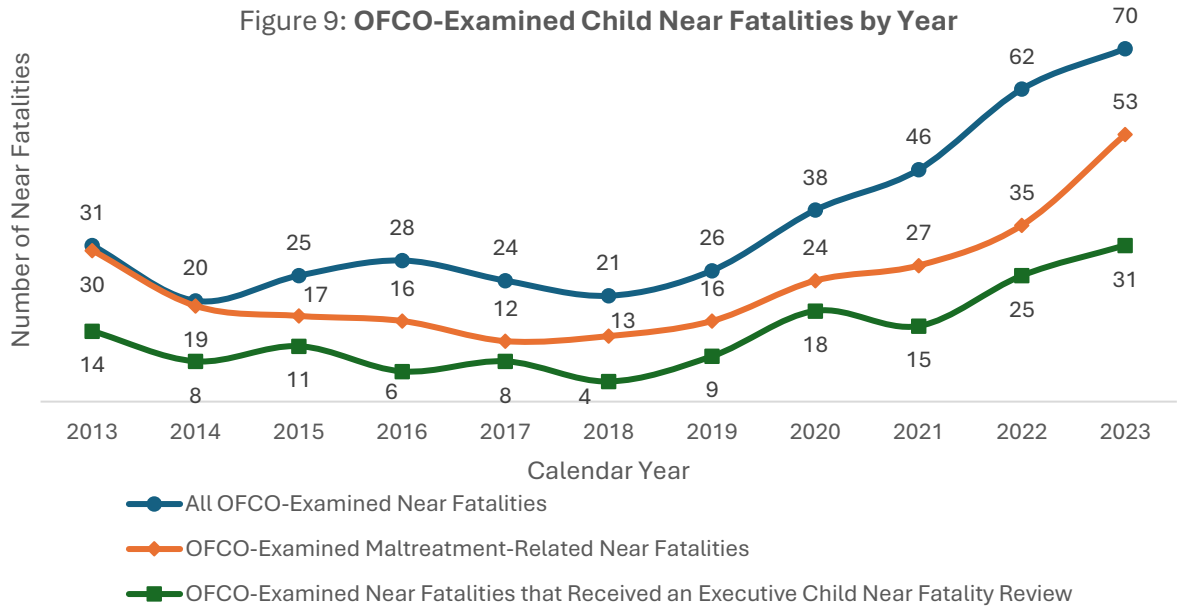
State law requires DCYF to notify OFCO of the near fatality[13] of any child who has been in the Department's custody, or receiving services, within the last 12 months.[14] OFCO conducts a preliminary review of all near fatalities involving alleged child abuse or neglect when the family had an open case with DCYF at the time of the near fatality or in the preceding 12 months, even if the subject child was not the recipient of Department services, and including "information only" referrals.

OFCO examined 70 near fatalities between January 1, 2023, and December 31, 2023. OFCO considered 53 of the near fatalities to be related to child maltreatment.[15]

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 Child Near Fatalities by Year**



[13] RCW 74.13.500 defines "near fatality" as "an act that, as certified by a physician, places the child in serious or critical condition."
[14] RCW 74.13.640(2).
[15] OFCO defines maltreatment-related near fatalities to be those in which a CPS investigation concluded that physical abuse and/or neglect by a caretaker caused the near fatality, or 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 near fatality.

MALTREATMENT-RELATED NEAR FATALITIES

OFCO identifies child near fatalities 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 12 months. Of the 70 near fatalities examined by OFCO between January 1, 2023, and December 31, 2023, 53 were determined to be caused by abuse or neglect, or abuse or neglect concerns were present. Approximately 68% of the maltreatment-related near fatalities were caused by neglect (36 fatalities). Most of the incidents involved children three years of age and under.

Figure 10: **Type of Maltreatment in Near Fatalities, 2023**

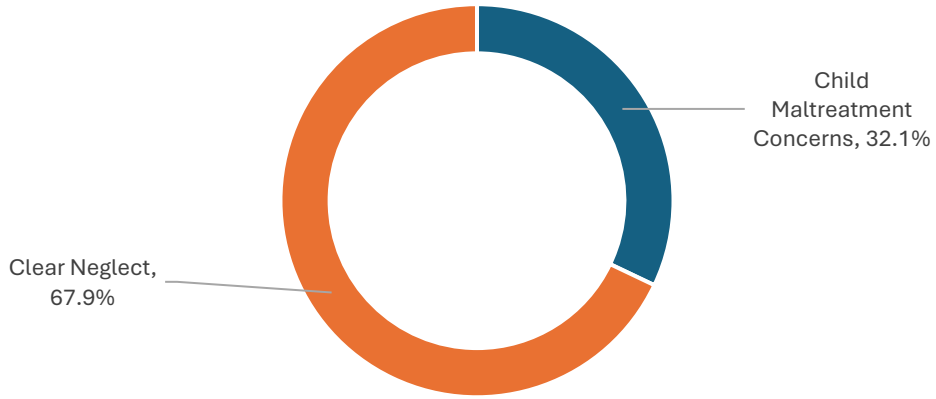
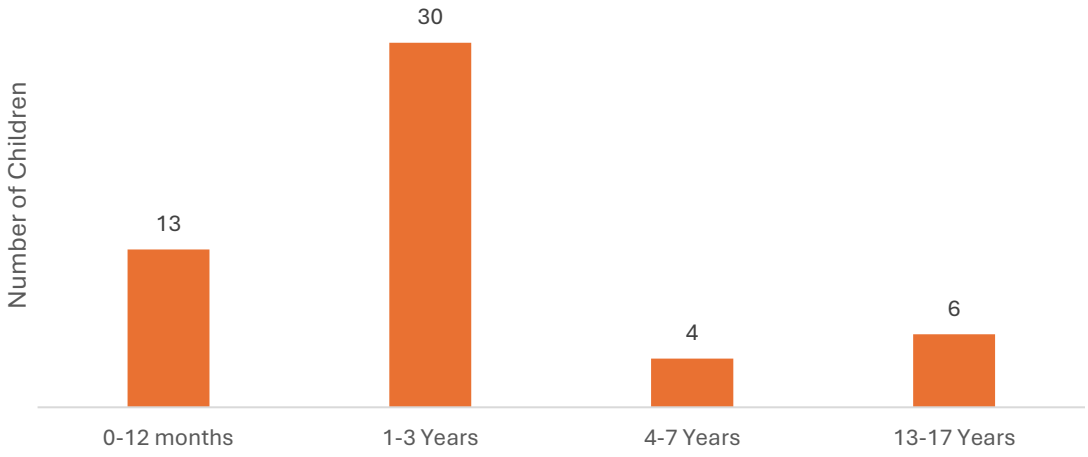


Figure 11: **Child Age at Time of Near Fatality, 2023**



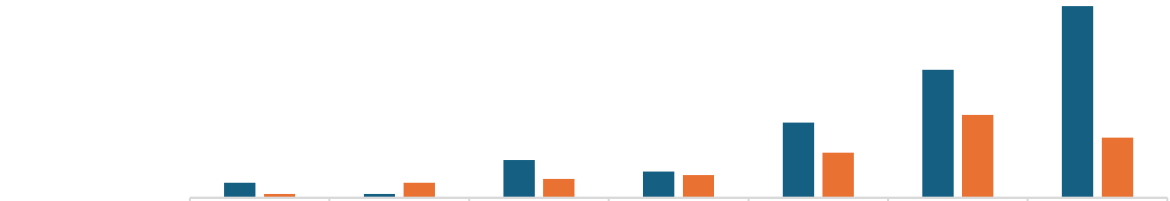
ACCIDENTAL INGESTION OF DRUGS AND DRUG OVERDOSES

OFCO has continued to see a significant increase in critical incidents involving a child's accidental ingestion of drugs and drug overdoses. Accidental ingestions and overdoses accounted for 20% of the fatalities (16 fatalities) and nearly 73% of the near fatalities (51 fatalities) examined by OFCO between January 1, 2023, and December 31, 2023.

Young children are particularly at risk. Of the 67 incidents involving accidental ingestions and overdoses by children examined by OFCO in 2023, 45 incidents involved accidental ingestion by children 11 years of age or younger, 20 involved accidental overdoses by youth between 11 and 22 years of age while using substances, and two involved intentional overdoses by youths ages 13 and 14.

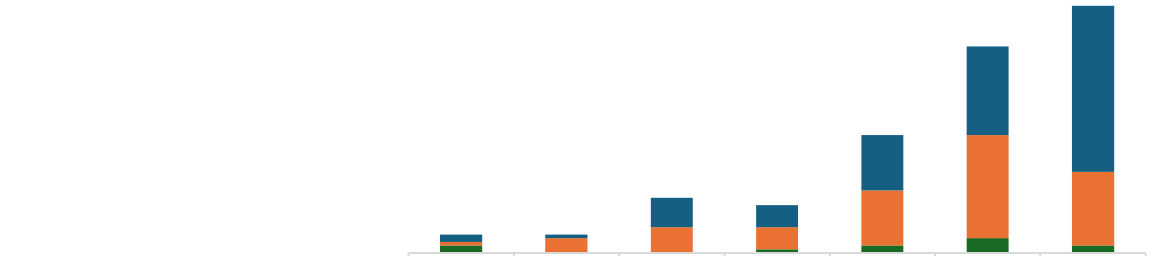
Eighty-five percent of critical incidents from accidental ingestion of drugs or drug overdose involved fentanyl (57 incidents). Fentanyl accounted for 39 of the 45 accidental ingestions by children 11 years of age or younger and 18 of the 20 accidental overdoses by youth between 11 and 22 years of age while using substances.

Figure 12: **Critical Incidents Involving Accidental Ingestion and Overdoses, 2017-2023**



	2017	2018	2019	2020	2021	2022	2023
Near Fatalities	4	1	10	7	20	34	51
Fatalities	1	4	5	6	12	22	16

Figure 13: **Accidental Ingestion and Overdoses, 2017-2023**



	2017	2018	2019	2020	2021	2022	2023
Accidental Ingestion, Ages 0 to 11	2	1	8	6	15	24	45
Accidental Overdose, Ages 11 to 22	1	4	7	6	15	28	20
Intentional Overdose, Ages 12 to 20	2			1	2	4	2

Figure 14: **Age of Children Involved in Accidental Ingestions and Overdoses, 2023**

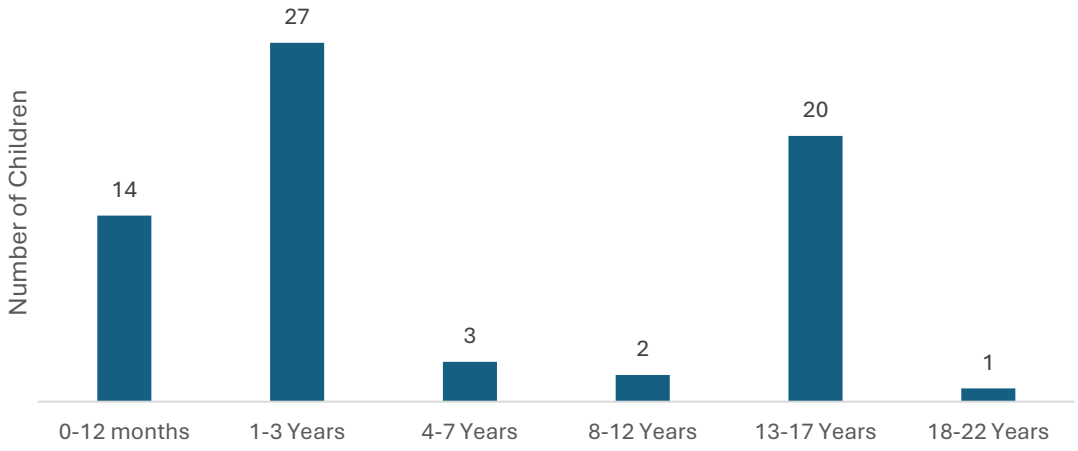


Figure 15: **Race and Ethnicity of Children Involved in Accidental Ingestion and Overdoses, 2023**

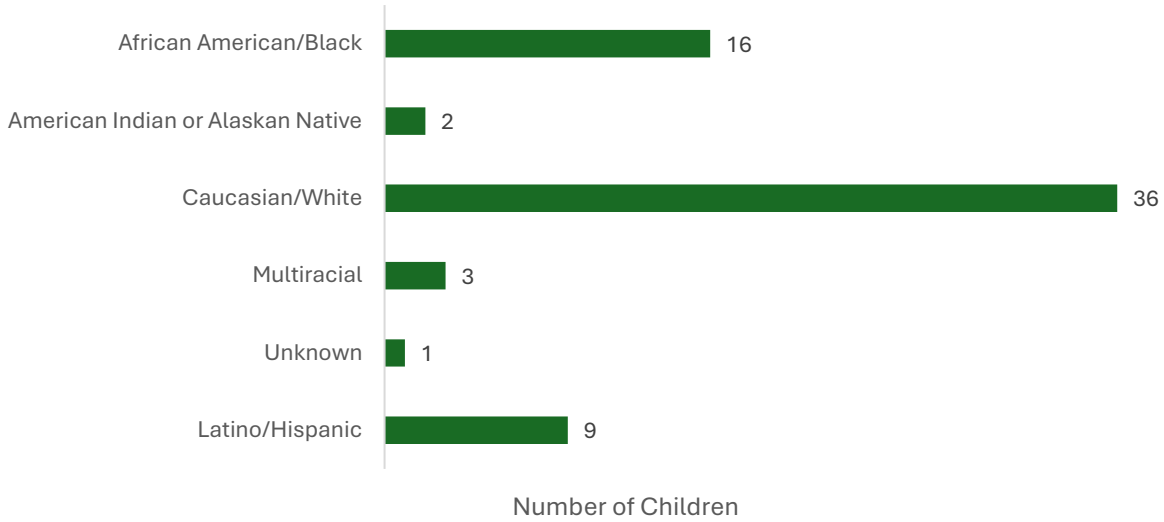
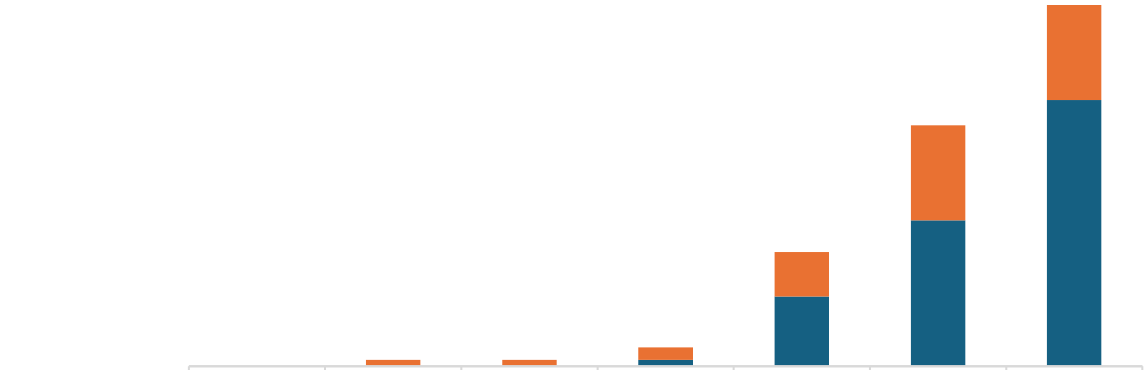
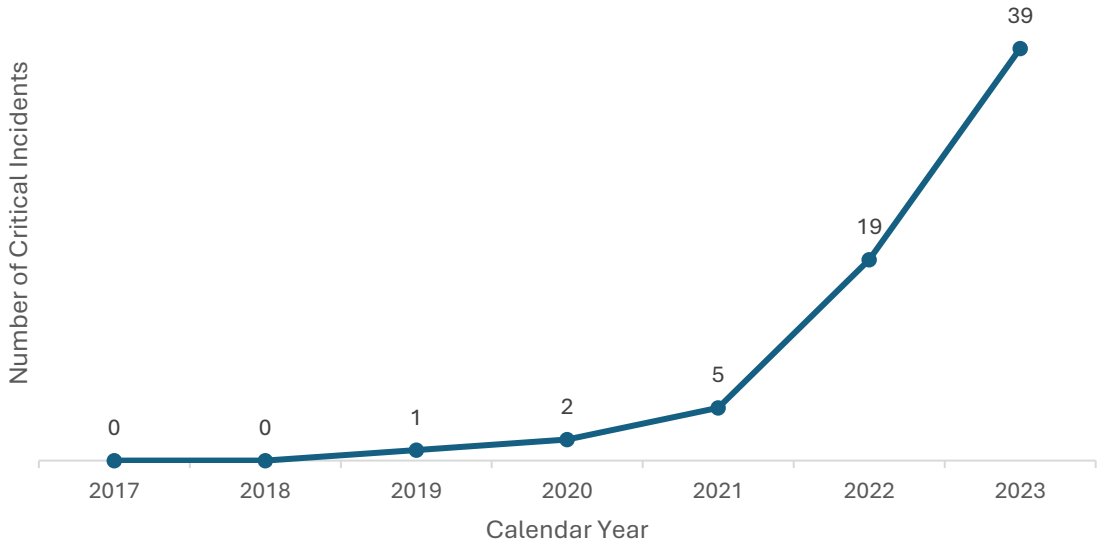


Figure 16: **Critical Incidents Involving Fentanyl All Children and Youth, 2017-2023**



	2017	2018	2019	2020	2021	2022	2023
Fatalities	0	1	1	2	7	15	15
Near Fatalities	0	0	0	1	11	23	42

Figure 17: **Critical Incidents Involving Accidental Ingestion of Fentanyl by Children Ages 0-11, 2017-2023**



NEW LAW AIMS TO ADDRESS FENTANYL CRISIS, PROTECT CHILDREN, AND STRENGTHEN FAMILIES

In 2024, the Washington state legislature passed SB 6109 which clarifies the standard for removing a child from the home due to the presence of imminent physical danger, in response to the fentanyl crisis and the lethal risks it presents to children.[16] Specifically, the law provides that a court must give great weight to the lethality of high-potency synthetic opioids when deciding whether or not to remove a child from the home.

The law also increases an array of services to support families in crisis, to minimize child trauma, and to strengthen families. Services include:

- A pilot program for contracted childcare slots for infants in child protective services in locales with the historically highest rates of child welfare screened-in intakes with parental substance use disorder being a factor in the case.
- Targeted contracts with existing home visiting programs in four locales with the historically highest rates of child welfare screened-in intakes. DCYF will provide training specific to substance use disorders for the home visiting program providers.
- Two pilot programs to implement an evidence-based, comprehensive, intensive, in-home parenting services support model to serve children and families from birth to age 18 who are involved in child welfare, children's mental health, or juvenile justice systems.
- A pilot program to include third-party safety plan participants and public health nurses in child protective services safety planning.
- Specific treatment and services to children and youth with prenatal substance exposure who would benefit from evidence-based services impacting their behavioral and physical health.
- Promotoras[17] in at least two communities to provide culturally sensitive, lay health education for the Latinx community, and act as liaisons between their community, health professionals, and human and social service organizations.

The law also increases training for judicial officers and child welfare professionals regarding child safety and the risk and danger presented to children and youth by high-potency synthetic opioids and other substances impacting families.

[16] ESSB 6109, Chapter 328, Laws of 2024, effective date June 6, 2024. 6109-S2.SL.pdf (wa.gov).

[17] A promotora is a lay Hispanic/Latino community member who receives specialized training to provide basic health education in the community without being a professional health care worker. Elder, John P.; Ayala, Guadalupe X.; Parra-Medina, Deborah; Talavera, Gregory A. (January 2009). "Health Communication in the Latino Community: Issues and Approaches". Annual Review of Public Health.

CHILD RACE AND ETHNICITY

Table 2: **Child Race and Ethnicity of Maltreatment-Related Critical Incidents, 2023**[18]

Race/Ethnicity	Fatality	Near Fatality	Total	% of Incidents	WA Children in Out-of-Home Care[19]	WA State Children[20]
American Indian/ Alaska Native	7	4	11	10.8%	17.0%	2.4%
Asian/ Pacific Islander	6	3	9	8.8%	3.0%	9.9%
Black/African American	10	10	20	19.6%	15.0%	5.1%
Hispanic	6	5	11	10.8%	17.0%	21.9%
White/Caucasian	14	30	44	43.1%	46.0%	72.2%
Unknown	6	1	7	6.9%	--	--

[18] OFCO reports race and ethnicity according to DCYF's WSRDAC/M standard: American Indian/Alaska Native, Multiracial combined with American Indian/Alaska Native and Black/African American, Multiracial combined with Black/African American, and Asian/Pacific Islander, Multiracial combined with Asian/Pacific Islander.
[19] Department of Children, Youth, and Families. Children in Care by Race/Ethnicity, Last Day of SFY 2016-2023. https://www.dcyf.wa.gov/practice/oiaa/agency-performance/cw?page=1.
[20] Office of Financial Management. Estimates of April 1 population by age, sex, race and Hispanic origin. 2020. https://ofm.wa.gov/washingtondata-research/population-demographics/population-estimates/estimates-april-1-population-age-sex-race-and-hispanic-origin. (*WSRDAC/M reporting standard: no).

SECTION II: IMPLEMENTATION STATUS OF FATALITY AND NEAR FATALITY REVIEW RECOMMENDATIONS

IMPLEMENTATION STATUS OF RECOMMENDATIONS

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 12 months.[21] 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[22] who was in the care of or receiving services from the Department at the time of the incident, or in the preceding 12 months.[23] 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.[24]

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.[25] These reviews 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.[26]

DCYF must issue a report on child fatality review results within 180 days following the fatality, unless granted an extension by the Governor.[27] 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).[28]

---

[21] 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 DCYF 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.

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

[23] 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.

[24] 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.

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

[26] RCW 74.13.640(3).

[27] Id.

[28] Individual child fatality reports are available at: https://www.dcyf.wa.gov/practice/oiaa/reports/child-fatality.

DCYF's Standardized Process to Consider Implementation of Fatality and Near Fatality Review Recommendations

In 2020, DCYF initiated a new process for implementing recommendations from fatality and near fatality reviews. The Department established a team to meet quarterly and discuss the recommendations from recently completed fatality and near fatality review reports.

The team includes the DCYF Risk Management Administrator, the Director of Field Operations, the Director of Child Welfare Programs, a Regional Administrator, an Indian Child Welfare Program Manager, a Quality Assurance/Quality Improvement Administrator, and the supervisor of the critical incident review team.

At the quarterly meeting, the team discusses how best to implement the recommendations. This includes deciding if the recommendations will be implemented, modifying the recommendations, and identifying a DCYF staff to lead the implementation, when applicable.

Some decisions require further discussion with, and approval from, the DCYF Secretary. The team meets quarterly with the Secretary to discuss the recommendations and implementation plans.

This process results in a more targeted approach to implementing the recommendations and agreement from all levels of the agency, including the DCYF Secretary.

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.[29] 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 January 1, 2023, and December 31, 2023.

During this period, DCYF conducted 17 fatality reviews and 32 near fatality reviews. At the time of this report, OFCO received executive reports for 45 of the 49 reviews. These 45 reviews produced 96 recommendations.

OFCO reviewed the information provided by DCYF and found that 55 recommendations were implemented or are in the process of being implemented. Twelve recommendations were considered but not implemented, and an additional ten recommendations were not implemented because they reflected current policy or practice. Fourteen recommendations are on hold, as the Department has not yet determined whether or not to implement the recommendation, and five recommendations had not yet been presented before the review committee.

[29] RCW 43.06A.110. OFCO reports are available at: www.ofco.wa.gov.

Table 3: **Child Fatality and Near Fatality Review Recommendations by Implementation Status and Targeted Organizational Level, 2023**

Status	Recommendations	Percent	Statewide (#)	Region (#)	Local Office (#)
Partial, Modified, Full Implementation	55	57.3%	50	3	2
On Hold	14	14.6%	10	4	0
Considered, Not Implemented	12	12.5%	12	0	0
Already Exists in Policy/Practice	10	10.4%	9	0	1
Not Yet Presented Before Review Committee	5	5.2%	5	0	0

Table 4: **Child Fatality and Near Fatality Review Recommendations by Topic, 2023**

Topic	Recommendations	Percent
Training	**29**	**30.2%**
Casework Practice and/or Staff Support	5	
Safety & Risk Assessment	3	
Substance Use and Child Safety	19	
Other Training	2	
Casework Practice	**60**	**62.5%**
Operations & Administration	13	
Policy & Procedure	15	
Safety Assessment & Planning	16	
Staff Support and/or Practice Consultation	10	
Other Casework Practice	6	
Partnerships with Community Professionals	**7**	**7.3%**

Table 5: **Status of Child Fatality and Near Fatality Review Recommendations by Topic, 2023**

Topic	Partial, Modified, Full Implementation	On Hold	Considered, Not Implemented	Already Exists in Policy/Practice	Not Yet Presented
Training	65.5%	24.1%	0.0%	6.9%	3.4%
Casework Practice	55.0%	10.0%	15.0%	13.3%	6.7%
Partnerships with Community Professionals	42.9%	14.3%	42.9%	0.0%	0.0%

APPENDIX: CHILD FATALITY AND NEAR FATALITY REVIEW RECOMMENDATIONS

As discussed above, 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 is not implemented.

Listed below by topic are the recommendations made in child fatality and near fatality reviews conducted from January 1, 2023, through December 31, 2023, and DCYF's implementation status for each recommendation. To preserve their intent and meaning, the following recommendations are quoted directly from the executive reports:

TRAINING *Casework Practice and Staff Support*	
DCYF should develop a system to prioritize essential trainings for line staff and supervisors so that those essential trainings are not overlooked or missed due to heavy workload or duty coverage struggles. Some of the essential training topics the committee noted are: • Completion and application of safety framework tools • Identifying and articulating substance use disorder signs • Domestic violence assessment • Clinical supervision	Status: Already Exists
Region 6 management should consider requiring staff from the Clallam and Jefferson Counties to attend the Advanced Guidelines for Difficult Conversations training offered by the Alliance.	Status: On Hold
The Committee discussed the Foundations of Practice SharePoint site. The Committee discussed many positive aspects, but the Committee recommends that a suggestion drop-box be added so that staff can leave anonymous questions to be answered and shared on the site for others to learn from. They also recommend that the office hours trainings be shared well in advance of their date so that more staff can be aware and take advantage of the trainings in real time.	Status: Modified Implementation, In Progress

TRAINING *Casework Practice and Staff Support*	
DCYF should request the Alliance have a calendar of trainings available to all child welfare staff. The Alliance should schedule trainings with more than one month's advance notice. Currently, one month's notice of upcoming trainings poses a scheduling barrier for many staff and results in the inability to attend trainings.	Status: Modified Implementation, In Progress
The agency should consider development of ongoing training (post-supervisor core training) to train supervisors on how to develop critical thinking skills and apply this learning to the field staff they supervise.	Status: On Hold

TRAINING *Safety and Risk Assessment*	
DCYF should consider an annual training requirement for all agency staff across all programs related to the assessment of physical child abuse and injuries.	Status: Modified Implementation, In Progress
Region 6 management will have a Quality Practice Specialist (QPS) pull a small sampling of CPS cases and review them to see how they adhere to the Child Safety Framework (the process of assessing child safety) utilized by DCYF. This case should be included in that sample. The Committee recommends the QPS staff assess for training needs specific to the Clallam and Jefferson County offices regarding all aspects of the Safety Framework but also regarding utilization of FTDMs, triage staffings, and prefiling or Assistant Attorney General consultations. Triage staffings are internal staffings within a region that consist of multiple disciplines from multiple offices. These staffings are used to discuss difficult situations and they result in recommendations for next steps to be taken by the assigned caseworker and supervisor. Prefiling staffings are also internal staffings to discuss cases for legal sufficiency to file a dependency petition.	Status: On Hold
To supplement ongoing training opportunities for field staff in this region, it is recommended that the QPS team offer workshop training opportunities on various topics related to assessment of safety and risk, case planning, etc.	Status: On Hold

TRAINING *Substance Use and Child Safety*	
The Committee recommended that DCYF consider revising the oral fluid testing training for field staff. The Committee suggested the training be condensed in order to reduce time as a barrier for staff becoming trained. The Committee also suggested utilizing field staff who are currently using oral fluid testing as part of their regular practice to assist in mentoring field offices who are not currently using oral fluid testing.	Status: Full Implementation, In Progress
The Committee recommended a reduction in barriers to fathers getting UAs by training a staff member in the Tumwater office to administer oral swabs.	Status: Full Implementation, Completed
DCYF should require intensive substance use disorder training during regional core training and then mandatory annual substance use disorder training thereafter to provide ongoing updates about the ever-changing landscape of substance use disorder issues. To support annual training, DCYF should consider using roving units.	Status: On Hold
DCYF should provide mandatory training to assist caseworkers in identifying the physiological signs of substance use, common behaviors related to substance use, and common environmental signs of substance use. The Committee noted that there is a law enforcement training provided for non-law enforcement personnel that DCYF may want to investigate.	Status: Modified Implementation, In Progress
The Committee respectfully recommends DCYF include the following in Substance Use Disorder (SUD) training: Caseworkers, including intake caseworkers, should consult an SUD expert or the DCYF SUD Lead when they encounter information in a case such as a report of a child describing a specific smell when their caregiver smokes something.	Status: On Hold
The Critical Incident Review team should create a training specific to fentanyl and what improvement opportunities and positive casework have been gleaned from fatality and near fatality reviews. The team should also change the name from Lessons Learned to a more positive name.	Status: Partial Implementation, In Progress
DCYF should provide mandatory training to all child welfare staff regarding fentanyl.	Status: Modified Implementation, In Progress

TRAINING *Substance Use and Child Safety*	
DCYF should provide a mandatory updated substance use training for all child welfare field staff. This training should be offered annually or every other year. The training should be provided by, or updated by, a subject matter expert (substance use treatment provider and/or law enforcement).	Status: Modified Implementation, In Progress
The Critical Incident Review team should create a training specific to fentanyl and what improvement opportunities and positive casework has been identified in fatality and near fatality reviews.	Status: Modified Implementation, In Progress
Region 4, King County, should consider extending an offer of DCYF training opportunities to the court and legal parties to include the following topics as available: • Child abuse and neglect training offered by a doctor specializing in child abuse • Substance Abuse: Fentanyl Risks • Trauma-Informed Care	Status: Full Implementation, In Progress

TRAINING *Substance Use and Child Safety*	
Development of a campaign that will include education and training opportunities for DCYF staff, contracted providers, and parents and caregivers regarding the risk of accidental ingestion of harmful substances to include Fentanyl/opioids. It is suggested this campaign include the following, but is not limited to these suggestions: • Brochures to provide to families/caregivers related to the risk of accidental ingestion for children. • Literature on the lethality of harmful substances related to child safety. • Yearly SUD training provided to DCYF employees and contracted providers in a multi-pronged effort for educating those individuals assessing child safety and providing education on a yearly basis. o It was suggested that yearly, the SUD program manager develop a training to include information related SUD themes and trends in the state, information related to assessing child safety, and resources for families that would be disseminated statewide to DCYF employees and contracted providers. o Additionally, it was suggested that yearly, local offices/regions designate individual(s) to coordinate with local public health and/or law enforcement to provide training and information to local offices related to trends and themes in their communities related to SUD.	Status: Modified Implementation, In Progress
DCYF has provided initial training to staff regarding HB 1227 implementation and practice changes. At the same time, the fentanyl crisis is increasing and has created unique challenges to assessing and safety planning for child safety, especially with infants and toddlers. To support skill development and efficacy, DCYF needs to create additional and ongoing education opportunities for practical application of HB 1227 changes and the intersection of cases involving fentanyl, including relationship-based assessment of the parent-child relationship when cases involve infants and toddlers (such as the Parent Child Interaction Scales Assessment). This should include short trainings and regular opportunities for consultation, driven by initial Quality Assurance/Continuous Quality Improvement evaluation of HB 1227 implementation.	Status: Partial Implementation, In Progress *There is already a process redesign that will address many of these items.*

TRAINING *Substance Use and Child Safety*	
DCYF has provided initial training to staff regarding HB 1227 implementation and practice changes. At the same time, the fentanyl crisis is increasing and has created unique challenges to assessing and safety planning for child safety, especially with infants and toddlers. To support skill development and efficacy, DCYF needs to create additional and ongoing educational opportunities for practical application of HB 1227 changes to cases involving fentanyl. These opportunities should include information on relationship-based assessments of parent-child relationships when cases involve infants and toddlers. These opportunities should be provided through short trainings as well as regular opportunities for consultation and should be driven by initial quality assurance/continuing quality improvement evaluation of HB 1227 implementation.	Status: Full Implementation, In Progress *DCYF is working with the Department of Health (DOH) to formulate a training and field guidance on safety framework*
DCYF has provided initial training to staff regarding HB 1227 Keeping Families Together Act implementation and practice changes. At the same time, the fentanyl crisis is increasing and has created unique challenges to assessing and safety planning for child safety, especially with infants and toddlers. In order to support skill development and efficacy, DCYF needs to create additional and ongoing educational opportunities for practical application of HB 1227 changes to cases involving fentanyl, including relationship-based assessment of the parent-child relationship when cases involve infants and toddlers. This should include short trainings and regular opportunities for consultation and should be driven by initial Quality Assurance/Continuous Quality Improvement evaluation of HB 1227 implementation.	Status: Full Implementation, In Progress *DCYF is working with DOH to formulate a training and field guidance on safety framework.*
The agency should offer ongoing and targeted training related to the impacts of child safety and Fentanyl use with the aim of increasing field staff awareness and providing consistent, statewide messaging and guidance on assessing child safety.	Status: Full Implementation, In Progress

TRAINING *Substance Use and Child Safety*	
DCYF should create an intranet page regarding substance use disorders. The page should include links to trainings or information about how to obtain trainings regarding substance use; what to look for when doing a walk-through of a home; what to do if you encounter substances or paraphernalia and a reminder to use precautions; the opioid pamphlet (DCYF 0112), photos of paraphernalia and substances; and testing information, among other resources. In essence, this intranet page would be a one-stop-shop to aid staff who are seeking information about substance use and how that interacts with their work as a DCYF employee. Ideally, this site would be available to all DCYF staff, not just child welfare employees.	Status: Full Implementation, In Progress
DCYF should create an intranet page regarding substance use disorders. The page should include links to trainings or information about how to obtain trainings regarding substance use; what to look for when doing a walk-through of a home; what to do if you encounter substances or paraphernalia and a reminder to use precautions; the opioid pamphlet (DCYF 0112); photos of paraphernalia and substances; and testing information, among other resources. In essence, this intranet page would be a one-stop-shop to aid staff who are seeking information about substance use and how that interacts with their work as a DCYF employee. Ideally, this site would be available to all DCYF staff, not just child welfare employees.	Status: Full Implementation, In Progress
DCYF should create an intranet page regarding substance use disorders. The page should include links to trainings or information about how to obtain trainings regarding substance use; what to look for when doing a walk-through of a home; what to do if you encounter substances or paraphernalia and a reminder to use precautions; the opioid pamphlet (DCYF 0112), photos of paraphernalia and substances; and testing information, among other resources. In essence, this intranet page would be a one-stop-shop to aid staff who are seeking information about substance use and how that interacts with their work as a DCYF employee. Ideally, this site would be available to all DCYF staff, not just child welfare employees.	Status: Full Implementation, In Progress

TRAINING *Substance Use and Child Safety*	
DCYF should create an intranet page regarding substance use disorders. The page should include links to trainings or information about how to obtain trainings regarding substance use; what to look for when doing a walk-through of a home; what to do if a caseworker encounters substances or paraphernalia, and a reminder to use precautions; the opioid pamphlet (DCYF 0112); photos of paraphernalia and substances; and testing information, among other resources. There should also be information about how to talk with youth about their own suspected or confirmed substance use and resources specific assisting to youth with substance use issues. The intranet page would be a one-stop-shop to aid staff who are seeking information about substance use and how that interacts with their work as a DCYF employee. This site would be available to all DCYF staff, not just child welfare employees.	Status: Not yet presented before the DCYF Recommendation Review Committee

TRAINING *Other Training*	
DCYF should create a child development e-learning for all case carrying staff and supervisors to take every 2-3 years. This training should be brief, provide basic details for typically developing and neurodivergent characteristics. This is meant as a refresher to what they have already learned in their core training.	Status: Already Exists
DCYF should update domestic violence (DV) training to include suggestions of alternative, discreet ways to provide DV resources to parents other than handing them materials. It can be dangerous to the survivor parent and the caseworker for the survivor parent to return to the perpetrator with DV resource materials. It is common practice in DV agencies to create fake contacts in a phone and add resources there or to help a client create a secret email account and send the resources there.	Status: On Hold

CASEWORK PRACTICE *Operations and Administration*	
DCYF should require joint supervisory meetings on cases carried simultaneously by more than one caseworker.	Status: Modified Implementation, In Progress

CASEWORK PRACTICE *Operations and Administration*	
DCYF should request legislative funding so that all offices have a Child Welfare Early Learning Navigator. The Committee discussed that this position has proven to be beneficial in engaging families with supportive services and resources and that may have been beneficial to the child and family. This can also help support the assigned caseworkers.	Status: Modified Implementation, In Progress
DCYF should weigh cases that require interpretation services at a higher level, similar to Indian Child Welfare cases. These cases require extra time and documentation.	Status: Modified Implementation, In Progress
Region 6 leadership and the Interstate Compact Supervisor should discuss alternative ways to assign Interstate Compact on the Placement of Children (ICPC) courtesy supervision cases.	Status: Full Implementation, In Progress
DCYF should hire a program manager specifically for DV. When hired, this person should evaluate all current policies, material, and trainings available and make appropriate changes to be in-line with current language and practice within this field of knowledge.	Status: Full Implementation, In Progress *The position has been established and DCYF is in the process of hiring.*
Each of the six DCYF regions should have a Substance Use Best Practice group, modeled after the one that currently exists in Region 4.	Status: Modified Implementation, In Progress *This is already being implemented in four regions.*
The Committee recommends that DCYF seek funding to create new positions. Those positions would be similar to social service support specialist (SSSS) and would be trained to conduct some of the Evidence Based Programs (EBP). The purpose of these new positions would be to help alleviate the struggle some offices, specifically rural ones, experience when they do not have contracted providers available to serve the families DCYF works with.	Status: Modified Implementation, In Progress
The Committee recommends that DCYF investigate the possibility of braiding funding with Medicaid and any other funding sources to help increase availability of transportation assistance for DCYF clients.	Status: Full Implementation, In Progress

CASEWORK PRACTICE *Operations and Administration*	
DCYF shall conduct a statewide survey of child welfare field staff to identify agency-specific needs to address child safety. The survey information would be utilized to inform requests for additional funding/supports from the Washington State Legislature.	Status: On Hold
DCYF should create a system to identify, prioritize, and/or recruit visitation providers who are willing to abide by the safety guidelines necessary to keep children safe at visits when their parents are using Fentanyl.	Status: Full Implementation, In Progress
DCYF should have a system to track data (such as the number of intakes where Fentanyl is involved, Fentanyl ingestion intakes, etc.) to inform training campaigns and create a rapid response messaging system that allows quick messaging to the line when new trends emerge.	Status: Considered, Not Implemented
In discussion with the field staff, the Committee learned this field office had been functioning at a reported 50% vacancy rate at the front-end programs (CPS, FAR and FVS) for several years. The Committee recognized this vacancy rate leads to high turnover of caseworkers, caseworkers with little experience, caseworkers with high caseloads and supervisors forced to carry cases. The Committee respectfully recommends DCYF prioritize efforts to recruit and retain caseworkers.	Status: Already Exists

CASEWORK PRACTICE *Operations and Administration*	
The Committee recommended that DCYF consider the following with the intent of creating a more streamlined and uniform system for caseworkers to have access to historical and current case concerns and information through the intake reporting form. It was recommended that DCYF consider the following changes to the intake reporting format: • Checkboxes and/or bullet points that clearly articulate the reported safety threats or risk in each intake, including an opportunity for a narrative. • Information about historical case information with the possibility of linking to prior case information and case outcomes from the intake. • Access to a link to prior interventions and services offered to the family by the agency from the intake report. In the absence of being able to make immediate changes to the current reporting system, the Committee respectfully recommended this be considered for future reporting systems with an interim suggestion that current intakes be recorded to include bullet points of the identified safety threat and/or risk in an easily readable format.	Status: Modified Implementation, In Progress

CASEWORK PRACTICE *Policy and Procedure*	
DCYF should consider a requirement that active efforts are made to connect families with resources when an early learning staffing or other consultation occurs and recommends resources for the family.	Status: Considered, Not Implemented
DCYF should amend its policy to say that the assigned caseworker will make all efforts to provide collateral information as to the purpose and scope of the following types of assessments: • Substance use • Psychological • Mental health • Domestic violence • Parenting	Status: Considered, Not Implemented

CASEWORK PRACTICE *Policy and Procedure*	
DCYF should consider developing a child welfare policy providing guidance for field staff on how to investigate, respond, and provide services if a parent has a suspected or diagnosed disability.	Status: Modified Implementation, In Progress
DCYF should review current trainings and/or policies regarding monthly health and safety visits to identify whether caseworkers receive information regarding what should be expected of private agencies and their case managers. This should include the contractually required quarterly reports as well as a discussion regarding all children in the home.	Status: On Hold
DCYF should require assigned courtesy caseworkers and supervisors to read the home study that corresponds to the family a child is placed with.	Status: Considered, Not Implemented
The Committee recommended that DCYF convene a workgroup to include field staff from all six regions to review DCYF Policy 4122 Case Transfer. The Committee would like the workgroup to consider the following: • How the case transfer policy may be revised to address the needs of families who are transient or unhoused in a timely manner when they move from county to county. • Identify a solution(s) to reduce office to office case transfer delays.	Status: Modified Implementation, In Progress
DCYF should develop guidance on the use of guardianships in non-court involved cases, which may require revising existing policies or developing a new policy.	Status: On Hold
DCYF should consider sending risk only intakes with newborns (non-CFWS) straight to FVS caseloads. All expectations of initial face-to-face visits, safety assessment, etc. would remain the same. The cases should have 30-day shared planning meetings to follow up on the case plan.	Status: On Hold

CASEWORK PRACTICE *Policy and Procedure*	
DCYF should consider a required staffing, similar to a transfer staffing, when a case is assigned for courtesy supervision based on an ICPC request from a sending state. The staffing should include Licensing Division staff who completed the home study, the courtesy caseworker and supervisor, as well as inviting the sending state caseworker and supervisor. ICPC could also be invited to this staffing. The purpose would be to discuss any possible concerns, needs for services or goods to help make the placement successful, and to establish, from the beginning, open communication between all parties.	Status: Full Implementation, In Progress
DCYF should consider requiring ICPC cases with children five-years and younger to have twice monthly health and safety visits for the first three months after placement in Washington State. This recommendation is an acknowledgment that the policy 4420 Health and Safety Visits with Children and Youth and Monthly Visits with Parents and Caregivers, identifies the need for more frequent contact by the caseworkers for this age group for FVS cases and CFWS cases when a child has been returned to a parent. This recommendation should only be complete if DCYF can correct caseload issues for the caseworkers assigned those cases. The Committee acknowledges the current caseloads are often higher than the standard or ideal number and that Committee does not want this requirement to be added unless the underlying caseload issue is ameliorated.	Status: Considered, Not Implemented
The Committee recommends that DCYF add specific language to the Family Practice Model to address that when CPS conducts Family Team Decision Making (FTDM) meetings, and it is likely that a case will move to FVS, that FVS is invited to the FTDM. If an FVS representative cannot be present, or if case transfer wasn't identified prior to the meeting, then the assigned FVS and CPS caseworkers will meet with the family to discuss the transfer of the case.	Status: Full Implementation, In Progress
DCYF should require a shared planning meeting when a child is born substance exposed and experiencing withdrawals. The purpose of the meeting would be to have all involved parties (parents, supports, providers, etc.) together immediately to discuss the needs of the family and engage in supportive services immediately.	Status: Considered, Not Implemented

CASEWORK PRACTICE *Policy and Procedure*	
DCYF should consider changing its policy to allow for case-specific direction around health and safety visit frequency, health and safety visit timeframes, and whether or not health and safety visits are unannounced. The decision making around these health and safety visit factors should take place during clinical supervisory meetings between the caseworker and supervisor.	Status: Already Exists
The Committee respectfully recommends that DCYF develop CPS program specific guidelines for providing monthly clinical supervision to encourage critical thinking.	Status: Not yet presented before the DCYF Recommendation Review Committee
The first recommendation is that DCYF remind child welfare staff, statewide, of the need to notify the licensing division of changes with a placement such as a new person in the home, child injuries/hospitalizations, pregnancy, caregiver changes, etc. Child welfare should consult with the licensing division regarding the wording sent to child welfare staff.	Status: Full Implementation, In Progress

CASEWORK PRACTICE *Safety Assessment and Planning*	
DCYF should consider formalizing a response to educate parents about the risks of Fentanyl. This may include, but is not limited to, the following suggestions: • Create access to Narcan kits for families and/or provide resources for families on how to obtain free kits. • Provide a lock box or lock bag to families accompanied by a caseworker discussion about the risks of Fentanyl/illicit substances.	Status: Full Implementation, Completed
The Family Practice Model will include practice profiles regarding working with families experiencing substance use and one for supervising workers who are handling cases involving substance use. The Committee would like to see guidance for supervisors on when to seek out subject-matter experts and how to provide clinical supervision regarding how substance use may impact child safety.	Status: Full Implementation, In Progress

CASEWORK PRACTICE *Safety Assessment and Planning*	
DCYF currently is working on a fentanyl campaign to educate and assist case workers who interact with families experiencing the use of fentanyl. The Committee recommends that the campaign include the discussion of relapsing, relapse planning, polysubstance use and how that differs from single substance use, even when a person is in recovery what discussions need to occur knowing that relapse is highly likely to occur. The Committee also recommends that there be printed material that can be provided to people that DCYF staff interact with that will educate them about how fentanyl can impact child safety, the benefits and use of naloxone/Narcan, and access to concrete goods through DCYF to safely store substances (prescribed and non-prescribed), and paraphernalia.	Status: Full Implementation, In Progress
DCYF should provide a training or resource to caregivers and supportive adults who live in the same home or provide support/caregiving to children involved with DCYF when there are allegations of substance use or misuse. This education should include information regarding typical behavior patterns displayed when a person is using or misusing substances and should include illegal substances, legal substances (alcohol and cannabis), and prescribed substances. The training or resource should be designed to provide these persons with a better understanding of substance related behaviors or actions that may impact child safety. The creation of the material or training should be done by a subject matter expert in the substance use field.	Status: Full Implementation, In Progress *HCA is creating this training and are working with DCYF SUD coordinator to ensure this training has a DCYF focus.*
The DCYF statewide program managers for Substance Use, CPS, FVS, and CFWS should work together to discuss how to integrate harm reduction strategies such as discussing relapse planning that incorporates child safety during relapse. This should be for families where one or more persons are or may be experiencing substance use as well as for families where a person or persons is in recovery. The Committee suggests that the completed work should be added to the Plan of Safe Care policy requirements.	Status: Full Implementation, In Progress
The Committee requested DCYF review the sleeping/bedroom arrangements of the children if the DCYF case remains open with the family, and this has not been previously addressed.	Status: Full Implementation, In Progress

CASEWORK PRACTICE *Safety Assessment and Planning*	
Consideration for DCYF to include Fentanyl test strips with harm reduction kits for families. If Fentanyl test strips cannot be provided, they suggested that DCYF identify where individuals may be able to access test strips in their local communities. The harm reduction kits should include a lockbox, Narcan, and literature about the risks to children and how to appropriately plan if a parent is using substances and/or has substances in the home. It was suggested that DCYF's SUD program manager consult with the Region 3 (Everett Office) to learn about the harm reduction work their team is doing with families.	Status: Already Exists
Consideration for DCYF to provide harm reduction kits including Narcan, Fentanyl test strips, and literature to visitation centers.	Status: Considered, Not Implemented
The Committee identified the increase in Fentanyl cases as a crisis for families and DCYF. In discussion with the caseworker, the Committee recognized an immediate need for resources, as well as reducing barriers to access to lockboxes, Narcan, and naloxone. The Committee recognized these recommendations were mentioned in prior reviews and encouraged DCYF to implement them. The Committee also encouraged DCYF to follow the proposals from its workgroup addressing Fentanyl cases.	Status: Full Implementation, Completed
DCYF should create and disseminate a document to inform line staff about Fentanyl safety tips specific to visitation/family time. The document should include tips for visits supervised by relatives and suitable others.	Status: Already Exists
The Committee recommends the office discuss with supervisors and caseworkers that when they are assigned to a case, regardless of who was assigned previously or how long the case was open, that full assessments of child safety (of all children, not just the identified victims) and other case aspects such as domestic violence, mental health, substance use, etc. are expected to occur. Prior to assignment to a new caseworker, supervisors will review the case, identify next steps, and if there are any incomplete aspects to the case.	Status: Already Exists

CASEWORK PRACTICE *Safety Assessment and Planning*	
The Committee identified that fentanyl is a uniquely powerful substance that affects people very differently than other substances. Because fentanyl's potency and HB 12275, the Committee recommends that DCYF draft examples of written documents for staff to use, such as dependency petitions or pick up orders, that outline the unique safety threats that fentanyl use poses to child safety which cannot be mitigated by the circumstances unique to a specific family. This information should also be available to staff on an intranet page.	Status: Not yet presented before the DCYF Recommendation Review Committee
The agency should require that all families involved with DCYF receive information about the dangers of Fentanyl and other opioids as well as receive concrete resources, such as a lockbox, Narcan, and literature highlighting the potential impacts to child safety related to parental substance use and misuse.	Status: Already Exists *This is in full effect. All regions have harm reduction kits that contain this information, including additional resources such as lockboxes, lock bags, test strips, naloxone, educational brochures, educational resources, medication, safe storage, flyers, and DOH PPE.*
Service Array – DCYF should explore contracting a provider(s) who can act as paid safety plan participants to assist with supervision, monitoring, and support tasks for families.	Status: Full Implementation, In Progress
DCYF should evaluate car seat alarms and other devices that provide a reminder to check the back seat of a car for children in car seats. The evaluation should include whether these devices should be required by foster parents who have children that require car seats. The evaluation should include assessing if DCYF could pay for those devices as opposed to requiring providers to purchase the devices themselves.	Status: On Hold

CASEWORK PRACTICE *Safety Assessment and Planning*	
DCYF should create and disseminate a field guide to caseworkers regarding opioid use like the one that has been provided on malnutrition. Some topics to highlight may be: • Overdose • Caseworker safety • Talking points like where are you using, where are storing your drugs, when was your last use? • Descriptors of what caseworkers might physically and behaviorally see when someone is using drugs vs when they're sober vs when they're prescribed medications for Opioid Use Disorder, like Suboxone or Subutex	Status: Full Implementation, In Progress

CASEWORK PRACTICE *Staff Support and/or Practice Consultation*	
The Committee respectfully recommended DCYF consider the following to address trauma that field staff experience in their work, increase workplace wellness, and field staff retention. Implementation of increased access to services and supports for field staff are suggested to include, but not limited to the following: • Access to ongoing mental health counseling provided by the agency for staff. • Mental health leave days provided to staff in addition to annual and sick leave. • Protected time following a critical incident so field staff have time to process and/or take leave as needed, without being assigned new work that requires immediate attention. • Development of emergency response teams that can provide coverage to offices experiencing a critical incident when field staff are on protected time and/or leave related to a critical incident.	Status: Partial Implementation, Completed *Mental health counseling aspects have been implemented. The rest are outside of the Department's scope.*
DCYF should create a place on the intranet site for child welfare staff to easily access the headquarters program managers. The program managers' names, emails, titles, and an explanation of what areas are covered in their work should be available all in one area. Field staff of all levels struggle to recall which individuals cover which areas of work and would like to be able to access the information in one area.	Status: Full Implementation, In Progress

CASEWORK PRACTICE *Staff Support and/or Practice Consultation*	
DCYF should create a place on its intranet site for child welfare staff to easily access the headquarters program managers. The program managers' names, emails, titles, and an explanation of what areas are covered in their work should be available all in one area. Field staff of all levels struggle to recall what person covers what area and would like to be able to access the information in one area.	Status: Full Implementation, In Progress
DCYF should increase the availability of substance use disorder resources for frontline caseworkers such as: • Concrete, evidence-based substance use disorder trainings; • Annual, required training on substance use disorder updates; • Regional, substance use disorder committees to staff cases (like R4 model, similar to SAY/PAY committee model); • Dedicated Regional Substance Use Disorder Lead positions to track trends, provide and track trainings, facilitate regional substance use disorder committee, communicate with staff, etc.	Status: Modified Implementation, In Progress *DCYF has increased resources for frontline caseworkers, making all SUD resources available to them. DCYF is also working on a decision package to ask legislation for funding for harm reduction kits. Trainings are available and are being innovated for conferences. The SUD Program Manager has been visiting DCYF offices to perform in-person trainings. Additionally, contracted SUDPs will be stationed within DCYF offices for consultation.*
DCYF should have a substance use disorder professional co-housed in each field office. This person could help support education for staff, go into the field with staff on cases involving substance use, and assist in obtaining substance use related services for clients.	Status: Partial Implementation, In Progress
Each region should have a Substance Use Best Practices Consultation Group. These groups help staff who have substance use questions or challenging cases by providing a group of subject matter experts to discuss and provide answers and/or support to the staff. There is one in the region where this case took place, but the Committee believes this is necessary for all staff statewide to have access to.	Status: Considered, Not Implemented

CASEWORK PRACTICE *Staff Support and/or Practice Consultation*	
Each region should have a Substance Use Best Practices Consultation Group (concept is the same as the DV Best Practice Consultation Groups)	Status: On Hold *All but one of the regions have SUD case staffing meetings once a month.*
Allow the statewide Substance Use Disorder Program Manager access to child welfare to communicate about trainings, regional leads, and best practice committees.	Status: Already Exists
The Committee respectfully recommends that DCYF develop a multi-disciplinary team response for families by providing internal mental health and domestic violence experts regionally. The mental health and domestic violence experts would be able to provide the following, but not limited to: • Provide case consultation to field staff related to their area of expertise. • Provide education to field workers about safety when assessing individuals with mental illness or domestic violence history. This may include but would not be limited to providing suggestions on engagement, identifying patterns of escalating behaviors, identifying danger, and developing a plan for response. • Be available to partner with field staff to meet families in the field, participate with shared planning meetings, and internal consultations. • Connect families with local resources to meet identified needs.	Status: Not yet presented before the DCYF Recommendation Review Committee
This review will be discussed with the Service Array Program Manager. The purpose of the discussion is to share the Committee's concern regarding a lack of contracted providers to support the work of the child welfare staff.	Status: Full Implementation, In Progress

CASEWORK PRACTICE *Other Casework Practice*	
The local office is recommended to explore if an interview can occur with the subject child by an interviewer specializing in use of interviewing techniques for non-verbal children. Also, it is recommended that the family be provided with a local resource for victim advocacy.	Status: Already exists

CASEWORK PRACTICE *Other Casework Practice*	
It is recommended that DCYF consider development of resources either through community-based partnerships, hiring DCYF contracted providers, or hiring internal staff who have specialized training to interview non-verbal children with Autism Spectrum Disorder and/or other developmental disabilities.	Status: Full Implementation, In Progress
The Committee recommended DCYF consider incentivizing parents' compliance and progress as a way to engage families and positively reinforce behavioral change. The Committee stated that there would need to be a clear boundary between concrete goods, which are items a family needs, versus an incentive. An incentive would not be tied to a basic need and would be an item a family may want. The Committee suggested field offices make incentive items readily available for the purpose of rewarding a family when a service (court ordered or voluntary) is completed, or the family is meeting other milestone markers in their case plan.	Status: Considered, Not Implemented
Clallam County will soon begin Early Childhood Courts within their Superior Court system. Included in this recommendation are differing aspects the Committee identified as supports necessary to have a successful Early Childhood Court as well as enhance and support best practice child welfare standards. a) The Intake and Early Learning Program Manager will meet with the Area Administrator to discuss the Plan of Safe Care, and make a connection between the Area Administrator and DCYF Strengthening Families Locally (SFL) team to discuss the SFL work in this area. These prevention efforts will help to integrate the work conducted by child welfare staff and hopefully also aid in building quality, professional relationships with community providers. b) The Intake and Early Learning Program Manager will also discuss Infant and Early Childhood Mental Health and the Parent Child Interaction (PCI) training available to staff. The Committee believes that having one or more PCI trained staff members will help enhance child safety assessments for DCYF staff. c) The Intake and Early Learning Program Manager will also assess, through conversations with the Area Administrator and/or staff, if outreach to mandatory reporters in the county is necessary.	Status: Full Implementation, In Progress

CASEWORK PRACTICE *Other Casework Practice*	
The Committee respectfully recommends the agency prioritize information sharing about the availability of Parent-Child Interaction (PCI) as well as create additional opportunities for agency staff to become certified PCI assessors, so all areas of the state have access to parent-child interaction assessment tools.	Status: Not yet presented before the DCYF Recommendation Review Committee
The second recommendation is that The Alliance message out through Caregiver Connection a reminder to all caregivers about the need to report to intake and notify licensors of injuries to children.	Status: Full Implementation, In Progress

PARTNERSHIPS WITH COMMUNITY PROFESSIONALS	
Data – DCYF should consider the following data-tracking and information-sharing opportunities to inform agency prevention priorities: • DCYF should explore a memorandum of understanding with DOH regarding child near fatalities and fatalities to share and receive data from DOH. • DCYF should consider tracking all cases where a child fatality or near fatality occurred and parental substance use was a factor. This would include, but not be limited to, cases when notification of the near fatality was DCYF's initial contact, open cases, or cases where DCYF had prior involvement with the family.	Status: Considered, Not Implemented

PARTNERSHIPS WITH COMMUNITY PROFESSIONALS	

Court Partnership – DCYF should consider the following information-sharing and training opportunities with court partners to increase educational awareness regarding child fatality and near fatality impacts in Washington state.
• DCYF should explore a memorandum of understanding with the Washington Administrative Office of the Courts (AOC) for information sharing purposes. Information sharing is suggested to include the following, but is not limited to the following:
  ○ Child fatality and near fatality cases
  ○ Cases where a child fatality/near fatality occurred following the denial of a request from the court, such as for protective custody or out-of-home placement.
• DCYF should consider offering curriculum to be included in the Safety Summit Project offered through AOC, to include information related to fatality and near fatality cases. This may include, but is not limited to, case studies, trends in critical incident reviews, and critical incident review data.
	Status:
	Full Implementation,
	In Progress

DCYF to consider developing a model where a CPS caseworker and parent ally are jointly working together to support families involved with CPS to reduce barriers to parent participation and engagement. This recommendation may consider the following, but is not limited to these suggestions: • Consideration to hire/contract with parent allies who would be assigned to each field office to assist CPS caseworkers navigating contacts with families. • Partnering with community-based organizations who provide parent ally programs to create opportunities for enhanced partnership to support DCYF's CPS programs.	Status: Considered, Not Implemented
DCYF should consider partnership with a community-based agency (or agencies) to respond to screen out intakes by connecting families with appropriate community-based resources to help prevent further involvement with the child welfare system.	Status: Full Implementation, In Progress

PARTNERSHIPS WITH COMMUNITY PROFESSIONALS	
The Area Administrator for Clallam and Jefferson counties will discuss the community relationships and the challenges currently faced by the staff in those offices with regional management. They will create a plan to build cooperative relationships with the community providers and discuss the challenges currently faced by the local child welfare staff. This would include the community partners involved in this specific case.	Status: On Hold
Based on the discussion with the field staff about the challenges in collaborating with local methadone provider(s) the Committee recommends that local office leadership connect with local methadone provider(s) to build a relationship and create an opportunity for information sharing about each agency's respective roles and services.	Status: Full Implementation, In Progress
DCYF should meet with the First Clinic to discuss the challenges experienced by some DCYF staff when interacting with the clinic during CPS and FAR cases and how the two agencies can work together to accomplish their required work. The First Clinic provides a much-needed service to families in Washington State. The Committee heard from staff, and some Committee members have heard from previous critical incident reviews, about struggles faced by DCYF staff when trying to work with families who are working with the First Clinic.	Status: Considered, Not Implemented