Office of the Family & Children's Ombudsman
An Independent Voice for Families and Children

IMPLEMENTATION STATUS OF CHILD FATALITY RECOMMENDATIONS AUGUST 2011

Office of the Family and Children's Ombudsman
Mary Meinig, Director Ombudsman
Colleen Hinton, Ombudsman
Rachel Pigott, Ombudsman
Patrick Dowd, Ombudsman

CONTENTS

STATE LAW GOVERNING CHILD FATALITY REVIEWS

The Department of Social and Health Services (DSHS) Children's Administration (CA) is required to conduct a child fatality review on any unexpected deaths of children who are in the care of or receiving services from CA, or have received care or services within the prior year.[1] The CA Assistant Secretary convenes an Executive Child Fatality Review (ECFR) when the fatality is the result of apparent child abuse or neglect by a parent or caregiver, and CA had an open case at the time of the child's death. ECFR teams are comprised of individuals who have no prior involvement in the case.

The purpose of reviewing child fatalities is to increase the agency's understanding of the circumstances around the child's death and to evaluate practice, programs and systems to improve the health and safety of children.[2] DSHS must issue a report on child fatality review results within 180 days following the fatality, unless an extension is granted by the Governor.[3]

In order to promote accountability and the consistent implementation of these recommendations, OFCO is required to issue an annual report to the Legislature on the implementation status of recommendations resulting from these fatality reviews.[4]

During the 2011 legislative session, SHB 1105[5] was enacted which refines the scope of fatalities subject to child fatality reviews, provides greater access to relevant information and for the public dissemination of child fatality reports.

- *Scope of CA Child Fatality Reviews*
  CA is required to review child fatalities when the child's death was suspected to be caused by child abuse or neglect. Child fatality reviews will not be required when the child's death was unexpected, but clearly accidental and unrelated to abuse or neglect. The department must consult with the Ombudsman to determine if a review should be conducted if it is not clear whether a child's death was the result of child abuse or neglect. In the event of a near fatality of a child, the department must promptly notify the ombudsman and may conduct a review at its discretion or at the request of the ombudsman.

- *Autopsy Reports and Supervising Agency Records*
  The Secretary of DSHS is authorized to access an autopsy report for purposes of conducting a child fatality review. Additionally, the department and the fatality review team have access to all records and files from a supervising agency that provided services to the child while under contract with the DSHS.

- *Public Information and Transparency*
  A child fatality review report is subject to public disclosure and must be posted on the department's public website. The department is authorized to redact confidential information contained in a child fatality review report to protect the privacy of victims of child abuse and neglect.

[1] See RCW 74.13.640.
[2] See DSHS CA Operations Manual chapter 5200 at http://www.dshs.wa.gov/ca/pubs/mnl_ops/chapter5.asp#5200
[3] Id.
[4] RCW 43.06A.100.
[5] Chapter 61 Laws of 2011, amending RCW 74.13.640 and RCW 68.50.105, effective date July 22, 2011.

INTRODUCTION

Between January 1, 2009 and April 30, 2010, the deaths of ninety children required a child fatality review by Children's Administration (CA).[6] The majority (sixty-six percent) of these fatalities was of children under the age of two and unsafe sleep environment either caused or was a risk factor in thirty-eight percent (18 of 47) of infant deaths.

Fatality reviews often result in recommendations to improve the child welfare system. During this reporting period, fifty-two of the ninety CA child fatality reviews and ECFRs resulted in 111 recommendations.[7] No recommendations were made in thirty-eight of the fatality reviews. The following report provides a summary and analysis of the 111 recommendations resulting from the child fatality reviews and how they have been implemented.

Part I of this report categorizes child fatality recommendations by common themes. The largest number of recommendations identified a need for increased training for case workers, supervisors and community providers, followed by recommendations concerning effective family interventions and by recommendations addressing Child Protective Services (CPS) intake procedures.

Part II summarizes the types of recommendations made in the child fatality reviews and the level of implementation. This section also examines why some recommendations have only been partially implemented or not implemented at all. Eighty percent of the recommendations are listed as "Completely Implemented." However, many of these recommendations were considered addressed through existing policies. In these situations, OFCO recommends that both CA and the child fatality review teams examine the underlying issues such as: whether or not policies were followed; if there are inherent problems with the policies; or if the identified issue represents a more widespread failure to follow policies.

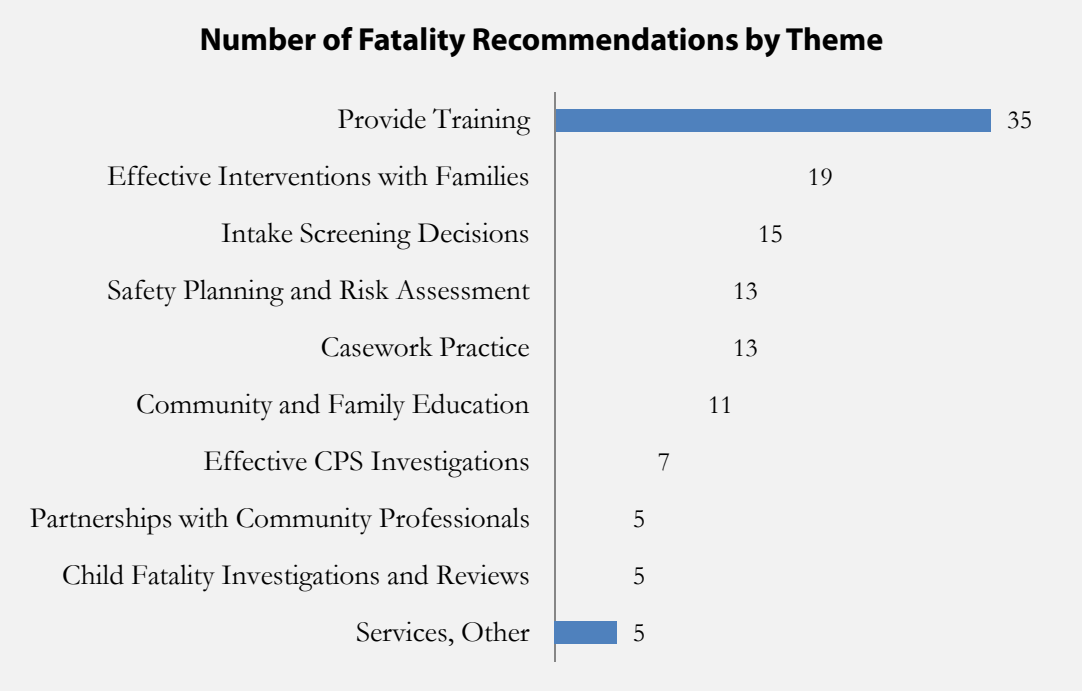
Part III highlights select recommendations that stood out as effectively targeting common issues in child fatalities such as safe sleep environment for infants and domestic violence, as well as CA practice issues including CPS intake screening decisions and safety plans.

As discussed in the conclusion, OFCO suggests that the department consider establishing a centralized process for conducting child fatality reviews and implementing recommendations. This would provide consistency in the review process and identify recommendations suitable for statewide implementation. OFCO also notes that a number of recommendations concerned CPS intake practices and recommends that the department convene a work group to examine steps to improve CPS intake decisions.

[6] Of these ninety child fatality reviews, six were conducted by Executive Child Fatality Review Teams.
[7] Complete reports on the reviews of all child fatalities during this period can be found at http://www.dshs.wa.gov/ca/pubs/fatalityreports.asp

PART I: COMMON THEMES OF CHILD FATALITY RECOMMENDATIONS

OFCO analyzed the 111 child fatality review recommendations to identify common themes and the number of times similar recommendations were made. The total number of recommendations when broken out by theme was 128 as some recommendations addressed more than one issue. The following chart presents the number of recommendations made within ten major themes.



As might be expected when reviewing an agency's actions after-the-fact, the largest number of recommendations (thirty-five) identified a need for increased or specific training for caseworkers, supervisors, or community providers. The next highest number of recommendations pointed to a need for more effective interventions with families (nineteen). Recommendations to sharpen and refine intake screening decisions, safety planning and risk assessment, and other casework practice, made up the next largest number of recommendations, with thirteen to fifteen recommendations made in each of those categories. Recommendations to educate families and communities about specific topics numbered eleven; and the remaining themes of strengthening CPS investigative practice, partnerships with community professionals, child fatality investigations and review, and expanding or improving services to families and licensed caregivers had five to seven recommendations. The following tables identify the issues addressed by specific recommendations within the ten major themes.

RECOMMENDATION THEME 1: PROVIDE TRAINING

Training Topic	Training Participants	Number of Recommendations
Safe sleep, Sudden Infant Death Syndrome (SIDS), Care for infants with special needs	Licensed/Unlicensed caregivers DCFS staff Child care providers	4 2 1
Safety/Risk Assessment and Safety Planning	DCFS staff	4
Domestic Violence	DCFS and CPS staff Early Family Support Services (EFSS) providers	2 1
Indian Child Welfare issues	DCFS staff	3
Obtaining quality photographic evidence	CPS investigators	3
Youth suicide prevention	DCFS staff	3
CPS investigative strategies	CPS staff	2
Partnership with Community Professionals	CPS staff, law enforcement, medical providers	2
Lessons Learned from fatality reviews	DCFS staff	1
Lessons Learned from review of intake screening decisions	DCFS staff	1
Thorough documentation of case activity	DCFS staff	1
Filing dependency petitions	CPS staff	1
Optimal use of assessments	DCFS staff	1
Use of criminal background checks	DCFS staff	1
Emergency protocols	Licensed caregivers	1
Responding to child fatalities in a daycare	DEL licensors	1
TOTAL		**35**

RECOMMENDATION THEME 2: EFFECTIVE INTERVENTIONS WITH FAMILIES

Intervention Type	Number of Recommendations
Ensuring referrals and access to needed services	6
Engaging families in needed services	3
Use of evidence based practice and services	3
Use of shared planning	2
Reduce chronic maltreatment	2
Other "good practice" recommendation	3
TOTAL	**19**

RECOMMENDATION THEME 3: INTAKE SCREENING DECISIONS

Area for Improvement	Number of Recommendations
Obtain thorough information at intake	7
Conduct review of screening decisions, develop consensus	7
Intake procedures regarding reports of fatalities	1
TOTAL	**15**

RECOMMENDATION THEME 4: SAFETY PLANNING AND RISK ASSESSMENT

Planning/Assessment Area	Number of Recommendations
Safe sleep for infants and provision of cribs	3
Background checks	3
Assess all children in home	2
Report illegal activity to law enforcement	2
Walk-through of home	1
Share family history with providers	1
Consult with domestic violence experts	1
TOTAL	**13**

RECOMMENDATION THEME 5: CASEWORK PRACTICE

Area for Improvement	Number of Recommendations
Utilize shared decision making	6
Improve case transfer process	4
Improve documentation	1
Ensure comprehensive monthly supervisory reviews	1
Provide clinical supervision to case-carrying supervisors	1
TOTAL	**13**

RECOMMENDATION THEME 6: COMMUNITY AND FAMILY EDUCATION

Education Topic	Target Audience	Number of Recommendations
Safe sleep/Infant care/SIDS education	Parents, caregivers, families	7
Grief and loss, information and referrals	Parents, families, tribal families	3
Youth suicide prevention	Schools, social service agencies	1
TOTAL		**11**

RECOMMENDATION THEME 7: EFFECTIVE CPS INVESTIGATIONS

Area for Improvement	Number of Recommendations
Complete investigations within timelines per policy	2
Seek medical consultation for unexplained and/or patterns of injuries	2
Obtain photographic evidence	1
Make collateral contacts to verify information reported by family	1
Clarify and standardize CPS findings regarding prenatal drug use	1
TOTAL	**7**

RECOMMENDATION THEME 8: PARTNERSHIPS WITH COMMUNITY PROFESSIONALS

Area Needing Strengthening	Participating Partners	Number of Recommendations
Coordinate joint investigations	CPS, Tribal law enforcement	1
Coordinate and collaborate in DV cases	CPS, Law enforcement	1
Coordinate and collaborate regarding health concerns in a licensed child care facility	DEL, Department of Public Health	1
Finalize Memorandum of Understanding with Tribe	CA, Tribe	1
Amend law/policy so youth can be kept in detention an extra day when caregiver cannot be located	JRA	1
TOTAL		**5**

RECOMMENDATION THEME 9: CHILD FATALITY INVESTIGATIONS AND REVIEWS

Area for Improvement	Number of Recommendations
Improve fatality review process (coordination with DEL)	2
Increase CA access to autopsy reports	1
Create specialized regional fatality investigation teams	1
Conduct additional review of specific fatality to assess for new allegations	1
TOTAL	**5**

RECOMMENDATION THEME 10: SERVICES, OTHER

Target Service	Target population	Number of Recommendations
Increase respite care payments, provide coordinated support from DCFS and DLR	Licensed caregivers	2
Increase mental health services	Child witnesses of domestic violence	1
Provide free cribs	Families with infants	1
Require reporting of health concerns in child care facilities	Licensed child care providers	1
TOTAL		**5**
GRAND TOTAL		**128**[8]

[8] The total number of recommendations when broken out by theme was 128 as some recommendations addressed more than one issue.

RECOMMENDATIONS IN NATIVE AMERICAN AND AFRICAN AMERICAN FATALITIES

As discussed in previous reports on child fatalities in Washington State, the number of deaths of Native American children is disproportionally high.[9] In 2009, for example, sixteen percent of the fatalities reviewed by OFCO were of Native American children, while Native American children made up only two percent of the Washington State population. Numbers for African American child fatalities are also disproportionally high. In 2009, seventeen percent of the fatalities reviewed by OFCO were of African American children, while African American children made up five percent of the overall state population. This pattern of racial disproportionality is found not only in child fatalities, but across the United States in all social welfare systems. The disproportionality in child fatalities may be reflective of the overrepresentation of children of color in the child welfare system, compared to their numbers in the general population.

Given the high disproportionality of Native American and African American children's deaths, OFCO reviewed the fatality recommendations made regarding deaths of these children during the reporting period, to determine whether there appear to be any trends in these specific recommendations.

Native American Children

During the period covered in this report, the deaths of seventeen Native American children were reviewed. Twelve of these reviews issued at least one recommendation. From these twelve reviews, thirty-three recommendations were issued, accounting for approximately thirty percent of the total fatality recommendations. OFCO found no apparent trend or pattern to these recommendations compared with the total recommendations reviewed for this report. Five of the fatalities, however, resulted in seven recommendations that specifically addressed Indian Child Welfare issues:

Theme	Recommendation
Training for DCFS regarding LICWACs	*The [DCFS] Area Administrator and Tribal Liaison will provide education and training to the Supervisor and social workers involved with this case.* OFCO note: this training was in relation to the appropriate use of LICWAC[10] staffing and jurisdictions of decision-making by LICWACs versus by Tribes.
Training for tribal law enforcement on CPS policy and procedures	*A designee from DCFS Toppenish office will provide a thorough CPS presentation to Yakama Nation Police (Patrol) to be followed by a question and answer session. To be completed by October 31, 2010.*
Training/corrective action for DCFS staff regarding notifications to Tribes	*ISSUE: The review team was not able to locate evidence of the proper notification to the Muckleshoot Tribe when the state filed dependency on [child]. [child's] alleged father was enrolled Muckleshoot. The team also was not able to locate documentation in the file that the Muckleshoot Tribe had been invited to FTDM's or other case staffings.*

[9] For example, see OFCO's 2010 Annual Report, page 69, at http://www.governor.wa.gov/ofco/reports/2010/ofco_2010_annual.pdf and OFCO's 2009 Annual Report, page 103, at http://www.governor.wa.gov/ofco/reports/ofco_09_annual.pdf

[10] "A LICWAC [Local Indian Child Welfare Advisory Committee] is a body of volunteers, approved and appointed by Children's Administration, who staff and consult with the department on cases of Indian children who: Are members of a Tribe, Band, or First Nations but for whom the Tribe, Band, or First Nations has not responded, or has chosen not to be involved, or is otherwise unavailable; or For whom the child's Tribe, Band, or First Nations has officially designated the LICWAC to staff the case; or Are defined as Recognized Indian Child." CA Indian Child Welfare Manual, Section 10.01(B)

	RECOMMENDATION: The team recommends that all staff working with ICW cases be reminded of this obligation.
Training for DCFS ICW staff on ICW conflict resolution	*The team has heard concerns that training on the issues of ICW conflict resolution protocol may not be clear in Academy[11] training, post-Academy ICW training, supervisors' trainings, and possibly other ICW trainings. The team recommends that Training Academy P&PI review the curriculum to ensure that conflict resolution issues are clear.*
Family and community education regarding dealing with grief and loss	*[The Regional CPS] Program Manager will follow up with the King County Medical Examiner's Office, and obtain a packet of [grief and loss] resource information that can be shared with clients and with Muckleshoot Indian Child Welfare.*
Strengthening State-Tribal partnerships	*Region 4 will offer a meeting with [the] Muckleshoot [Tribe] to discuss the State-Tribal partnership in addressing families with repeated referrals for maltreatment.*
Strengthening State-Tribal partnerships	*Region 4 and the Muckleshoot Tribe should consider finalizing a memorandum of understanding.* OFCO note: this recommendation appears to be targeted at clarifying each entity's roles and responsibilities in child welfare cases.

Four of these recommendations were reported as being completely implemented. Two recommendations, to provide training on ICW conflict resolution and to finalize a State-Tribal Memorandum of Understanding, were reported as being partially implemented. The recommendation to strengthen State-Tribal partnership to address chronic maltreatment of children, was reported as being "beyond the scope of the Child Fatality Review to make recommendation regarding state-tribal matters", i.e. as having no implementation effort.

African American Children

During the period covered in this report, the deaths of thirteen African American children were reviewed. Nine of these reviews issued at least one recommendation. From these nine reviews, twelve recommendations were issued, accounting for approximately eleven percent of the total fatality recommendations. OFCO found no apparent trend or pattern to these recommendations compared with the total recommendations reviewed for this report. A possible exception was that four (thirty-three percent) of the recommendations addressed a need for community and family education in the areas of safe sleeping environments for infants (two recommendations) and resources to assist families in dealing with grief and loss (two recommendations).

[11] Children's Administration's Training Academy for staff.

PART II: IMPLEMENTATION STATUS OF FATALITY RECOMMENDATIONS

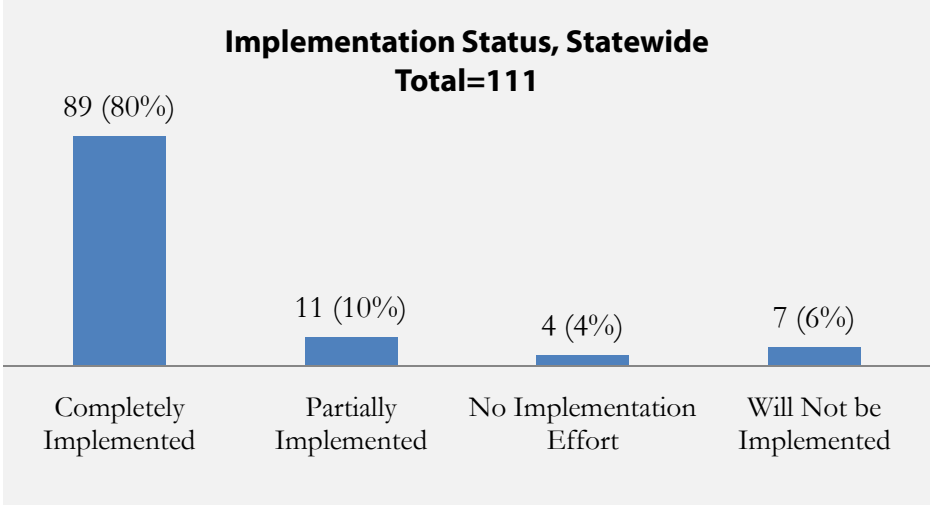
In order to assess the implementation status of child fatality review recommendations, OFCO reviewed all child fatality and ECFR reports and compiled recommendations for this reporting period. OFCO then sent an online survey to CA Headquarters[12] and to each region, requesting an update on the status of these child fatality review recommendations. The survey listed each recommendation and asked CA to categorize the implementation status as one of the following: completely implemented; partially implemented; no implementation effort; or will not be implemented. In addition, the survey asked for a brief description of the status of the implementation effort. CA Headquarters collected the responses from each region and added information about the implementation of ECFR recommendations.[13] OFCO reviewed the survey results and reconciled how CA categorized the status of each recommendation with the specific description of implementation efforts.

Five recommendations pertained to the Department of Early Learning (DEL) a separate agency responsible for licensing child care facilities. OFCO contacted DEL and obtained information regarding status of these recommendations.

This section discusses: the types of recommendations and whether the recommendation addresses local, regional or statewide issues; the implementation status of these recommendations; and why certain recommendations have only been partially implemented or not implemented at all.

Implementation Status

Based on CA's survey response to OFCO, the majority (eighty percent) of child fatality review recommendations have been completely implemented. Ten percent of the recommendations are reported to have been partially implemented, four percent had no implementation effort, and six percent will not be implemented.



Source: Office of the Family and Children's Ombudsman, March 2011 based on analysis of DSHS CA responses

[12] This survey was sent on October 14, 2010, and survey responses were received on February 3, 2011.
[13] OFCO acknowledges the time and effort spent by each CA region, Headquarters and by DEL and appreciates the detailed responses provided.

What Does "Completely Implemented" Mean?

Whether a recommendation has been fully or partially implemented can be a subjective analysis and open to debate. OFCO's report reflects CA's designation of a recommendation's implementation status and not a determination made by OFCO. In some instances, OFCO questions CA's decision that a recommendation has been "Completely Implemented." For example, the following recommendation called for specific training on investigations regarding unexplained injuries to non-verbal children, and the use of medical evaluations, including full skeletal surveys. CA's response referred to a 2008 training and available training through the regional medical consultant. The response however does not indicate if training on these specific topics actually occurred.

Note: CFR recommendations presented in italics throughout this report are taken verbatim from Child Fatality Review reports, and CA response regarding implementation is taken verbatim from CA responses sent to OFCO.

Medical Evaluations of Children:

A two month old infant died of natural causes. The family had an open DCFS case at the time of death. DCFS found that the parents had neglected the infant prior to the death based on injuries found post-death that were determined to have been inflicted, but did not cause the death.

Recommendation: *Social workers should be trained to strongly recommend a full medical evaluation, including exploring with the medical provider the possibility of a full skeletal survey, when there has been a series of unexplained injuries to a child, particularly a non-verbal child. A combination of other risk factors such as those that existed in this case, of course raises the risk significantly. The team recommends that this issue be raised in the next "Lessons Learned" or other such training in the region.*

CA Response: *The Children's Administration implemented a 2008 Policy on Response to Serious Physical Abuse and Sexual Abuse. Staff were trained in April 2008. Ongoing training is offered by Region 3 Medical Consultant Dr. Frances Chalmers on indicators of serious physical abuse injuries and appropriate evaluation and treatment.* ***Completely Implemented***

When Existing Policy is Not Followed

Moreover, OFCO found that a large number of recommendations reported by CA to have been "completely implemented" – over one third – were based on CA's determination that the recommended action represented an existing policy, procedure or practice. OFCO's survey listed just four choices for categorizing a recommendation's implementation status – "completely implemented", "partially implemented", "no implementation effort", and "will not be implemented." The more appropriate category choice for this set of recommendations might have been "will not be implemented" since CA is indicating that no action is necessary in these instances.

In many instances, OFCO found that CA's response simply stated that the recommendation was addressed through existing policy, without a deeper analysis of why the policy in question was not followed or describing corrective action to assure future compliance. For example:

Case Transfers Between Offices and Regions:

An eight year old child died from drowning. The fatality review team noted concerns about the case transfer process that occurred early in the case history.

Recommendation: *CA should consider looking at current policies and practice expectations regarding case transfers between offices and between regions, especially involving voluntary placement and voluntary services cases. It is suggested that expectations for staffing transferring cases specifically consider including the requirement that supervisors and assigned workers from both sending and receiving offices to be part of the staffing.*

CA Response: *CA has a policy regarding transfer of case records between regions. Operations Manual 13841. Case Transfers Between Regions.* ***Completely Implemented***

In other cases, CA's response not only indicated that the recommendation represented existing policy, but also discussed other actions taken in response to the recommendation. For example, Region 1 consistently reported that issues and recommendations that arise out of child fatality reviews are discussed at a regularly scheduled meeting for all Area Administrators, Intake and CPS supervisors in the region. The following is an excellent example of multiple regions implementing a fatality review recommendation in an effective manner.

Shared Decision Making Meetings:

The review of a SIDS death of a nine month old infant in a foster home found that shared decision making staffings had not occurred prior to the placement of two siblings.

Recommendation: *Shared decision making staffings (CPT, FTDM, Administrative staffing) should be utilized regarding the possible placement of children in out of home care.*

CA Response: *Current policy exists regarding utilization of shared decision making processes. Region 2 was invited to participate in the review in order to share conclusions/recommendations with individuals who had been involved with the case in Region 2. Practice Consultant, Marilee Roberts, provided training to the Ellensburg office on 2/17/10 regarding use of CPT, FTDM and thorough supervisory reviews. This recommendation was also reviewed with Region 1's Consensus Building group. Participants are AAs, Intake and CPS Supervisors.*
Completely Implemented

In a third example, CA's response explains why existing policy and practice was sufficient and implementation of the CFR recommendation was unnecessary:

CPS Intake and Screening Decisions:

A two month old infant died from blunt force trauma inflicted by the mother's boyfriend. A referral from a mandated reporter did not screen in for investigation one month prior to the infant's death.

Recommendation: *Re-contacting referents making reports of child abuse/neglect, particularly mandated reporters, to assist in screening decisions is recommended. Asking if they have additional information regarding safety or risk factors and what expectations regarding CA intervention they have may can be used in making screening decisions. Record additional information, if any, under the Additional Risk Factors tab on the intake report.*

CA Response: *Policy (CA Practice and Procedures Guide 2220) requires both intake workers to conduct a comprehensive interview of the referrer making an allegation of child abuse or neglect. The intake unit must assess risk to children and make screening decisions based on the information provided by the referrer. Policy also requires the intake units complete emergent intakes within 1 hour and non-emergent intakes within 4 hours. Re-contacting the referrer within minutes or hours after the initial call is not necessary.* ***Completely Implemented***

When CFR Recommendations Replicate Existing Policy or Practice: Deeper Analysis Will Direct Future Practice

The following Executive Child Fatality Review illustrates the need for deeper analysis when a recommendation represents an existing policy or practice. This review resulted in eight specific recommendations. CA reported six of the eight recommendations were completely implemented, as the recommended policies or practices were already in place. The department's response however does not address why policies were not followed; nor does it identify corrective action.

Case Background

An executive fatality review of the death of a three month old infant found that prior CPS investigations of the family had been inadequate and communication between community providers and CPS was inconsistent and lacked coordination. The review also found that the family's child abuse and neglect history and history of prior termination of parental rights had not been sufficiently taken into account in screening of CPS referrals and conducting risk assessments of the family.

The infant had been brought to the emergency room with no pulse and was not breathing. A relative reported that the parent had tried to suffocate the child. An ophthalmologist diagnosed the infant with retinal hemorrhages consistent with Abusive Head Trauma. However, the medical examiner's autopsy determined the cause of death was brain damage of unknown etiology.

The infant's mother had given birth to her first child at age thirteen. The subject child was her fifth child. Parental rights had been terminated to the two oldest children. The three youngest children were in the mother and boyfriend's care at the time of the subject child's death. Family problems included parental drug use, criminal activity, domestic violence, and chronic child maltreatment. The mother had a history of seventeen CPS referrals. The ECFR team reviewed each referral and CA intervention with the family, as well as medical records of the children, and other community services involved.

The eight recommendations made by the ECFR team are presented here with the agency's response regarding their implementation status.

Recommendation #1: *The department should facilitate sharing the child's past social history with his/her providers (e.g. medical providers and developmental specialists as well as mental health professionals). Knowing a child's complete social history ensures that those who evaluate the child have an accurate history of not only pre-natal exposure, but also the environment, nurture, nutrition and availability of caring parents or other adults in his/her past. The social history can assist in identifying children who are victims of neglect. These children are at significant risk of further neglect and death if they are returned to a negligent environment.*	***Completely Implemented.*** *Current policy (CA Practice and Procedures Guide 4517) requires social workers to share all known health information about the child with the medical provider who completes the Initial Health Screen (IHS). The social workers must also provide all information and recommendations from the IHS to the child's current caregiver(s). The social worker must document the dates and results of all Early and Periodic Diagnosis and Treatment (EPSDT) examinations including those that occur after the initial 30 day EPSDT in the FamLink Health/Mental Health Page. Social workers must also provide the child's caregiver all EPSDT results and assist them with obtaining any recommended services for the child. Social workers routinely discuss with mental health providers, case history of children on open cases.*
Recommendation #2: *Observed urinalysis strengthens the evidence gathered during the investigative process and increases test validity. In communities where observed urinalyses are available, CPS investigators should confirm their request for an observed test when making a referral.*	***Completely Implemented.*** *The statewide contract with providers contracted to conduct urinalysis already requires that provider observe when a UA is gathered. Social workers should not have to request the UA be observed, though it may be necessary to remind the provider of their contractual obligation.*
Recommendation #3: *The department should consider providing photography training to CPS investigators as a means to ensure the quality and preservation of photographs while emphasizing the value of photographs as evidentiary information.*	***Completely implemented.*** *The use of photographs as a tool for CPS investigators is part of CPS academy training curriculum as well as post-academy investigator training curriculum. Taking a Photo with Detective King during the CPS Investigative training as well as DLR/CPS Specialized Track Week. Due to budget issues this contract was eliminated June 30, 2010. This recommendation was also reviewed with Region 1's Consensus Building group. Participants are AAs, Intake and CPS Supervisors.*
Recommendation #4: *When multiple agencies and service providers over time have worked or are working with a family or have referred them for intervention, it is recommended to convene a multi-disciplinary or child protection team staffing. Staffings should be as early as possible in the case to ensure coordination and communication of services provided. Staffings can ensure the evaluation of family compliance and progress. Participation by family members should be included to represent priorities and solutions recommended and identified by the family.*	***Completely Implemented.*** *CA has several policies that require or supports convening of multi-disciplinary staffings. The Transition Plan for Youth Exiting from Care (CA Practice and Procedure Manual 4301) requires a multi-disciplinary staffing to youth, 17.5 years old, who are exiting from care. CA Practice and Procedure Manual 4301 policy also lists 4 multi-disciplinary staffing to be held within the first year a child is in placement. These staffings are held to address safety, permanency and well being. These staffing*

	should include service providers, members of the child's family, tribe, and a CASA/GAL. CPT staffings (CA Practice and Procedure Manual 2562) are also an option for conducting a multi-disciplinary staffing.
Recommendation #5: *The supervisory review of intakes should include a review of the intake history of the family including both assigned and screened out intakes. The review should be used when considering assignment of the intake based on allegations of child abuse/neglect meeting the Washington Administrative Code 388-15-009 definition or the presence of risk factors.*	***Completely Implemented.*** *Policy requires both intake workers and supervisors review referral history when making screening decisions on new intakes. This is also information that is given at the Intake Track Week training.*
Recommendation #6: *Comprehensive CPS investigations conducted should include but are not limited to the following:* • *Secure photo documentation of the home environment and children (particularly in cases where home conditions are an identified issue),* • *Complete multiple collateral contacts and retain supporting documentation and contact information in the case file.* • *Utilize internal prognostic or CPT staffings, as required by policy, consistently to help ensure child health and safety,* • *Complete monthly supervisory reviews, as required by policy, as a means to monitor case intervention and progress*	***Completely Implemented.*** *These recommendations are all covered in required and ongoing training for social workers. Photo documentation of the home environment is covered in Child Abuse Investigation & Interviewing 4 day training and in the Worker Safety training. Making multiple collateral contacts is covered in Child Abuse Investigation & Interviewing training, Intake Track Week, CA Social Worker Academy, DLR/CPS Track Week, and DLR Licensing Track Week; The utilization of prognostic staffings is covered in Child Abuse Investigation & Interviewing training, CA Social Worker Academy, DLR/CPS Track Week, and DLR Licensing Track Week.*
Recommendation #7: *The department should develop and review the feasibility of creating regional serious injury/near fatality/suspicious death investigation teams. Establishing teams in each region can ensure adherence to investigative protocols while supporting and assisting staff to complete a comprehensive and thorough investigation.*	***No Implementation Effort.*** *The implementation of this recommendation is not feasible at this time due to limited resources. Such a team would require several staff to handle investigations throughout the state.*
Recommendation #8: *Increase inter-agency training on collaboration and information sharing between medical providers, law enforcement and CA with a focus on recognizing the dynamics of child abuse and neglect.*	***Partially Implemented.*** *Interagency collaboration and training already occurs in most regions, most notably at CPTs which include representatives from law enforcement and medical community.*

A great deal of resources and expertise are channeled into reviewing a fatality with the goal of improving the system and preventing similar child deaths in the future and CA responses regarding the implementation status of the fatality recommendations should reflect enhanced practice and in some cases system change. OFCO raises the following observations and questions to be considered when a fatality review concludes that agency staff failed to follow existing policy or practice:

1. Was the fatality review committee aware of the existing policy when it made the recommendation? If so, was the focus of the recommendation on ensuring compliance with existing policy rather than creating new policy to address a gap or improve practice?

2. A recommendation to follow existing policy does not address why the policy was not followed and begs the larger question of whether it represents typical practice in other cases either locally, regionally, or statewide. Further analysis might include looking at:
    a. Was the policy not followed because of budget and/or time constraints, or ineffective supervision?
    b. Does the failure to follow policy represent inherent problems with the policy, such as redundancy, lack of specificity, or the existence of competing policies with no clear direction as to which takes priority?

3. How is a recommendation to follow existing policy implemented? These recommendations should prompt CA to take a deeper look at whether the failure to follow policy in the case reviewed represents a more widespread failure to follow policy, and whether there is a need for improved training or communication regarding expected practices and procedures, for the particular staff involved in the case under review or CA staff in general.

4. Are the findings of the fatality review regarding failure to follow existing policy communicated broadly to staff? How are the "lessons learned" from the fatality communicated, and to which levels of staff?

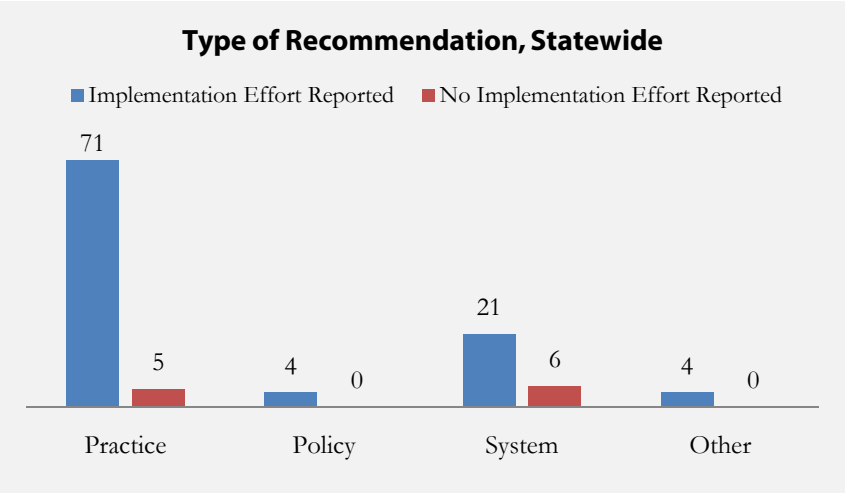
Implementation Status by Region

In general, child fatality reviews identify issues and concerns in a given CA region or office. Implementation status therefore reflects efforts made in a given site and not whether a recommendation has been implemented statewide.

	Complete Implementation	Partial Implementation	No Implementation	Total
Region 1	8	0	1	9
Region 2	5	0	1	6
Region 3	27	3	0	30
Region 4	25	4	4	33
Region 5	1	1	1	3
Region 6	5	0	0	5
CA Headquarters	13	3	4	20
DEL[14]	5	0	0	5
TOTAL	**89**	**11**	**11**	**111**

Type of Recommendations

The Children's Administration categorizes recommendations as addressing "Practice," "Policy," "System" or "Other" issues. "Other" would include recommendations aimed at a "contract issue" for example. As in previous years, practice-level recommendations were implemented at the highest rate (just over nine out of every ten recommendations), while system-level recommendations were implemented at the lowest rate (three out of four recommendations) – albeit still a high rate, considering the typical barriers to system-level change. The vast majority of recommendations concern "Practice" issues, while only a small number of recommendations address "Policy" issues. This would indicate that in general, adequate policies are in place, while following existing policies and other practice issues are reoccurring concerns.



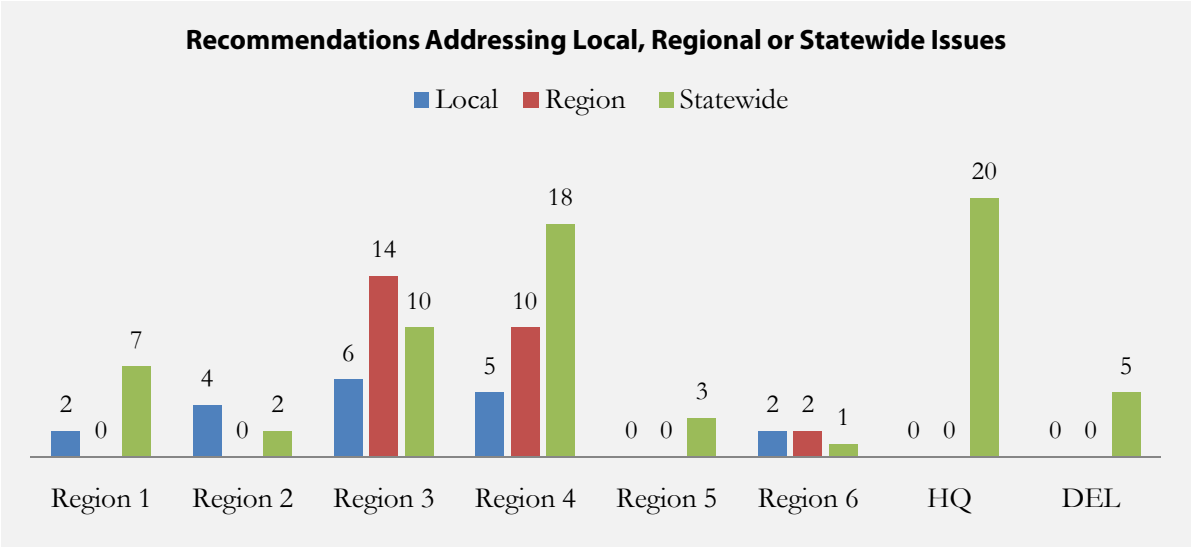
Source: Office of the Family and Children's Ombudsman, March 2011 based on analysis of DSHS CA responses

[14] Of the five DEL recommendations, three were made by Region 5 and two were made by Region 6.

Recommendations Targeting Local, Regional or Statewide Issues

OFCO categorized recommendations as targeting local, regional or statewide issues. Some recommendations may be aimed at statewide practice, but the region in which the fatality review occurred implements the recommendation on a regional level, since that is the level within the region's authority. Conversely, a recommendation targeted at a local office can be implemented at the regional or statewide level.

The graph below shows fatality review recommendations from each region targeting local, regional and statewide issues. The majority of recommendations address statewide issues, suggesting that fatality recommendations can have a wide impact around the state.



Source: Office of the Family and Children's Ombudsman, March 2011 based on analysis of DSHS CA responses

Examples of Recommendations and Implementation Level

The following examples illustrate implementation of recommendations at the local, regional and statewide levels. These examples also represent recommendations that were for the most part clear, specific, practical, and useful.

Local recommendation regarding criminal background checks:

Recommendation: A fatality review of the SIDS death of a four month old infant found that there was a lack of clarity among social workers in a local office regarding when and how to access criminal background checks on relative caregivers. Training on this topic was recommended.

CA Response: CA reported that this recommendation was completely implemented after an office wide training was completed, conducted by the regional Quality Assurance Manager and Background Check Lead.

Regional recommendation regarding youth suicide awareness:

Recommendation: The fatality review of the death of a teen resulted in a recommendation that the Regional CPS Program Manager and the Area Administrator seek training resources regarding youth suicide awareness and prevention that could be offered at no cost to the agency.

CA Response: *The Region 4 CPS Program Manager is a member of the King County Child Death Review Team. The team has reviewed at least ten youth suicide cases 2009-10. Based on these reviews, Public Health sent letters to King County school districts and social services providers about the risks of teen suicide, and about the availability of free training through the Washington Youth Suicide Prevention Program @ www.yspp.org. King County Mental Health and YSPP are offering free suicide awareness/prevention training for professionals. Region 4 staff have been informed; information has been shared with Regions 3 & 5.* ***Completely Implemented***

Statewide recommendation resulting in new state law:

Medically dissenting opinions on the manner of death of a one year old child with a genetic condition led to this recommendation. The medical examiner ruled the death a homicide, but CA did not make a finding of child abuse or neglect on the caregiver based on medical consultation that stated injuries could have resulted from the child's genetic condition or life saving efforts.

Recommendation: *RCW 26.44.030 authorizes CPS to obtain records from all mandated reporters (including Medical Examiners) when there is an active investigation of child abuse and neglect. However, RCW 68.50.105 limits who is entitled to receive autopsies and post mortem reports and records. CPS is not identified in that RCW as being entitled to access such reports unless the deceased child is legally dependent with the state. The existence of competing statutes has proven a barrier for CA in obtaining, in a timely manner, information regarding suspicious deaths of children. Efforts have been made by CA over the last several years to get legislated change so that CA may be authorized to obtain autopsy and investigative records from Medical Examiners and County Coroners. It is recommended that DSHS and Children's Administration continue to pursue this matter with the legislature. Comment: RCW 26.44.030 authorizes law enforcement and CPS to exchange information on cases being investigated for child maltreatment. The information flow between Pierce County law enforcement agencies and CPS has generally been good. The barriers encountered with law enforcement in this case appear to reflect the unusual circumstances of the case rather than a pattern of problems that would require inter-agency discussion.*

CA Response: *In 2009 DSHS submitted request legislation that included a section authorizing the release of autopsy reports to CA staff for the purposes of conducting the CFRs. This bill was not passed out of committee. In 2010, CA has once again submitted request legislation to change RCW 68.50 to allow for the release of autopsy reports to CA for conducting CFRs.* ***Completely Implemented***

During the 2011 legislative session, SHB 1105 was signed into law[15] authorizing the Secretary of the DSHS to receive an autopsy report for the purpose of conducting a required child fatality review.

[15] http://apps.leg.wa.gov/documents/billdocs/2011-12/Pdf/Bills/House%20Passed%20Legislature/1105-S.PL.pdf

Recommendation implemented on local and regional levels regarding improving collaboration with law enforcement:

A ten month old infant was found unresponsive in a crib. The infant's room and internal body temperature were high enough for the medical examiner to state that the cause of death was hyperthermia (over-heating).

Recommendation: *The review team concluded that there may be a pattern among investigators of undue reliance on law enforcement, given the differences in methods and goals of investigation. The team recommended continued training for agency staff in working with law enforcement.*

CA Response: *In 2009, Intake Specialists unit had a meeting with some local law enforcement representatives. They discussed the difference between CPS worker's role and Law Enforcement's role on a case. Regional Program Managers are working with Area Administrators and Law Enforcement on a work plan and training regarding this topic. Ongoing efforts to ensure Law Enforcement representatives are invited to participate in Regional Child Fatality Reviews. Children's Administration staff were reminded at a 2010 Policy Roll Out Training that staff should not postpone assessment of safety during an ongoing Law Enforcement investigation.* ***Partially Implemented***

Partially Implemented Recommendations

CA reported approximately ten percent of the child fatality recommendations as partially implemented.

ICW Training:

A two month old infant died of natural causes. The family had an open DCFS case at the time of death. There was uncertainty about the appropriate response to a difference of opinion regarding the direction of the case between the state worker and the tribe.

Recommendation: *The team has heard concerns that training on the issues of ICW conflict resolution protocol may not be clear in Academy training, post Academy ICW training, supervisors' trainings, and possibly other ICW trainings. The team recommends that training Academy P&PI review the curriculum to ensure that conflict resolution issues are clear.*

CA Response: *The CA Training & Development unit will review our ICW training with NICWA, the contracted provider for ICW training, to make sure conflict resolution is clearly presented in the ICW training.* ***Partially Implemented***

Child Fatalities Training:

An eight year old child died from a drowning.

Recommendation: *CA should consider revitalization of an annual statewide offering of "Lessons Learned from Child Fatalities" presentations available in every region, and update the materials to reflect identified issues from recent Child Fatality Reviews including this review. It is recommended that "Lessons Learned" presentations reflect more a practice focus than policy focus.*

CA Response: *"Lessons Learned" training was offered throughout the state by request of the office or region. Lessons Learned was added to, and presented at, the CA Supervisor Academy. Lessons Learned was also presented at the CPS Post Academy, the DLR Academy and at a CA*

Extended Leadership meeting (attended by RAs, Deputy RAs, and AAs from all 6 regions). ***Partially Implemented***

Recommendations with No Implementation Effort

CA reported four (four percent) of the recommendations had not been implemented at all, and seven (six percent) of the recommendations will not be implemented.

OFCO looked at each of these recommendations to determine if it was reasonable that the recommendation was not implemented. OFCO found that all of the recommendations that were not implemented were reasonable based on the recommendation being moot, lack of funding, or being outside of CA's control.

Impact of Budget Reductions

CA stated that five recommendations were not implemented because of a lack of funding. Given the current budget climate, future recommendations will need to focus on utilizing available resources. For example, hospitals and pediatricians may be asked to spend extra time educating new parents about safe sleep practices, a function previously performed by public health nurses during home visits. The following recommendations illustrate the type of recommendations that were not implemented due to budget constraints.

Early Family Support Services:

A two year old child died from an infection and the medical examiner could not determine if the injury that lead to the infection was inflicted or an accident. The parents were founded for neglect by CA for not seeking medical care for child who was clearly ill and in pain in the days leading up to the death. The child's family had a history of referrals that did not screen in for CPS investigation, but they had been referred to EFSS services in the past.

Recommendation: *The review committee identified recent legislation (HB2106) which will establish a 'performance based contracting' system for all CA contracted service providers by January 1, 2011. In the event the EFSS [Early Family Support Services] program is restored, EFSS program performance and evaluation will be required. Developing a method to assess the inherent value of EFSS services through evidence based practice data can assist in noting a reduction in risk and/or show a decrease in recidivism rates is essential in evaluating the program's long term value and effectiveness in supporting child health and safety.*

CA Response: *EFSS was not restored to any Region 2 office.* ***Will Not Be Implemented***

Chemical Dependency Professionals:

An eight year old child died from drowning.

Recommendation: *In 2006 CA began to fund out-stationed Chemical Dependency Professionals (CDP) in DCFS offices around the state to provide, among other things, onsite consultation and education for social workers regarding substance abuse and co-occurring disorders. At its fullest implementation there were 22 out-stationed CA CDP positions in the state, which reduced to 8 in 2009. While recognizing the current DSHS budget constraints, it is recommended*

that DSHS and CA re-evaluate the need for additional out-stationed CDPs in DCFS offices around the state.

CA Response: *CA evaluated expansion of CDPs in local offices. While this is a valuable case support, budget reductions do not support expansion and these positions are likely to end.* ***Will Not Be Implemented***

Serious Injury/Death Investigation Teams:

A three month old infant was found unresponsive while bed-sharing with both parents. The death was caused by a brain injury resulting from lack of oxygen, but it could not be determined what caused the lack of oxygen.

Recommendation: *The department should develop and review the feasibility of creating regional serious injury/near fatality/suspicious death investigation teams. Establishing teams in each region can ensure adherence to investigative protocols while supporting and assisting staff to complete a comprehensive and thorough investigation.*

CA Response: *The implementation of this recommendation is not feasible at this time due to limited resources. Such a team would require several staff to handle investigations throughout the state.* ***No Implementation Effort***

DV Training for Service Providers:

A two year old child died from head trauma inflicted by the mother's boyfriend. The death was ruled a homicide. The family was referred to EFSS services one month prior to death.

Recommendation: *The current DSHS Central Contracted Services EFSS County Program Agreement and EFSS Client Service Contract require CA to provide mandatory EFSS training for all direct EFSS service staff. It is recommended that the contract be amended to specifically require domestic violence training for all EFSS direct service staff, through CA if available, or as acquired by the provider agency from community sources*

CA Response: *CA will continue to evaluate this recommendation and will develop a plan based on available resources.* ***Will Not Be Implemented***

Recommendations for the Department of Early Learning

Five of the 111 fatality review recommendations stemmed from two fatalities in daycare facilities that are licensed through the Department of Early Learning (DEL). DEL and DSHS have a service-level agreement (SLA) that CA's Division of Licensed Resources (DLR) conducts investigations on allegations of child abuse or neglect in DEL licensed facilities. Although DSHS/CA conducts a fatality review on any child death occurring in these facilities, recommendations regarding DEL practice and policy are clearly outside of DSHS' jurisdiction. DEL participated in the fatality review in these cases, and OFCO contacted DEL for information regarding the implementation status of these five recommendations, and received the following updates on action taken by that agency. OFCO categorized all five recommendations as being completely implemented.

A four year old child died after contracting E.Coli at a daycare facility licensed by DEL and resulted in the two following recommendations.

Coordination Between DEL and the Health Department:

Recommendation: *The Clark County Health Department will request the presence of the licensor when making a visit to a facility that may involve serious health issues in that facility whenever possible. This recommendation should be conveyed to all county health departments, or to the Washington Health Officer's Association. DEL and the Clark County Public Health Department will continue to work on communication barriers, including clear notification when recommendations are made to close a facility based on issues involving communicable diseases or other serious health concerns.*

DEL Response: *These recommendations are for Clark County Health to initiate contact with DEL in matters involving serious health issues and are specific to the health department jurisdiction. DEL believes that the medical director of the Clark County Health Department will convey the recommendation to the health officer's association. DEL has continued and will continue to work on communication with Clark County and other local health jurisdictions.*
Completely Implemented

Reporting of Serious Health Concerns:

Recommendation: *WAC changes should be considered to require reporting of serious health issues or communicable diseases, consistent with the requirements for child care centers.*

DEL Response: *Existing WAC requires the reporting of serious health issues, but could be more specific and aligned with child care center WAC. The future family child care WAC, revisions nearing the filing of a CR102, will include these changes. WAC changes (including current WAC changes) include broad stakeholder input which has included local health jurisdictions, as well as review by the Department of Health.* **Completely Implemented**

The following three recommendations stemmed from the SIDS death of a five month old infant in a DEL licensed daycare facility. The infant had been placed on an adult bed to sleep.

Expanded Infant Care Training:

Recommendation: *DEL should consider changing the training infrastructure for child care licensing to include expanded Infant Care curriculum. This could involve incorporating SIDS training as part of 20 hour S.T.A.R.S. training or as pre-service training. The DEL Southwest Services Area Manager stated during the review that DEL is currently exploring options for conducting state-wide on-going education opportunities for DEL staff regarding infant death and sleep environments. It is recommended that DEL continue with such efforts, possibly utilizing resource information as made available on-line by the National Sudden and Unexpected Infant/Child Death & Pregnancy Loss Resource Center which offers materials specific to child care (www.sidscenter.org/childcare). As a separate department within state government, DEL should consider assuming primary responsibility for conducting reviews in cases where there is no CA involvement and the child death in licensed child care is not attributable to child abuse or neglect*

DEL Response: *DEL notes that there is already a SIDS related training component in child care license orientation framework. DEL is currently working on expanding child care licensing orientation to an on-line delivery system, which will include a SIDS related component. DEL is completing work for on-line staff training, which will go-live in Spring 2011 and includes an educational component around SIDS. The recommendation regarding expanded SIDS training for licensees has been referred to professional development work, and recommendations for future core curriculum for licensees. DEL will consider the recommendation of reviewing cases where child deaths occur where there is no CA involvement. Given current fiscal & FTE limitations, DEL does not plan to formally implement this recommendation at this time. DEL notes that the particular incident that provides this recommendation did involve CA.* **Completely Implemented**

Inter-Agency Child Fatality Investigation Memo of Understanding:

Recommendation: *Discussions between DEL and CA/DLR at the state level are recommended in order to clarify which child death situations in child care facilities will be investigated by DLR/CPS. It is suggested that the result of such discussion would be a Memo of Understanding between the agencies*

DEL Response: *The SLA referenced by CA/DLR adequately responds to the recommendation for DEL. DEL followed up with CA/DLR, and no additional memorandum of understanding is necessary or required.* **Completely Implemented**

DEL Child Fatality Training:

Recommendation: *DEL should consider offering training for selected staff from each DEL office or larger service area regarding responding to child fatalities in licensed child care. This might include Sudden Unexplained Infant Death Investigation (SUIDI) training or First Responders and Collaboration-Preservation-Observation-Documentation (C-POD) Training from the Washington State Criminal Justice Training Commission*

DEL Response: *DEL will consider this in training offered to DEL licensors. This type of training would be beneficial in general, however DEL does not believe this training to be mandatory, given that DEL licensors are not the primary responding investigator; and the existing SLA establishes the leadership hierarchy in responding to such incidents in the following order: Law Enforcement, DLR, and DEL.* **Completely Implemented**

PART III: ANALYSIS OF SELECTED FATALITY RECOMMENDATIONS

A number of recommendations stood out as being particularly well-crafted or effectively targeting common issues such as safe sleep environments for infants, SIDS education, and the role of domestic violence in child fatalities. Themes that emerge in recommendations deserve ongoing attention with the goal of developing best practice.

Of course, implementation of a recommendation does not necessarily result in improved practice or effective systemic change. Further study of related outcomes would provide helpful evaluation data to enable the agency to focus its efforts on strategies that will have the greatest impact on improving practice and systems.

Safe Sleep Environment for Infants

Year after year and consistent with the total number of child fatalities in Washington State[16], about half of CA fatality reviews involve infants under the age of one year. A medical examiner or coroner noted that an unsafe sleep environment either caused or was a risk factor in thirty-eight percent (18 of 47) of infant deaths that CA reviewed. Primary prevention efforts target new parents to educate them about the risks associated with bed-sharing. OFCO's 2010 Annual Report describes in detail public education efforts throughout the state addressing safe sleep environments.[17] Recommendations about safe sleep and SIDS education were made in all regions. For Example:

Family Education on SIDS:

A ten month old infant was found unresponsive in a crib. The infant's room and internal body temperature were high enough for the medical examiner to determine the cause of death to be hyperthermia (over-heating).

Recommendation: *The team recommends that at the next regional CPS supervisors' meeting there be discussion of a regional protocol for education of selected families related to SIDS risks. This could include training by a certified SIDS trainer in "risk management" of SIDS, i.e., discussion of how to reduce risk of SIDS in co-sleeping situations.*

CA Response: *In 2010, Intake staff began asking referents about the safe sleeping environment and parental awareness of safe sleeping practices related to any child under the age of 12 months on all new intakes. Intake staff then document the safe sleeping information on the intake. This serves to inform the assigned social worker about potential risk of SIDS. In March 2010, trained all Region 3 staff and supervisors on assessing safe sleeping environment and engaging families in discussions about safe sleeping practices. Specifically, staff were trained to inform families on the factors that increase and decrease the likelihood of SIDS. Informational materials addressing safe sleeping practices were supplied to all staff for distribution to caretaking families. The 8 tribes in Region 3 have been invited to participate in training on safe sleeping practices. A Regional Program Manager is certified to train on the Native Babies Safe Sleeping curriculum. Currently safe sleeping practices are being highlighted within the Region. Social work staff are encouraged to submit practice examples of how they have implemented safe sleeping education and assessment with families. Social workers submitting practice examples receive a safe sleeping kit donated by Northwest Infant Survival and SIDS Alliance Foundation.* ***Completely Implemented***

[16] http://www.dshs.wa.gov/pdf/ca/FatalitiesinWa.pdf
[17] http://www.governor.wa.gov/ofco/reports/2010/ofco_2010_annual.pdf p. 71-72.

Educating Caregivers:

The medical examiner determined the death of a dependent, six month old infant was sudden and unexplained with contribution from improper bedding and face down placement.

Recommendation: *Packets of information given to relatives at the time a child is placed in their home should include information on safe sleep. This office will verify that their packets have that information. Additionally, this issue will be included in the next 'Lessons Learned' training in the region.*

CA Response: *In March 2010, trained all Region 3 staff and supervisors on assessing safe sleeping environment and engaging families in discussions about safe sleeping practices. Specifically, staff were trained to inform families on the factors that increase and decrease the likelihood of SIDS. Print and electronic Informational materials addressing safe sleeping practices were supplied to all staff for distribution to caretaking families.* ***Completely Implemented***

Collaboration Between CA and Public Health:

A three month old infant died of SIDS while there was an open CPS case and the mother had met with a public health nurse (PHN) for services.

Recommendation: *Children's Administration should consider collaborating with public health and others to find the most effective ways to inform clients about infant death risks and to have the clients comply with that information.*

CA Response: *Region 4 works closely with Public Health, NISSA, the Infant Safe Sleep Workgroup, the Equal Start community Coalition and other stakeholders to promote safe sleep. NISSA has provided us with safe cribs, which we distribute to clients. We also provide clients with safe sleep literature and illustrations. Region 4 has a contract with Public Health - Seattle & King County for PHN services on open cases. The contract is for the Early Intervention Program (EIP). The PHN's serve about 200 children per month, including infants, toddlers and preschoolers. Many of the EIP referrals are for families with infants. The nurses routinely teach infant sleep safety to clients. Region 4 has a contract with Public Health - Seattle & King County for PHN services on open cases. The contract is for the Early Intervention Program (EIP). The PHN's serve about 200 children per month, including infants, toddlers and preschoolers. Many of the EIP referrals are for families with infants. The nurses routinely teach infant sleep safety to clients.* ***Completely Implemented***

Infants with Special Needs

One child fatality review recommended that CA "explore the development and implementation of a training which focuses on care for special needs infants for licensed care providers."[18] Although DLR noted that the PRIDE training for foster parents already includes much of this information, CA has developed and implemented a Medically Fragile Quality Assurance plan, as described in the Braam Oversight Panel Monitoring Report 8, updated in June 2010:[19]

> CA will collaborate with Health Rehabilitation Services Administration (HRSA) to develop and implement a Quality Assurance Plan to clarify, strengthen, and monitor practice expectations for medically fragile children. *(August 2010)* The quality assurance plan will address the following items to ensure medically fragile children:
>
> - Receive appropriate medical care
> - Are placed with caregivers that receive consultation, ongoing training, and support regarding their caretaking responsibilities
> - Are placed with caregivers that report satisfaction with the level of support they receive
> - Are accurately identified as medically fragile, based on the established definition used by HRSA, CA social workers and CHET Screen specialists
> - Are appropriately identified as medically fragile in FamLink

Intake Screening Decisions

CPS Intake screens referrals based on the information reported. If a referral meets the criteria to be screened in for investigation, a response time is assigned based on the severity of risk to the child's safety. If a referral does not meet the threshold for investigation, it is screened out and CPS documents the information, but takes no further action. In the course of a child fatality review, screening decisions on previous referrals are always examined. Aspects of prior referrals that are often examined during fatality reviews are whether the intake worker obtained thorough information from the referent, whether the information was clearly documented, and to what extent prior history of referrals on a family was assessed when making the screening decision. The following recommendations related to intake screening decisions were completely implemented by CA:

Referral History:

A two year old child died from an infection. The medical examiner could not determine if the injury that led to the infection was inflicted or accidental. Multiple referrals were not screened in for investigation on this family and the review team did not agree with all of these screening decisions.

Recommendation: *Every referral, regardless of the screening decision, should include a review of the referral history of the family including both screened in and screened out referrals, The consideration of family history supports more accurate screening decisions. This report and recommendations should be reviewed with the Intake Units that screened the intakes on this family.*

[18] Fatality Review can be accessed at: http://www.dshs.wa.gov/pdf/ca/09-27.pdf
[19] http://www.dshs.wa.gov/pdf/ca/BraamCompliancePlan_Response8revised.pdf

CA Response: *Policy requires both intake workers and supervisors review referral history when making screening decisions on new intakes. This is also information that is given at the Intake Track Week training. The findings of the review were shared with the Area Administrator for the Toppenish and Sunnyside offices with specific emphasis on the intake screening decisions and risk assessment. This information was then to be shared with the intake units of both offices. In addition, a statewide Practice Consultant provided safety and risk assessment training to both offices following this fatality review.* ***Completely Implemented***

Screening Decisions:

A thirteen year old was found deceased, six months after her parents had reported her to be missing. The review team questioned some of the screening decisions of the six prior CPS referrals made earlier in this family's history.

Recommendation: *With the transition to FamLink, intakes can no longer be screened down or out once completed by intake. The region has addressed the issue of screening decisions through quarterly consensus building meetings. In addition to consensus building, the region is moving forward with a plan to review the intake decisions in this office and all offices in the region. A review team, led by the deputy regional administrator, will conduct random reviews of intakes in offices throughout the region. This team will assess if intake screening decisions are appropriate. This plan will also emphasize the importance of assessing risk to teen populations*

CA Response: *An intake review was conducted in April 2010 in the Vancouver DCFS office. This review was conducted by a group of staff from outside of Region 6 and led by the Central Intake Area Administrator. An intake review was conducted in June 2010 in the Tumwater DCFS office. This review was conducted by the Deputy RA, a program manager from Region 6 and the statewide Intake program manager from HQ. Intake consensus building meetings occurred with Region 6 intake supervisors in July 2010. An intake consensus building meeting occurred in December 2010 with Region 6 intake supervisors and intake workers. Ongoing intake consensus building occurs via email between Region 6 intake supervisors and Regional staff. There will be a statewide intake review in January 2011.* ***Completely Implemented***

Intake Guidelines for Child Fatality Reports:

A medically fragile six month old infant was found deceased face down in soft bedding. Little else is known about the circumstances of the death of this infant.

Recommendation: *It is known that CA has convened a work group to review the child fatality reporting and child fatality review process. Consideration could be made to look at developing intake guidelines for taking child fatality reports, to include suggestions for intake workers as to specific questions to ask, depending on the source of the fatality notification. This could provide more consistency across intake units in the state with regard to child fatality intakes.*

CA Response: *Although there were no recommendations or suggestions specific to Region 5, the Pierce West intake supervisor and R5 CPS Coordinator met in March, June and October 2010 to work on developing a "guideline for intake workers when processing fatality notification information" that would be available to Region 5 intake workers as part of a larger intake desk guide that is in development stage in Region 5. This is not a formal quality assurance project, but merely a "time permitting" self-initiated project seeking to improve practice within the region.*
Partially Implemented

Domestic Violence

The fatality of a fourteen year old youth shot by her mother's boyfriend before he shot and killed himself, prompted a close look by the fatality review team at the role of domestic violence in child fatalities. One of the recommendations was to invite domestic violence experts to provide training to CPS supervisors. The implementation by the local office exceeded the actual recommendation. CA reported that:

> *Training was completed on Oct. 6, 2010. Bellingham Area Administrator had a one day retreat with Supervisors related entirely to DV [domestic violence] issues. We spent 2 hours with 2 staff (managers) from the Whatcom County Domestic Violence and Sexual Assault Center going over our new handbooks* [Social Worker's Practice Guide to Domestic Violence, CA DSHS, February 2010][20] *and also other issues related to DV. The DV staff provided a training for all Whatcom County SW (social work) staff on October 6, 2010.*

In another fatality, the review team took issue with a CPS finding in 2006 that a mother, failed to protect herself and her children from an assailant who tried to kill her. The team recommended that "workers should become familiar with the [CA] new policy on domestic violence, which strongly discourages this practice in favor of holding the perpetrator accountable." This recommendation was reported by CA to be completely implemented as:

> *Region 4 workers have received training on the policy, plus an orientation to the Social Worker's Practice Guide to Domestic Violence.*

Conflicting Policies Regarding Structured Decision Making and CPT Staffings

The review of the death of a four month old infant from undetermined causes identified a significant practice issue regarding the use of the Structured Decision Making (SDM) tool. Although there was no open CA case on the child or family at the time of death, a CPS investigation had been closed ten months prior to the infant's death. The review team identified conflicting policies regarding case staffings[21]:

> **Issue identified by the child fatality review**: *At the end of the September 2008 investigation, the Structured Decision Making (SDM) tool was used in this case with an outcome of "moderately high risk." According to Executive Order 95-04 and Child Protection Team (CPT) policy, a "moderately high risk" designation involving a child six years and younger meets the criteria for a CPT staffing. However, the SDM tool produces more cases with this designation than can possibly be accommodated by the CPTs. With an awareness of this, statewide practice direction at the time the SDMs were being instituted nearly two years ago was that until there was a reconciling of the SDM policy with the CPT policy, social workers were to use the "old" risk assessment tool to determine if a case needed to be staffed by the CPT. The issue now is that two years have elapsed since the SDM was instituted, and the issue has never been reconciled. Due to turnover among social workers, there are now many social workers investigating cases and completing SDMs that do not know anything about the "old" risk assessment tool, and therefore would have no idea about how to determine if a case that measures "moderately high" on the SDM should actually be evaluated to determine if a CPT staffing is necessary.*

[20] Available at: http://www.dshs.wa.gov/geninfo/pubs3.html
[21] http://www.dshs.wa.gov/pdf/ca/09-36.pdf

Recommendation: *Consideration should be given to adjusting policy so that the Structured Decision Making policy is compatible with the Child Protection Team policy regarding the determination of when a high/moderately high risk case is to be staffed with the CPT.*

CA Response: *The incompatibility between the SDM and CPT policies results in a high number of cases requiring a CPT staffing. The SDM risk assessment is completed earlier in the case and is based on history. This has increased the number of families falling in the moderately high and high risk categories. The increase in the number of families in the moderately high and high risk categories results in a backlog of cases to be staffed at CPTs and limits CPT's ability to expedite staffing high risk cases. The CPT policy cannot be changed by CA as it is created by an Executive Order. A statewide committee (the Family Engagement Team) is addressing the requirement of case staffings. The committee is considering a means of combining CPT and FTDM staffings to address the issue of social workers being burdened with attending too many required case staffing.* ***Partially Implemented***

Use of Case Reviews to Improve Practice

The following recommendation targets a specific practice issue concerning a Family Team Decision Making (FTDM) meeting and is not a recommendation to change future case practice. A random case review was conducted as a result of this recommendation to determine if the identified issue represented a more widespread problem throughout the region. Such case reviews can be an important step in determining if a recommendation to change or create policy is necessary.

Participants in a Family Team Decision Making Meeting:

A six month old infant was placed with their parent on an in-home dependency and died from accidental positional asphyxiation.

Recommendation: *FTDM team from the [date redacted] meeting should have included others such as providers, other family support and direct supervisor. Postponing the meeting would have been appropriate given the placement of the child was not imminent or emergent. The Area Administrator has agreed to conduct reviews of shared decision making policy and practice with her area supervisors by September, 2010.*

CA Response: *Per the request of the Toppenish field office Area Administrator, a Headquarters Program Consultant conducted random case reviews of open and closed cases from all programs from the Toppenish, Goldendale, and White Salmon field offices. These reviews were conducted on September 16-17, Toppenish cases; September 24, Goldendale cases; September 30, White Salmon cases. Outcomes to these reviews were shared with the Area Administrator, supervisors and line staff from these offices.* ***Completely Implemented***

PART IV: CONCLUSION

CFR recommendations most often address policy, system and practice issues only on a local or regional level. While a recommendation implemented in a local office may have statewide application, there is no system in place to review CFR recommendations, identify those applicable statewide and prioritize recommendations for implementation. DSHS should consider developing a protocol for the timely and consistent transfer of knowledge learned from fatality reviews so that this information is shared between regions and regions are informed about the implementation status of recommendations.

Additionally, child fatality review findings and recommendations should be tailored in a way to identify and address specific issues. Otherwise, little is learned or accomplished through the review process. For example a recommendation that simply restates an existing policy (such as "the supervisory review of [CPS] intakes should include a review of the intake history of the family") prompted an accurate but inadequate response from the department that the recommendation is completely implemented. Left unaddressed are the underlying questions of whether or not this policy was followed, if adequate supervision occurred, if barriers were present that interfered with compliance with policy and what if any corrective action should be taken.

One possible solution would be to establish a centralized process for all child fatality reviews. This would improve consistency in the review process and improve review findings and recommendations. It would also enable Children's Administration to identify statewide trends, identify recommendations addressing systemic issues and oversee implementation of prioritized recommendations in a coordinated manner.

Finally, OFCO noted that CFR recommendations concerning CPS intake focused on the review of prior referral history, inquiry and documentation of risk factors, and quality assurance. These issues were also identified and discussed in a statewide intake review recently conducted by CA.[22] For example, CA's intake report found that "practice was inconsistent in the area of gathering sufficient information related to the child's vulnerability and documenting the caregiver's characteristics relevant to safety threats to the child" and "inconsistent practice as to what degree of the family's history of [child abuse and neglect] was summarized in the intake."[23] OFCO recommends that CA convene a workgroup to further examine these issues, national best practices and identify steps to improve the quality and consistency of CPS intake decisions.

[22] *The Children's Administration Central Case Review Report- Child Protective Services Intake Review*, March 2011.
[23] Id.