IMPLEMENTATION STATUS
OF
CHILD FATALITY RECOMMENDATIONS

JUNE 2013

OFFICE OF THE FAMILY AND CHILDREN'S OMBUDSMAN
MARY MEINIG, DIRECTOR OMBUDSMAN
PATRICK DOWD, OMBUDSMAN
COLLEEN HINTON, OFCO SPECIAL PROJECTS

CONTENTS

EXECUTIVE SUMMARY

This report describes the implementation status of recommendations made in child fatality reviews conducted by the Children's Administration (CA). During this reporting period, from May 1, 2010 to December 31, 2011, CA reviewed the deaths of 93 children and these reviews resulted in 152 recommendations. OFCO found that 82 percent of the recommendations were either completely implemented or echoed existing policy or procedure.

While the majority of these recommendations have been either completely or partially implemented, OFCO identified several recommendations that have not been implemented and warrant further consideration. Of particular note, the department has not taken action regarding the following three recommendations:

- Identify and utilize current agency staff who are trained in providing chemical dependency treatment to better address related issues in cases and clientele
- Provide training to agency staff on serving families with preterm (or "preemie") infants, given increasing trends in preterm births and associated health risks
- Enhance existing policy regarding health and safety visits to include an assessment of the perimeter surrounding a family's home

Also, OFCO found other recommendations that would require legislative action to implement. For example:

- Allow the timeframe in which the department may destroy case records to reset upon the receipt of subsequent allegations of child maltreatment
- Require that mandated reporters receive training on an annual basis
- Require all persons, not just mandated reporters, to contact Child Protective Services (CPS) or law enforcement if they believe or suspect a child has suffered from abuse or neglect
- Require law enforcement officers to notify CPS whenever a child is present or near a parent or caretaker involved in a domestically violent relationship

These recommendations deserve further attention by agency administrators and legislators in order to improve the safety and welfare of children served by our child welfare system.

As discussed in this report, changes to state law governing the types of cases subject to fatality reviews, and improvements initiated by the department to enhance the review process should lead to more focused and effective recommendations. Additionally, the department's partnership with state universities and *Partners for Our Children* to redesign training for students and child welfare professionals provides an opportunity to incorporate lessons learned and recommendations from child fatality reviews into the training curricula.

STATE LAW GOVERNING CHILD FATALITY REVIEWS

The Department of Social and Health Services (DSHS) Children's Administration (CA) conducts a child fatality review when the death of a child was suspected to be caused by child abuse or neglect, and the child was in the care of or receiving services from DSHS/CA at the time of death, or in the year prior.[1] If it is not clear whether a child's death was the result of abuse or neglect, the department must consult with the Office of the Family and Children's Ombudsman (OFCO) to determine if a review should be conducted. The CA Assistant Secretary convenes an Executive Child Fatality Review (ECFR) team comprised of professionals with relevant expertise 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 granted an extension by the Governor.[3] These reports are subject to public disclosure and must be posted on the department's public website. The department is authorized to redact confidential information contained in these reports to protect the child's privacy.[4]

In order to promote accountability and the consistent implementation of recommendations from fatality reviews, the Ombudsman is required to issue an annual report to the Legislature on the implementation of these recommendations.[5]

INTRODUCTION

Between May 1, 2010 and December 31, 2011, the deaths of **93 children** resulted in a child fatality review by CA. The following report provides a summary and analysis of the 152 recommendations emanating from those reviews, and how they have been implemented. During this reporting period, Washington's child fatality statute was revised significantly. Prior to July 22, 2011, the department was required to review *all* unexpected deaths, from any cause, of children in the care of or receiving services from CA at the time of death or in the year prior. Now, the agency is required to review only those deaths suspected to be caused by abuse or neglect, for the same group of children.[6] Therefore, many of the child deaths included in this reporting period were "unexpected," but not caused by abuse or neglect.

---

[1] See RCW 74.13.640. Prior to the passage of SHB 1105 in 2011, CA was required to review any unexpected deaths of children who were in the care of or receiving services from CA, or had received care or services in the last year.
[2] See DSHS CA Operations Manual, Section 5200 at http://www.dshs.wa.gov/ca/pubs/mnl_ops/chapter5.asp#5200
[3] Id.
[4] Individual child fatality reports are available at: www.dshs.wa.gov/ca/pubs/fatalityreports.asp.
[5] RCW 43.06A.110. This requirement began in 2008 and OFCO's first report appeared in our 2009 Annual Report, covering fatalities occurring from 2005 to 2008. OFCO's second report was a stand-alone report issued in August 2011, covering recommendations resulting from reviews of fatalities occurring between January 1, 2009 and April 30, 2010. This is OFCO's third report on this topic. OFCO reports are available at: http://www.governor.wa.gov/ofco/
[6] See RCW 74.13.640.

Part I of this report highlights select recommendations that resulted in significant changes to child welfare policy or practice. For example, recommendations that were implemented addressed: monitoring vulnerable children during a CPS investigation; the use of a global assessment tool for child safety; the timely completion of CPS investigations; communication between CPS social workers and medical consultants; and improved training for the child welfare workforce. Child fatality recommendations are organized by nine common themes. The prevailing theme identified a need for improved training for caseworkers, supervisors and community professionals. The second-largest number of recommendations targeted casework practice.

Part II summarizes the types of recommendations and the level of implementation. This section examines why some recommendations have been only partially implemented, or not implemented at all. Sixty-one percent of the recommendations are reported as fully implemented. Another twenty-one percent were considered to be already addressed through existing policies.[7] Nine percent were partially implemented, while another nine percent were not implemented at all.

Part III highlights local initiatives to implement fatality recommendations, and discusses some recommendations that were not effectively implemented.

Part IV discusses promising results from improvements in the fatality review process. Significant changes in child welfare law and policy highlighted in this report are some of the positive outcomes of a greater statewide focus on implementing fatality recommendations and disseminating the lessons learned from this important process.

[7] OFCO's 2011 implementation report suggested that CA take a closer look at such recommendations to determine why existing policies weren't followed, and whether there are inherent problems with these policies.

PART I: SIGNIFICANT CHANGES IN CHILD WELFARE LAW AND POLICY ARISING FROM FATALITY RECOMMENDATIONS

Since OFCO's 2011 report on the implementation of fatality recommendations, the criteria and procedures for fatality reviews has changed significantly. As mentioned in our introduction, fatality reviews are now only required in cases of suspected abuse or neglect, rather than all unexpected deaths of children whose family had an open case with CA or a CPS referral within the prior year. Additionally, in the event of a near fatality of a child, the department must promptly notify OFCO, and may conduct a review at its discretion or at the request of the Ombudsman. All reviews are now conducted as Executive Reviews by a review team consisting of professionals who are unrelated to the case and have relevant expertise.[8] The Ombudsman participates in every review. These changes took effect on July 22, 2011, 15 months into the 20-month period covered by this report.

A second significant development is that by August 2012, CA established a **centralized process** for conducting fatality reviews. All fatality reviews are now facilitated by one of three staff who coordinate reviews and compile the review committee's findings and recommendations. The findings and recommendations are then communicated directly to trainers with the agency's new staff training resource, the Alliance for Child Welfare Excellence. In this way, critical lessons learned from these fatalities will be incorporated in trainings and disseminated to CA staff.

As a result of these recent changes, OFCO has observed that the fatality review process and product have improved in terms of consistency and quality. Recommendations are more targeted, specific and feasible.

A. Recommendations Resulting in Major Policy and System Changes

During this reporting period, there were **a number of significant changes in policy, protocol or system changes that occurred statewide** in large part as a result of recommendations made by fatality review committees.

1. CPS monitors vulnerable children more closely during CPS investigations.

A seven-year-old child was killed in a car accident when his mother was driving while intoxicated.[9] There was an open CPS case following reports that the mother drove intoxicated with the children every day, the home was in poor condition, and the children were being neglected due to the mother's alcohol abuse. There had been three prior investigations by CPS in the past seven years, all involving the mother's drinking and driving with the children, and overall neglect of the children.

The fatality review committee found that the CPS case had been open for 55 days at the time the child was killed, and there had only been one home visit by the CPS investigator during that

[8] RCW 74.13.360

[9] Executive Child Fatality Review, I.C., conducted on January 7, 2011.

time, to conduct an initial face-to-face contact with the children and parents. Existing policy did not require children to be seen by the assigned worker after that initial contact. The review committee identified this as a significant gap in safety monitoring of children in an open CPS case.

The committee recommended that just as children in out-of-home care and families receiving voluntary services through CPS are required to be seen by the assigned caseworker every 30 days, children involved in open CPS investigations should also be seen every 30 days.

A 20-month-old toddler died from severe trauma as a result of physical abuse inflicted by the mother's boyfriend.[10] *There was an open CPS case at the time, after the child had arrived at day care with a black eye. The family's CPS history included a dependency on an older child.*

The fatality review committee found that the CPS case had been open for 81 days at the time the child was killed, and there had only been one home visit by the CPS investigator to conduct the initial face-to-face contact with the children and parent. The mother had given birth to a new baby in the interim.

The committee recommended that children involved in open CPS investigations be seen every 30 days.

Agency takes action: CA policy now requires CPS social workers to conduct 30-day Health and Safety visits in **all CPS investigative cases open longer than 90 days**.[11]

2. CA adopts more effective tool for assessing child safety.

A one-month-old infant died while co-sleeping with her parents.[12] *There was no open case with CA at the time of the child's death. The family had two prior CPS referrals in the preceding three years. Both alleged substance abuse by the mother, including driving while intoxicated with an older child in the car. The second referral was investigated, and closed as "unfounded."*

The review committee found that while the CPS investigation met the minimum policy requirements, additional information from collateral contacts such as the mother's physician, the

[10] Executive Child Fatality Review, N.L., conducted on September 12, 2011.
[11] CA internal memo to all staff, 3/12/13, "Monthly visits with child victims of CPS cases open beyond 90 days."
[12] Child Fatality Review #10-60, completed on November 17, 2010.

child's physician and the WIC[13] program staff would have better informed the CPS investigation and assisted the family in gaining access to needed services.

The committee recommended that CPS investigators conduct a global assessment of child safety that goes beyond the incident-focused investigation.

A nine-month-old infant died from Sudden Unexpected Infant Death (SUID).[14] The child had been placed on a pillow on her stomach with a blanket covering her back and legs. The family had an open CPS case at the time of the child's death, after a child allegedly ingested methamphetamine while visiting this home. The intake was the sixteenth report on this family in less than four years. There were two older children in the family.

The review committee found that there had been six CPS investigations involving this family prior to the infant's death and that additional information from collateral contacts would have helped determine risks to the children's safety, and identify appropriate services. In this case, contact with the referrers to CPS, law enforcement, and the children's health care providers would have revealed valuable information.

The committee recommended that CPS investigators conduct a global assessment of child safety that goes beyond the incident-focused investigation.

Agency takes action: The agency initiated a new safety assessment and safety planning tool in November 2011, the Child Safety Framework,[15] to provide a more global assessment of child safety. A subsequent fatality review committee noted that the new tool:

> supports and assists social workers in assessment, identification, and management of safety threats throughout the life of a case. The patterns in the [currently reviewed case] of child maltreatment reports, domestic violence, and substance abuse would be thoroughly identified in the new assessment, moving the practice away from incident-focused work to a comprehensive assessment of how this family functioned. The Child Safety Framework also [stresses] the importance of verifying information gathered [from parents] by contacting collaterals and other child welfare partners working on a case.[16]

[13] The federally-funded Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides nutrition services and health care referrals for low-income mothers and children up to age five who are at nutritional risk.
[14] Child Fatality Review #10-63, completed on April 19, 2011.
[15] CA Practices and Procedures Guide, Chapter 1100: Child Safety Section.
[16] Executive Child Fatality Review, M.S., conducted on October 27, 2011, page 8.

3. Access to autopsy reports enables more comprehensive fatality reviews.

A two-and-a-half year old child died of severe trauma resulting from physical abuse by his mother's boyfriend.[17] *There had been six CPS intakes involving the mother in the two years preceding the child's death, alleging neglect and physical abuse of this child and older siblings. Previous physical abuse allegations included burn marks, a black eye, and bruises on this child, as well as bruises on an older sibling.*

The review committee found that CA's limited access to the autopsy report was a barrier in discussing the child's medical issues during the course of the review.

The committee recommended amending RCW 68.50.10 to allow release of an autopsy report to CA when a child's death is the result of alleged abuse or neglect.

A one-month old infant died while co-sleeping with her parents.[18] *[This fatality is described under #2 above.]*

The review committee had several questions regarding the circumstances of the child's death, but did not have access to the autopsy report, which includes the death scene investigation.

The committee recommended legislation to allow CA access to autopsy reports to include the death scene investigation report.

Legislature takes action: In 2011 the Legislature amended state law allowing CA access to autopsy reports in child fatalities suspected to be caused by maltreatment.[19]

4. State adds significant resources to ensure timely completion of CPS investigations.

A 20-month-old toddler died from severe trauma resulting from physical abuse inflicted by her mother's boyfriend.[20] *[This fatality is described under #1 above.]*

[17] Executive Child Fatality Review, B.M., conducted on January 6, 2011.
[18] Child Fatality Review #10-60, op. cit.
[19] HB 1105 amended RCW 68.50.105.
[20] Executive Child Fatality Review, N.L., op. cit.

The review committee found that the assigned worker's workload (as well as that of the entire CPS unit) compromised the worker's ability to meet practice expectations in this case. There was a 75-day period without any significant investigative follow-up activity or visit by the CPS worker. Similarly, required monthly supervisory consultations and staffings did not always occur due to the unit's workload.

Among other recommendations to address workload issues, the committee recommended that supervisors receive a monthly report listing CPS investigations open longer than 45 days without an extension, as a means to support supervisors in monitoring workload. The committee further recommended compiling a statewide report regarding the occurrence of monthly supervisory reviews by office and program area to determine where there may be barriers to completing these reviews.

Governor and agency take action: The above recommendation was made in September 2011.[21] CA subsequently developed a data report for CPS supervisors to track CPS investigations open longer than 45 days. A new supervisory review tool was also introduced to assist supervisors in tracking the date of case assignment. Regarding the tracking of supervisory reviews of cases, a tracking tool available on CA's intranet can be used by both supervisors and Area Administrators to measure whether the 100% case reviews required by policy[22] are occurring in any given unit.[23] More importantly, the Governor recently approved additional CPS positions, effective in April 2013, to eliminate the backlog of pending investigations and ensure high-quality investigations that are completed in a timely manner.

5. CPS strives for more effective consultations with Child Protection Medical Consultant group.

An eight-month-old infant died from severe trauma as a result of physical abuse by her father.[24] CPS had an open case at the time, following a report made nine days earlier that the infant had suffered a skull fracture.

The review committee found that CA had consulted with its contracted medical consultants (the Child Protection Medical Consultant (CPMC) group,) regarding the skull fracture. The medical consultant's initial opinion was that the injury was the result of "probable" accidental trauma. The review committee found that "while the injury may have plausibly been accidental, the social worker made no additional inquiry as to the degree of probability or actual likelihood that the event was inadvertent rather than intentional."[25] The committee also noted that "while consultation with medical professionals is often critical to gathering information for

[21] OFCO's 2011 and 2012 Annual Reports also highlighted the problem of CPS investigations not being completed in a timely manner.
[22] CA Operations Manual, Chapter 6223: Supervisory Monitoring.
[23] Per telephone conversation with CA Deputy Assistant Secretary, Randy Hart, on 4/25/2013.
[24] Executive Child Fatality Review, L.F., conducted on April 19, 2012.
[25] Ibid., page 6.

investigation and assessment, medical opinion should not be the only source of information when assessing risk or safety, or making a final decision."[26]

The committee recommended that "in cases where the medical opinion may be that an injury is 'plausibly accidental', social workers should ask for a more specific estimate of probability [or] 'how likely' is it that the injury was accidental or non-accidental?... This would increase the ability of social workers to understand and assess the safety needs of the child as well as support investigative findings that are based on a 'more likely than not' standard of proof."[27]

Agency takes action: CA subsequently met with the state CPMC group to discuss ways to improve communication between doctors and department social workers when consulting on child injury cases. As a result, changes were made to the referral form used by social workers to obtain these consultations. The new referral form is now in use.

B. Comprehensive Redesign of Training for Child Welfare Workforce

At least **seven recommendations** concerned the need for improved training of CA staff, particularly regarding domestic violence, as well as specialized training for supervisors, and cross-training between CA functions for all staff. In May 2012, DSHS announced the creation of the Washington State Alliance for Child Welfare Excellence, a new partnership to provide training and professional development for Washington's child welfare workforce.[28] The Alliance combines the resources of University of Washington School of Social Work, UW Tacoma social work program, Eastern Washington University's School of Social Work and the former child welfare training academy of DSHS, with a research component provided by Partners for Our Children.[29] According to DSHS, as of May 2012, Alliance staff members were working with CA teams in each region "to research, plan and implement the transition to the new, enhanced training and professional development system. Early implementation will focus on supervisor and new social worker training. The remaining components of the system will follow, including foster parent training."[30]

The following is a detailed and specific example of a Child Fatality Review (CFR) recommendation regarding staff training[31] and the agency's response: [32]

CFR Recommendation: *CA should consider new social workers as in training status for up to 90 days minimum and should consider implementing the following training and mentoring strategies: Partner in training social workers with experienced, mentor social workers. In training social workers will not be assigned cases for 45 days. If assigned cases prior, the in training social worker should be assigned as a secondary with the mentor social worker as the primary social worker assigned to the case. If staffing resources do not allow for partnering, in training social worker*

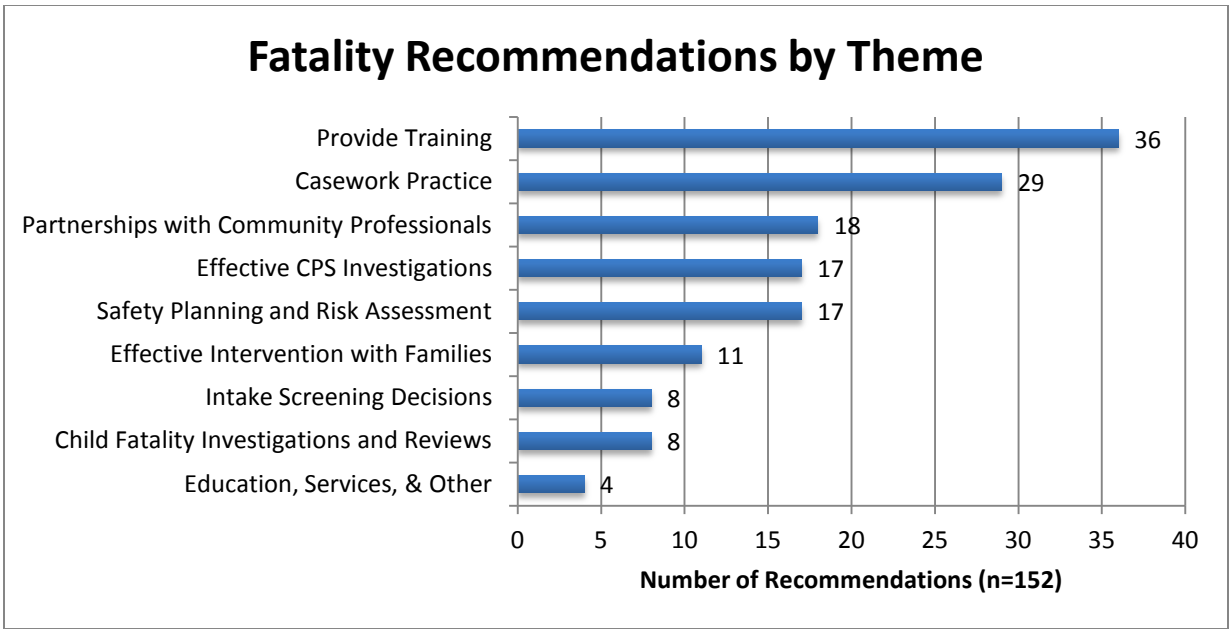
[26] Ibid., page 8.
[27] Ibid., pages 7 & 8.
[28] See http://socialwork.uw.edu/research/smart-partnerships
[29] A policy and analysis group collaborating with UW School of Social Work, DSHS and private philanthropy.
[30] See press release on May 10, 2012 at http://dshs.wa.gov/mediareleases/2012/pr12022.shtml
[31] Executive Child Fatality Review, I.C., reviewed on 6/29/2011.
[32] CFR recommendations presented in italics throughout this report are taken verbatim from Child Fatality Review reports, and CA responses in italics similarly are taken verbatim from CA responses sent to OFCO.

has daily supervision with assigned supervisor. CA should develop a checklist of case types to ensure in training social worker has exposure to and experience with a variety of cases while in training, to include: Newborn victim cases; Non-verbal victim cases; Adolescent victim cases; Substance abusing and addicted caregivers; Mentally ill caregivers; Physical abuse; Sexual abuse; Negligent treatment or maltreatment; Chronic maltreatment.

CA Response: *Currently the Training Alliance, with its University Partners, are developing a Proposed Plan for Regional Academy Training that will be field tested in Region 1. This is a structured learning program that addresses the knowledge and skills identified as foundation level competencies. The learning program is the initial, intensive, task-oriented training that prepares newly hired social workers and social service specialists to assume job responsibilities. The program begins on the first day of employment and lasts for 60 days or the first two months of employment. Competencies are used to assess learning needs and to identify the curriculum modules completed during this time. Each module contains an on-the-job application wherein the new employee is learning and applying the knowledge and skills before completing the module. Close observation and supervision occurs throughout the first two months, provided by an Alliance Coach. The Coach and the new employee's supervisor stay in contact throughout the program with regular progress reports and debriefing sessions. Every newly hired social worker will be assigned a coach. Coaches may have one or a small group of newly hired social workers at one time. The coach, in collaboration with the participant's supervisor, will determine when he or she has met the required Foundational competencies. The completion of the Foundational process of learning allows the new hire to receive a full caseload and enter into the next level of In-Service learning. This will be implemented in 2013.*

C. Common Themes of Child Fatality Recommendations

OFCO analyzed the **152 child fatality review recommendations** made during this reporting period to identify common themes. The largest number of recommendations—close to one-quarter (23 percent)—identified a need for increased or specific training for caseworkers, supervisors, or community professionals. The next highest number of recommendations (19 percent) dealt with the agency's casework practice. Recommendations addressing the agency's partnerships with community professionals, improvements in CPS investigations and promoting child safety accounted for another 11 to 12 percent of recommendations respectively. The following chart presents the number of recommendations within nine major themes. A summary of all the recommendations made within each of the nine themes is presented in Appendix A.



Source: Office of the Family and Children's Ombudsman, April 2013 based on analysis of DSHS CA responses

PART II: IMPLEMENTATION STATUS OF FATALITY RECOMMENDATIONS

For this reporting period, **152 recommendations were issued regarding 93 child deaths**[33] reviewed by CA. This includes **seven recommendations** that were directed at the **Department of Early Learning** (DEL), a cabinet-level agency outside of DSHS that licenses and monitors child care facilities in Washington.

In order to assess the implementation of child fatality recommendations, CA Headquarters provided OFCO with information regarding the implementation status of recommendations issued in all fatalities reviewed by CA, for child deaths that occurred from May 2010 through December 2011.[34] CA categorized the implementation status of each recommendation as completely, partially, or not implemented, and provided a brief description of the implementation effort.[35]

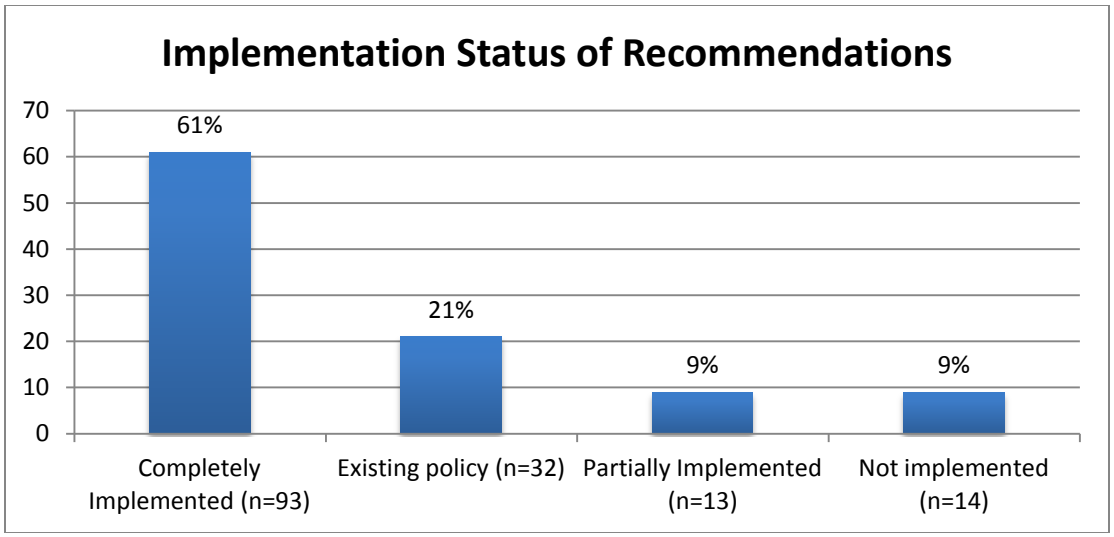
This section of the report discusses:

- The implementation status of fatality recommendations;
- Whether the recommendations targeted system, policy, or practice issues; and
- Whether the recommendations addressed local, regional, or statewide issues.

A. Implementation of Fatality Recommendations

OFCO reviewed the information provided by CA and in some cases, sought additional or updated information to determine the implementation status that was most accurate. OFCO sought similar information from DEL. Based on OFCO's review, **61 percent** of child fatality review recommendations have been **completely implemented**. Another **21 percent** of recommendations echoed **existing policy**. **Nine percent** of recommendations were **partially implemented**; while another **nine percent** saw **no implementation** effort.

[33] The document CA provided to OFCO contained fewer recommendations and some recommendations contained sub-parts. OFCO counted these as separate recommendations. Some fatality reviews produced no recommendations at all.
[34] Reviews are completed up to six months following the fatality which delays reporting on the implementation status of the review recommendations. OFCO's reporting period for fatality recommendations therefore captures the *deaths* that occurred during that period rather than *reviews* that were conducted in that period.
[35] OFCO acknowledges the time and effort spent by each region, Headquarters, and DEL in gathering this information, and appreciates the detailed responses provided.



Source: Office of the Family and Children's Ombudsman, April 2013 based on analysis of DSHS CA responses

In OFCO's 2011 report on this topic,[36] CA listed 80 percent of recommendations as being **completely implemented**; however, this number included recommendations that **duplicated existing policy**.[37] Similarly, for the current reporting, 82 percent were either completely implemented (61 percent) *or* duplicated existing policy (21 percent). In this report they are listed separately for greater accuracy. The other two categories also remained remarkably similar for the current and last reporting periods. In 2011, ten percent of recommendations were **partially implemented**, and another ten percent were **not implemented**.

What Does "Completely Implemented" Mean?

For the most part, CA responses indicating that a recommendation had been completely implemented included a description of how it had been implemented. For example:

> Recommendation: *The review committee recommends social workers complete a global assessment of safety beyond the incident focused investigation. The review committee is aware that CA is currently consulting with the National Resource Center for Child Protection and is working to develop and implement a global assessment of safety.*[38]
>
> CA Response: *The Child Safety Framework*[39] [implemented on 11/14/2011, after this recommendation was made] *meets the requirements of this recommendation.*

In this example, although CA reported no implementation due to "existing policy", OFCO categorized the status as being "completely implemented" since the recommendation predated the

[36] Issued in 2011, and covering the period from January 2009 through April 2010. See at http://www.governor.wa.gov/ofco/reports/implementation_recommendations_2011.pdf
[37] This was a significant improvement over the 2005-2008 reporting period, when only 38 percent of recommendations were reported as completely implemented.
[38] CFR recommendations presented in italics throughout this report are taken verbatim from Child Fatality Review reports, and CA responses in italics similarly are taken verbatim from CA responses sent to OFCO.
[39] CA Practices and Procedures Guide, Chapter 1100: Child Safety Section.

implementation of the agency's new safety/risk assessment model in November 2011 (the Child Safety Framework).

When Recommendations Duplicate Existing Policy

In our 2011 report, OFCO found that over one-third of the recommendations that CA reported as being "completely implemented" were based on CA's determination that the recommended action represented an existing policy, procedure or practice. OFCO pointed out that this explanation deserves a deeper analysis of why the policy in question was not followed, or what corrective action was taken to assure future compliance. During the current reporting period, fewer recommendations fit this category (about 21 percent compared with about 37 percent in 2011), but many of the implementation descriptions did not address why existing policy was not followed and what was being done to correct this. Since all fatality reviews are now Executive Reviews and the fatality review process has become centralized, this type of recommendation should be less likely to occur. Instead, the review committee makes a "finding" if an existing policy was not followed, with the expectation that the agency will take corrective action to ensure existing policies are followed in future.

Here is an example of a specific recommendation that CA indicated as a duplication of existing policy.

Thorough Sharing of Information for Optimal Case Planning

> Recommendation: *CA must ensure a complete case history is conveyed to care givers and service providers (e.g. medical providers, mental health professionals, care providers, etc.) to provide a baseline for case planning. When multiple agencies and service providers over time have worked or are working with a youth and family or have referred them for intervention; a thorough overview of the case must be shared. In addition to the packet of information forwarded to a care provider, information provided must include a comprehensive summary of the case history, service intervention and significant events to date. The review committee suggested this discussion should occur in person or telephonically prior to placement to ensure appropriate case plan development in the proposed home/facility. CA can utilize several existing venues where this information can be shared (e.g. Multiple Disciplinary Teams, Shared Planning Meetings, Family Team Decision Making (FTDM) Meetings) and assist in developing communications across systems and ensure a comprehensive plan of care is developed. At minimum staff participating in such staffings should include the assigned CA social worker and supervisor, BRS* [Behavioral Rehabilitation Services] *facility staff and the CA Regional BRS Program Manager. As noted above a comprehensive staffing may have led to a request for additional supervision supported by BRS funding sources.*
>
> CA Response: **Existing policy.** *Child Placement Referral Form includes child specific information and is to be shared prior to placement. FTDM meetings are held prior to placement when possible. Case plan is shared through an ISSP. All relevant CA staff and family supports are invited to FTDM meetings.*

In this example, the review committee acknowledges existing shared planning practices such as FTDMs, but gives examples of additional avenues for communication of case information that is not addressed in the CA response. While CA reported this recommendation as representing existing policy and requiring no further action, OFCO disagreed and re-categorized it as only partially implemented. OFCO reasoned that while some elements of this recommendation reflect existing policies, other recommended actions are not covered by the "existing" policies mentioned, and would require additional steps to ensure that a complete case history is provided to caregivers and service providers in every case. Furthermore, OFCO found this recommendation to be very specific, and goes beyond what is in current policy. OFCO believes that the intent of the recommendation is to urge the agency to share case information in a more detailed, structured, and meaningful way with a broad range of staff and community partners, than was practiced in this case. Since existing policy does not address the full extent of this recommendation, OFCO considers this recommendation to be only partially implemented.

In other instances, CA's response indicated that the recommendation represented existing policy, but also discussed other actions taken in response to the recommendation. For example:

Proper Use of Reunification Assessments, and other Practice Concerns

> Recommendation:[40] *Overall the Child and Family Welfare Services (CFWS) worker appeared to demonstrate good practice in most areas of social work and case management. Two minor issues noted during the Child Fatality Review were that some case notes by the CFWS worker were not entered in a timely manner, and that the legal record for the deceased child was never updated from initial Shelter Care status (clerical function). More pronounced in terms of identified practice concern was the failure to utilize the CA Reunification Assessment tool per practice expectations [see CA Practice and Procedure Guide - Section 43051]. The decision in early December 2010 to proceed towards reunification/trial return home with the initiation of unsupervised overnight visits between mother and her two daughters appears reasonable and utilized available shared decision making venues (e.g., Child Protection Team (CPT), FTDM, court). However, the Reunification Assessment tool was not utilized prior to coming to the reunification decision, but rather after the transition process (overnight visits) had already begun. While there is evidence of a completed Reunification Assessment for the older sibling, no Reunification Assessment was ever initiated in FamLink for the medically fragile child who died while on overnight visitation with her mother.*
>
> CA Response: **Existing policy**. *Additional actions taken: Both the CFWS social worker and her supervisor participated in the review and received feedback regarding quality work as well as where practice needed improvement. The CFWS Area Administrator also attended the review and participated in the discussions about practice improvements. The legal record for the now deceased child was updated following the Child Fatality Review to reflect correct legal history. Currently the [respective] Division of Children and Family Services (DCFS) offices are in process of moving FamLink input of children's legal history from a clerical function to CFWS supervisor function to improve immediacy*

[40] This "recommendation" is written as a "finding", as many recommendations were. Presumably, what is recommended is that some corrective action be taken to address the practice errors identified by the review committee.

and accuracy of legal action documentation. Refresher training on Reunification Assessment and Transition & Safety Planning was initiated prior to this Child Fatality Review. The refresher opportunity was required for all CFWS social workers and CFWS supervisors in [the involved] DCFS offices. The first of the four-hour training sessions occurred on March 21, 2011. The fourth and final training session occurred on May 12, 2011. Additionally, CFWS supervisors have been notified that effective June 1, 2011, completion of the Reunification Assessment and Transition and Safety Plan will be expected on all cases where return home is the primary plan and must be shared at Permanency Planning and CPT staffings.

In a few instances, CA's response explains why existing policy and practice was sufficient and further action to implement the recommendation was unnecessary. For example:

Case Transfers Between Offices

Recommendation: *Conduct more thorough and complete history checks on all cases received in the* [involved] *office.*

CA Response: *This is already an investigative standard.*

In this instance, the supervisor of the case had participated in the fatality review, acknowledged the practice errors identified, and stated a commitment to avoid such errors in the future. No further action was required.

Recommendations Needing Further Implementation Effort

CA reported approximately nine percent of the child fatality recommendations (n=13) as partially implemented. In some cases, the recommendation was still in the process of being implemented. In others, part of the recommendation may have been implemented, and there is no plan to implement the remaining part(s). For example:

Recommendation: *The primary worker to a case should be notified via Tickler whenever someone else enters a note on their assigned case. If the information is significant to a high profile, serious injury or child fatality, the primary assigned social worker should also receive a phone call by the person entering this information. This information will be forward to the Famlink design team and to* [the] *Regional Administrator.*

CA Response: *A change request to CATS has been submitted.*

OFCO followed up with CA Technology Services (CATS), who reported that the change request has been accepted but not yet implemented. The technical team is assessing this recommendation to determine the best method to flag or alert the primary worker when significant information is entered on an assigned case.

Recommendation: *The department* [should] *continue to refine/revise the Shared Decision Making (SDM) tool and provide training to social work staff about use of the tool.*

CA Response: *Training regarding the use of the SDM has been provided. The SDM has not been refined or revised.*

Recommendation: *CA should consider the development of additional training opportunities that address the complexity of mental health and behavioral issues in children and adolescents. This enhanced training will support care providers, CA staff and its partners in addressing issues related to youth with special needs and may support and assist in sustaining least restrictive placements for youth. Training opportunities which introduce and provide specific information related to mental health and their related behavioral issues can support care providers and social workers in caring for youth diagnosed with such issues. Training such as medication management, accessing community resources such as the Designated Mental Health Professional (DMHP), intervention strategies, re-directing behaviors, safety planning and monitoring were several topics suggested by the review committee.*

CA Response: *Chemical dependency and mental health training is provided on a regular basis. Partnering with foster parent training is also provided on a regular basis.*

In the above example, CA reported the recommendation as being partially implemented, presumably on the basis that some specialized training for workers exists. The review committee, however, appeared to be recommending much more specific and targeted training than was already being offered to CA staff. In this example, OFCO agreed with the agency's categorization of this recommendation as being partially implemented due to the comprehensive new training that is in the process of being developed for CA staff.[41]

Recommendations Not Implemented

Nine percent (n=14) of the recommendations were not implemented at all. OFCO examined each of these recommendations to determine why, and found that most often this was either due to lack of funding, being outside of DSHS' control, or other legitimate factors. However, a few of these recommendations seemed fairly easy to implement and it was unclear why they remained unaddressed.

Recommendations Requiring Additional Funding

State and federal budget reductions since 2008 have impacted services that are available to families. Nevertheless, only three recommendations were not implemented because of a lack of funding. While participating in fatality reviews, the ombudsman observed that review committees were keenly

[41] See previous detailed discussion in Part I Section B. of this report, pages10-11.

aware of the tight state budget and avoided making recommendations that would require significant funding. These three recommendations are: identify ways to increase public health nurse services; co-locate domestic violence advocates in CA offices; and increase the number of Division of Licensed Resources (DLR)/CPS investigators and licensors. Another recommendation acknowledged the negative impact that the elimination of co-located chemical dependency professionals in CA office was having on CA's services for chemically dependent clients, and recommended looking for other ways to achieve the same goals.

Recommendations Requiring Legislative Response

Likewise, there were several recommendations that were reported by CA as "not implemented" as they required changes in legislation that were out of CA's control. Nevertheless, the agency could assess such recommendations to determine whether this is an idea that should be brought to the legislature's attention. There is certainly precedence for recommendations from fatality reviews leading to legislative changes. One recent example was the passing of a law[42] in 2011 allowing CA access to autopsy reports for the purpose of conducting a child fatality review, at least in part due to a recommendation made by a fatality review. OFCO suggests that these recommendations receive further consideration:

- *Records destruction timeframes should re-set and start over when subsequent allegations of child abuse and neglect are received. If an "information only" intake is screened and a new intake is received within three years, the three year timeframe should adjust and the "information only" report be retained.*

- *The review committee recommends that consideration be given to amending RCW 26.44.030 to include any person who has reasonable cause to believe or suspect a child has suffered from any abuse or neglect shall make a report.*

- *Mandated reporters identified in RCW 26.44.030 should be required to review the Department of Social and Health Services mandated reporter training materials on an annual basis.*

Recommendations Not Implemented and Without Explanation

The following four recommendations appear to be reasonable and practical, yet CA provided no rationale as to why they had not been implemented. OFCO suggests that these recommendations be reconsidered by the agency.

- *The department should conduct a survey to identify social workers currently employed by the department who are also Chemical Dependency Professionals. These staff could be utilized as local experts and assist social workers, particularly those less experienced, with cases involving chemically dependent clients.*

[42] See HB 1105.

- *CA should consider offering training to social workers on preterm ("preemie") babies. Given the increased number of preterm deliveries nationally and the increasing research regarding short and long term health and disability risks, awareness of the subject may be beneficial to those providing public child welfare services. It is suggested that such training could be offered in a web-based format that could be blended with other related training (e.g., infant safe sleep).*

- *CA should consider reaching out collaboratively with state law enforcement to support the introduction of new legislation that would require law enforcement officers to promptly notify CPS whenever a child is present or in close proximity to a situation involving domestic violence of a parent or caretaker, regardless of any observable harm to the child. Such notification could then be retained by CA in the statewide child welfare information system, FamLink. This would be similar to the efforts made in 2010 in enacting RCW 46.61.507, which requires law enforcement to notify CPS of DWI (Driving While Intoxicated) situations whereby a child is present and the operator of the vehicle is a parent, custodian, or caretaker.*

- *In referencing social worker monthly health and safety visits the committee recommends enhancement to the existing policy to include an outside perimeter assessment of a home. It was recommended CA could utilize information contained in the C-POD Guidelines (Collaboration, Preservation, Observation and Documentation) used by first responders when responding to child fatalities and serious physical injury cases. The observation component includes information on how to assess both the outdoor and indoor environment of a home/facility.*

Fatality Reviews Resulting in No Recommendations

A small number of fatality reviews issue no recommendations at all. However, this can be misleading, as in some cases, CA had already taken some kind of corrective action to address an identified problem. Therefore, the review committee recommended no further action. For example:

> In the review of the death of a four-month-old infant in which the sleeping environment was identified as a major concern,[43] the committee found that a CPS intake had been received just four weeks prior to the child's death. The intake had been screened for Alternate Intervention, and a letter was sent informing the parent about the referral and available community resources. Following the death of this child, the local DCFS office contracted with a public health nurse to respond to most intakes screened for Alternate Intervention. In addition, the office changed its practice related to all Alternate Intervention cases as follows:

[43] Executive Child Fatality Review, C.C.-W., reviewed on 4/23/2012.

1. Safe sleep education is given in all cases in which there is an infant in the family, regardless of the allegations in the intake.
2. Face to face contact will be made with all families for intakes that are screened in for Alternate Intervention.

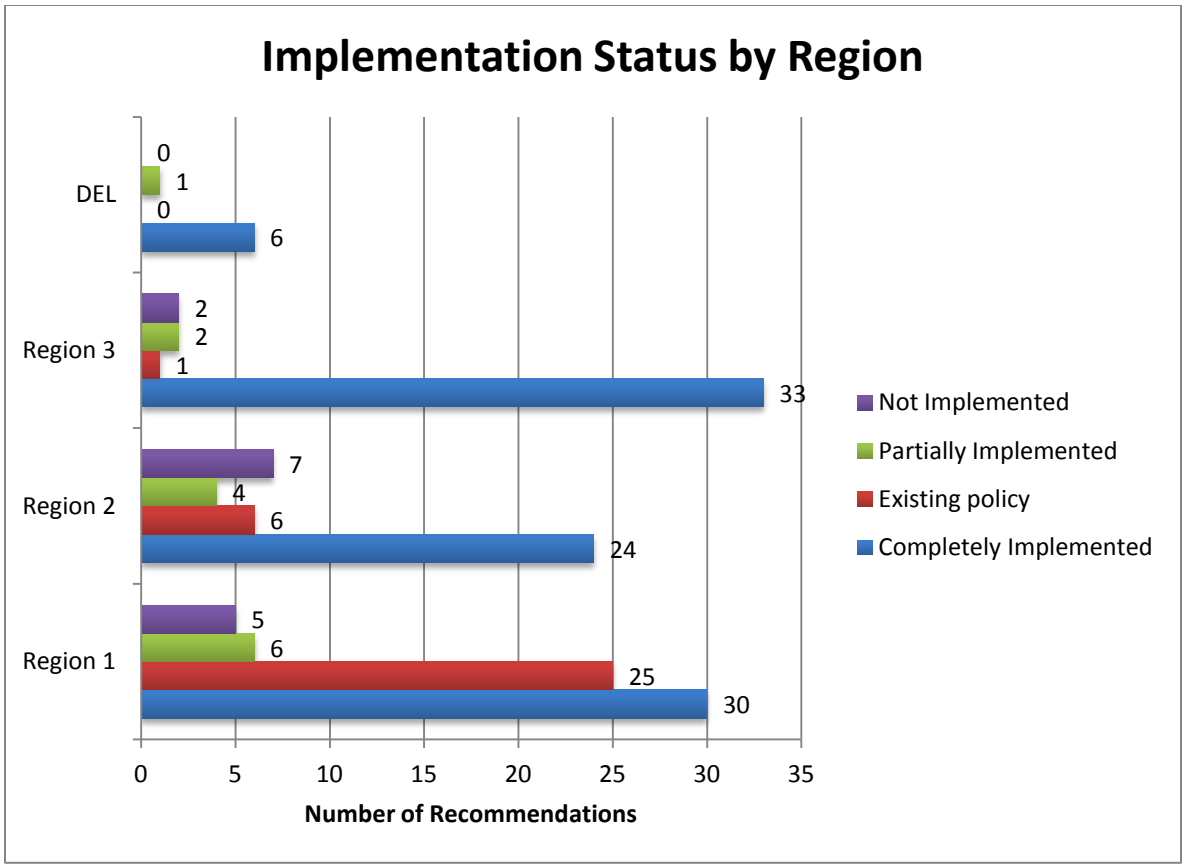
Timely corrective actions such as these may be attributable in part to the internal CA Critical Incident staffings initiated by the CA Assistant Secretary in January 2010. Case staffings with key local, regional and Headquarters staff, usually occur on the first business day following a child fatality or other critical incident.[44] The Ombudsman is routinely invited to attend these internal staffings, where important information and updates are shared. These staffings serve to discuss the incident, share information and assist in crisis intervention, as well as trouble-shoot any immediately identifiable problem areas in the agency's management of the case. It is worth bearing in mind, then, that the implementation of fatality recommendations does not fully capture all actions DSHS has taken in response to child fatalities.

B. Implementation Status by Region

For the purposes of this report, recommendations are reported by the region in which the fatality occurred. Even if a recommendation targets a statewide issue or recommends that action be taken statewide, the recommendation is still counted under the region from which the recommendation originated. The table below shows the *percent of fatalities reviewed* in each region, together with the *percent of fatality recommendations* coming out of that region.

Region	Percent of Fatalities Reviewed	Percent of Fatality Recommendations
1	35.5 %	43.5 %
2	28 %	31.5 %
3	36.5 %	25 %

[44] Critical incidents include fatalities, near-fatalities, and other critical incidents occurring in licensed foster homes or other facilities, or on open CA cases in general. Notifications are generated to key staff as well as to OFCO, via the AIRS reporting system.

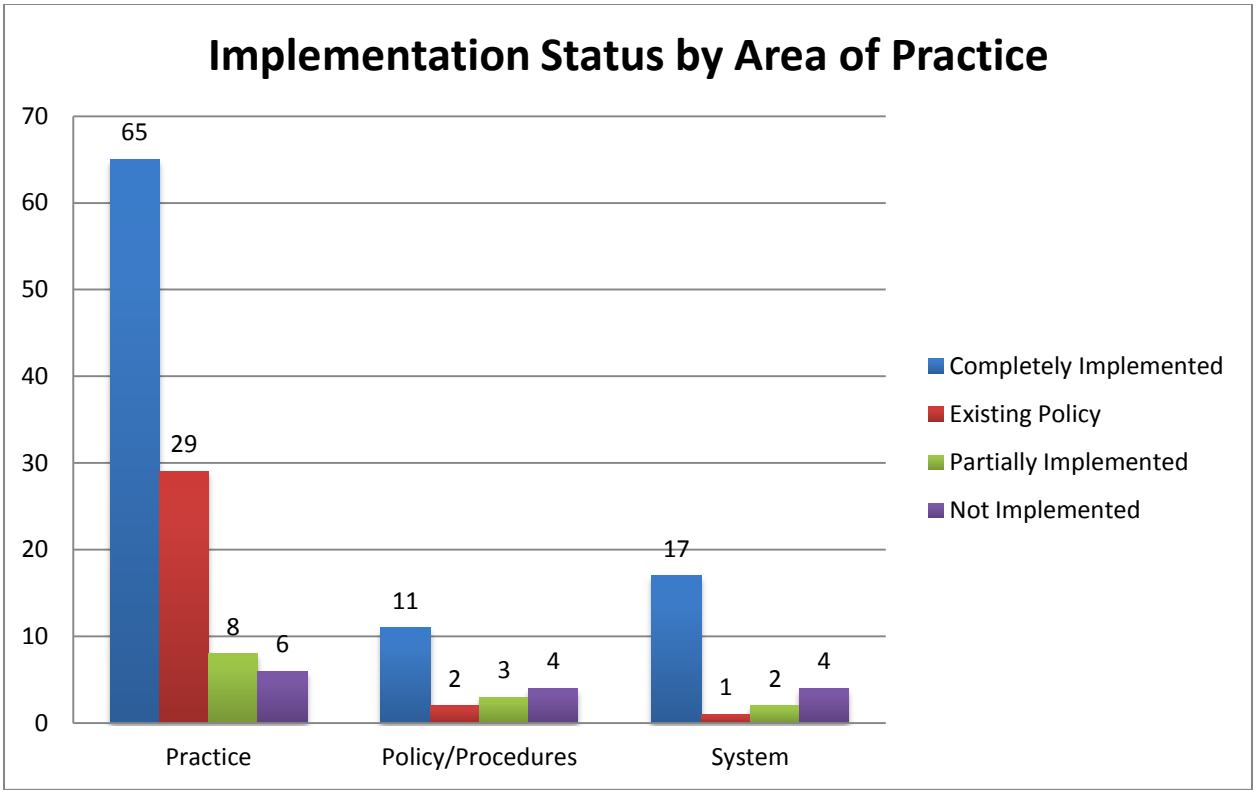


Source: Office of the Family and Children's Ombudsman, April 2013 based on analysis of DSHS CA responses

All three regions reported that implementation was complete on the majority of the recommendations. Region 3 had the highest rate of implementing its recommendations (87 percent), followed by Region 2 (58 percent), while Region 1 completely implemented less than half its fatality recommendations (45 percent). Region 1 also categorized the highest percentage of recommendations as representing existing policy (38 percent of the region's total recommendations). This may indicate that regional fatality review committees in Region 1 tended to make these kinds of recommendations more often than committees in other regions. Additionally, CA states that recommendations specific to Region 1 were implemented and that recommendations made in Region 1, but specific to the entire state were only implemented 45 percent of the time.[45]

[45] Written response from CA received by OFCO Director Meinig on June 17, 2013.

C. Implementation Status by Area of Practice

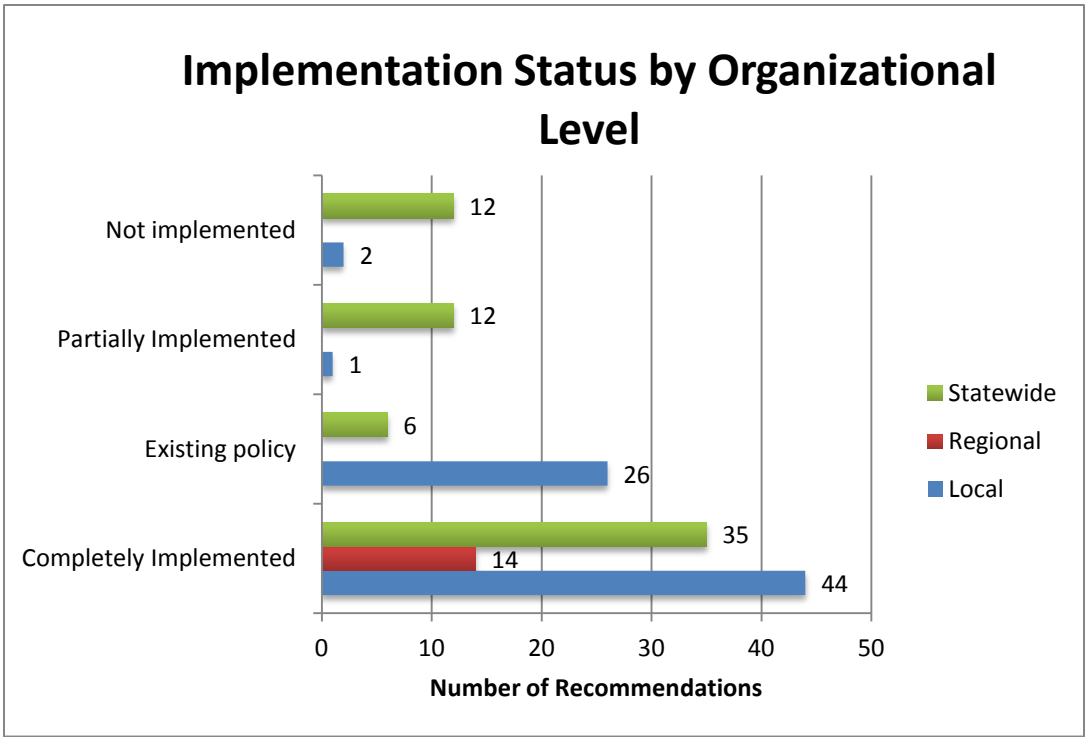


Source: Office of the Family and Children's Ombudsman, April 2013 based on analysis of DSHS CA responses

OFCO categorized each recommendation according to the type of change or area of practice targeted: change in practice; change in policy or procedures; or more widespread system-level change. The trend for the implementation of the various types of recommendations has remained quite consistent since 2005. Practice-level recommendations were both made and implemented at the highest rate—70 percent of the recommendations were directed at the practice level, and of those practice-level recommendations, not counting the recommendations representing existing policy, more than eight out of ten were completely implemented. Policy-level recommendations were made at a significantly higher rate in this reporting period compared to prior years— a full 13 percent (20 recommendations) addressed a need for a change in policy or procedures, compared to just four recommendations in the last reporting period. System-level recommendations were made slightly more often (16 percent of total recommendations) than those directed at the policy level, and considering the typical barriers to system-level change, were completely implemented at a very high rate (70 percent).

D. Implementation Status by Organizational Level

OFCO also looked at whether each recommendation was implemented at a local, regional or statewide level. Some recommendations may be aimed at statewide practice, but the region in which the fatality review occurred implements the recommendation on a regional level. Conversely, a recommendation targeted at a local office might be implemented at the regional or statewide level.



Source: Office of the Family and Children's Ombudsman, April 2013 based on analysis of DSHS CA responses

The above graph shows the implementation status of recommendations classified by each of the three organizational levels. Of the total number of recommendations that were completely or partially implemented, 43 percent were addressed at the local level, 44 percent at the statewide level, and only 13 percent at the regional level. The fact that a large percentage of fatality recommendations are having statewide impact is encouraging. Furthermore, when OFCO examined the locally implemented recommendations, most were aimed at addressing local practice concerns, which may not have been applicable statewide. Similarly, the fact that only a small number of recommendations were implemented at the regional level may indicate a more centralized approach taken by the agency in recent years to develop consistency in the regions and improve the system statewide. The following examples illustrate implementation of recommendations at the local, regional and state levels:

- **A local DCFS Office strengthens its partnership with a local Head Start Program and reinforces mandated reporter requirements.**

  Recommendation: [The review found that allegations of abuse had been reported by a Head Start program over 72 hours following the program learning of the abuse, and that the employee contacted the parent about the child's injuries prior to making the report.] *The mandatory reporting law requires notification to law enforcement or DSHS at the earliest opportunity but no later than 48 hours. The review committee* [recommended that] *the Area Administrator … review the Memorandum of Understanding between CA and Head Start* [and provide the Head Start staff with] *a refresher training related to mandated reporting.*

  CA Response: *The Area Administrator met with the Head Start counterpart, and mandated reporter training was provided for the Head Start staff.*

- **A region takes on educating CA staff about safe sleep environments.**

  Recommendation: *More education on safe sleep environments should be provided throughout DSHS's administrations, and for families served by the Children's Administration.*

  CA Response: *Safe sleep education was provided to the past and current CPS social workers working with this family by the regional Safety Program Manager. The Safety Program Manager invited the Director of the Northwest Infant Survival and Sudden Infant Death Syndrome (SIDS) Alliance to the next quarterly Intake, CPS and Family Voluntary Services (FVS) Supervisors' meeting to provide training on the topic of safe sleep environments.*

- **CA updates policy to improve health and well-being of medically fragile children in foster care, and provides training to assist in implementing the policy.**

  Recommendation: *Headquarters should review the current overcapacity approvals system so there aren't too many medically fragile children placed in one foster home. The Safety Program Manager will follow up with the Regional representatives at the upcoming Placement Coordinators statewide training to ensure the training includes information on the special considerations needed for medically fragile children. The Safety Program Manager will also ensure staff are trained about the updated Medically Fragile Child policy. The policy specifically directs staff to develop a caregiver support plan to ensure medically fragile children's day-to-day needs are met.*

  CA Response: *New policy regarding medically fragile children was implemented on May 31, 2011. See Practices & Procedures Manual #45171. CA staff have been trained on the new policy.*

This policy defines medically fragile children, specifies how their needs are to be assessed, and directs workers to develop a Caregiver Support Plan that addresses training and support needed by the caregiver to meet the child's needs, and a plan for respite and emergency care.

- **A recommendation to develop a statewide protocol is not implemented.**

  Recommendation: *The team recommended CA HQ staff create a protocol to address funeral expenses of both dependent and nondependent children when a child dies on an open CA case.*

  CA Response: *This decision is determined locally on a case-by-case basis.*

E. Recommendations for the Department of Early Learning

Seven of the 152 fatality recommendations stemmed from reviews of fatalities in child care facilities licensed through the DEL. DEL and DSHS have a service-level agreement that CA's DLR investigates allegations of child abuse or neglect in DEL licensed facilities. Although DSHS/CA conducted a fatality review[46] on any child death occurring in these facilities, recommendations regarding DEL practice and policy are beyond DSHS' authority. DEL participated in the fatality review in these cases, and OFCO contacted DEL for information regarding the implementation status of these seven recommendations. OFCO categorized **six of the seven recommendations** as being **completely implemented**, with one being partially implemented.

1. Recommendation: *The team recommended that Department of Early Learning (DEL) ensure their DEL website has information about safe sleep environments and Sudden Infant Death Syndrome (SIDS)/Sudden Unexpected Infant Death (SUID).*

   DEL Response: **Completely Implemented.** *A link is on our DEL website that goes to the National Institute of Child Health and Human Development regarding most up to date information on SIDS.*

2. Recommendation: *The team also recommended that the DEL newsletter provide [the above] information to providers.*

   DEL Response: **Completely Implemented.** *SIDS information has gone out to providers via our newsletter and DEL still discusses SIDS as part of orientations for new providers.*

3. Recommendation: *The DEL Northwest Area Service Manager should meet with local residential and referral agencies to discuss having them train daycare providers on the topic of Safe Sleeping and SIDS awareness.*

[46] CA no longer conducts child fatality reviews for DEL. See CA response to OFCO Director Meinig received June 17, 2013.

DEL Response: **Completely Implemented.** *This has been discussed with Child Care Aware.*[47]

4. Recommendation: *DEL should recommend that WAC 296.170.1360 define continual checks for napping infants in a day care setting as fifteen to twenty minute intervals.*

   DEL Response: **Partially Implemented.** *The referenced WAC was changed in March 2012 to a new WAC. A rule change as proposed would, however, require the state to open negotiations with Service Employees International Union according to RCW around family child care rules.*
   However, there is a specific section in current family home child care (referenced) that addresses reducing risk of SIDS 170-296a-7100 (effective March 31, 2012), one subsection states: "(5) Take steps so infants do not get too warm during sleep If a blanket is used, it must be lightweight and be placed no higher than the infant's chest with the infant's arms free; and…"
   It is also addressed in the Parent Policies subsection - SIDS 170-296a-2375 in items to be provided to the parent or guardian, "(15) If applicable, infant/toddler care including SIDS prevention, feeding, diapering and toilet training;…". [see caring for our children standard 3.1.4.1, safe sleep practices and SIDS/suffocation risk reduction].

5. Recommendation: *DEL should arrange with Deborah Robinson, a recognized expert in infant sleep safety, to provide training to licensors.*

   DEL Response: **Completely Implemented.** *Training on SIDS was provided to DEL licensing staff statewide.*

6. Recommendation: *DEL should consider adding a requirement that the room temperature for a sleeping infant should not exceed 68 degrees F.*

   DEL Response: **Completely Implemented.**

7. Recommendation: *DEL should inform licensing trainers about training resources on safe sleep environments and SUID prevention.*

   DEL Response: **Completely Implemented.** *DEL regularly updates our information on SIDS.*

[47] A statewide network of local child care resource and referral programs.

PART III: ANALYSIS OF SELECTED FATALITY RECOMMENDATIONS

The more specific and practical a recommendation is, the more successfully it can be implemented. The majority of reviews in this reporting period were conducted by regional fatality review teams rather than executive review committees.[48] OFCO found that many of the recommendations made in the regional reviews were worded as either a finding of the review or a work plan to address a finding, rather than a recommendation for possible further action. This may be in part due to the fact that the people with the power to implement the many recommended actions targeted at the local level were likely members of the review team and were able to instantly commit to a plan of action to remedy an identified problem. OFCO finds that the more recent executive reviews have yielded fewer, but more specific and effectively targeted recommendations. Nevertheless, a number of recommendations in this reporting period stood out as being particularly well-crafted or effectively targeted, and appeared to have a correspondingly effective implementation. Some examples are presented here. Of course, implementation of a recommendation does not necessarily result in improved practice or effective systemic change, let alone a reduction in child fatalities in the child welfare system.[49] Further study of related outcomes would provide helpful evaluation data to focus the agency's efforts to have the greatest impact on improving practice and systems.

A. Improved Collaboration and Casework Practice at the Local Level

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

CFR Recommendation[50]	CA Response
The fatality investigation found that the coroner had prematurely determined the cause and manner of death of a child to be natural (from a heart condition), until toxicology results were received showing lethal amounts of morphine in the child's body. The cause and manner of death were then amended.[51]	The County Coroner agreed that in the future, the cause and manner of death would not be released until any requested toxicology testing has been received. This new protocol was implemented with immediate effect.

[48] The reverse will be true for fatalities reviewed from 2012 onward due to the previously referenced statutory change in RCW 74.13.640 in mid-2011.
[49] For a discussion on the use of child fatality data and evaluating the effectiveness of child protective services, see the April 2013 edition of The Sounding Board: News and Reviews in Child Welfare by Dee Wilson, at http://deewilson.wordpress.com/.
[50] The recommendations and CA responses in this table are taken largely but not fully verbatim from Fatality Review reports and the CA document provided to OFCO regarding their implementation status.
[51] This is an example of a recommendation that is written as a finding in the Fatality Review report.

The lack of available chemical dependency professionals (CDPs) to social workers for consultation, intervention, and planning presents a significant void. Having CDPs out-stationed in local offices is best; one CDP for an entire region is not practical or realistic. The department should consider working with local county providers and setting up similar network meetings around the state.	County providers of services for chemically dependent clients have begun monthly meetings to address budget cuts, reduction in resources, and how to maximize existing resources.
[The] Area Administrator and Indian Child Welfare (ICW) Supervisor will develop a transfer checklist to ensure tribal worker receives pertinent case information when taking jurisdiction. [The local CA] office will identify a supervisor to assist the local tribe with the newly available read-only Famlink for tribal access.	The administrator and supervisor found that such a checklist already existed and the ICW unit began to use this. The supervisor also ensured there was a shared planning meeting or family team decision meeting before transferring cases to tribes. A supervisor was identified to assist the tribe with FamLink access, and headquarters staff also made themselves available to assist the tribes directly with this.
When CPS Supervisors are reviewing a CPS screened out intake involving a tribal family, they should communicate with a tribal case manager to ensure the intake should still screen out.	[The] Area Administrator addressed this topic at the next All Staff meeting, as well as with the Tribe. The topic was also addressed at the next CPS Supervisors meeting.
The review committee recommended that contact be made with [the local] Police Department by CA staff and offer to provide training regarding mandated reporting and provide them with phone numbers to call when a No Contact Order is violated and there is a child in the home.	The training was provided and contact information provided to the Police Department.
The Family Reconciliation Services worker was unfamiliar with working with military families and navigating military social services. Engagement with the family might have been improved had a worker familiar with military families been involved. It is recommended that [the region] develop a plan to improve the expertise of social work staff working with military families.	A plan to improve the expertise of social work staff working with military families was created.

B. Agency Misses the Intent of Some Recommendations

A few recommendations appeared to be thoughtful and well-intended but perhaps too unclear to be effectively implemented. CA's response regarding their implementation status seemed to miss the point of the recommendation. Two examples are presented here.

- In this example, the review committee recommends that the agency make follow-up calls to people who make child abuse reports, and provides specific reasons why this is good practice.

  Recommendation: *The committee found CA best practices include asking the referrer if they would like a call back regarding CA's decisions or actions on the information provided. The committee suggested that when call-backs to a referrer are completed the referrer may provide additional information or make subsequent calls of concern. Call-backs to referrers elicit support from referrers and the community in reporting child abuse and neglect.*

  CA Response: **Completely implemented.** *As of December 2, 2012, there was a new case note category [in FamLink] that allows the social worker to document "Contact-Referrer". This activity code already existed for intake; DLR/CPS and provider notes. Intake workers are able to mark a box on the intake form when the referrer requests a call back. Existing policy addressing this recommendation:*
  2331. Investigative Standards
  A. The assigned social worker must:
  Contact the referrer if the intake information is insufficient or unclear and may provide information about the outcome of the case to mandated referrers.

The agency's response describes only:
- How the assigned worker can document a call back to a referrer.
- The fact that the intake worker can mark a box IF the referrer asks for a call back, but does not say that the intake worker should inform the referrer that they have this option.
- Quotes the policy stating that workers can call referrers back *if* the information they reported is unclear.

A careful re-reading of the recommendation implies that the committee believed that calling referrers back regardless of whether they asked for a call back or whether the information they provided was clear or not, is the best practice. The agency's response, though reported as "completely implemented", does not indicate any change in practice or policy to call referrers back as a matter of course. OFCO re-categorized this recommendation as "partially implemented" as the agency is still not calling referrers back as a matter of course.

- In another example, OFCO concluded the recommendation for heightened collaboration between professionals goes beyond existing CA policies.

Recommendation: *Given the dynamics in this family the review committee found utilizing a multi-disciplinary team (MDT) decision making approach may have resulted in*

increased objective recognition and understanding of the family patterns. It is recommended when multiple agencies and service providers over time have worked or are working with a family or have referred them for intervention, CA convene a multi-disciplinary team. While the primary purpose may typically be to help team members resolve difficult cases, MDT teams may fulfill a variety of additional functions. They can promote coordination between agencies, provide a 'checks and balances' strategy to ensure the interests and rights of all concerned parties are addressed; and identify service gaps and breakdowns in coordination or communication between agencies or individuals. MDT's can enhance the professional skills and knowledge of individual team members by providing a forum for learning more about the strategies, resources, and approaches used by various disciplines.

CA Response: **Existing policy**. *CPT's are made up of a diverse group of professionals from multiple disciplines. They frequently have the same individuals as the local CPT's. In addition, the FTDM process brings together a group of professionals for the sole purpose of promoting coordination between agencies, providing a 'checks and balances' strategy to ensure the interests and rights of all concerned parties are addressed; and identify service gaps and breakdowns in coordination or communication between agencies or individuals.*

This case involved the death of a six-month-old infant, who was the seventh child born to the mother. The medical examiner attributed the infant's death to Unexpected Infant Death of Undetermined Cause and Manner. The family had a long history of CPS involvement, dating to the mother's childhood. One of the older children had died just over two years prior to the death of this infant. Four of the older children had a prior dependency, which was dismissed in the year preceding this infant's death. The family was difficult to engage in services, yet had been involved with multiple systems and providers over the years. OFCO's reading of the Fatality Review report indicated that due to the particularly troubled history and complex dynamics in this family, the review committee was recommending a higher level of interdisciplinary coordination and collaboration than may be typically sought in most cases.

The review committee clearly did not see an optimal level of collaboration, *despite* existing avenues and policy, and saw gaps in information-sharing as a result. Although four CPS referrals had been made since the premature birth of the subject child, the family had been difficult to contact and was unwilling to engage with the social worker. The findings of the fatality review suggest that a lack of collaboration with involved professionals prevented a more aggressive and timely response to concerns regarding the safety of the children. The committee noted that "this case could have benefited from a critical review and analysis of all information" available through, for example, "clinical supervision, case staffings, child protection teams and multidisciplinary team staffing."[52]

[52] Executive Fatality Review report, S.R., date of death 6/18/2011, reviewed on 9/23/2011.

C. Coordinated Response to Domestic Violence for Every Local Community

The following recommendation made by an Executive Fatality Review conducted in March 2011[53] was made almost two years after the introduction of the new policy mentioned by CA in its response. The review committee was probably aware that such a statewide policy exists, given the typical participants in an Executive Review, and it is likely that the review committee was referring to additional action the agency should take to ensure that the policy is being implemented in practice. The CA response does not give any indication as to how a coordinated response to domestic violence has been implemented in local communities, yet CA reported this recommendation as being completely implemented.

Recommendation: *Children's Administration (CA) should consider initiating the development of a Domestic Violence and Child Maltreatment coordinated response guideline for local communities similar to that of King County. Primary participants should include the judicial officers and other program staff in criminal and civil courts; law enforcement agencies; the Office of the Prosecuting Attorney; the Washington State Attorney General; Public Defender Agencies; and the DSHS/CA.*

CA Response: **Completely implemented.** *A statewide Domestic Violence and Maltreatment policy was implemented in July 2009.*

D. Safe Sleep Environment for Infants

Infants account for about half of all child fatalities, and the sleeping environment for infants continues to be a prevalent factor in causing infant deaths. While fatality recommendations continue to identify the need for community education about safe sleep practices, there were significantly fewer recommendations addressing this topic in this reporting period (eight recommendations) compared to the last reporting period (18 recommendations). This may be due to continued training efforts around the State to ensure that families with infants and the professionals involved with them are aware of the risk factors in bed-sharing and other unsafe sleep environments. OFCO has also noted good documentation by caseworkers that they have talked with families with infants about safe sleep environments.

[53] Review of S.M.-T.H., date of death 9/28/2010, reviewed on 3/25/2011.

PART IV: CONCLUSION

The implementation of child fatality recommendations has evolved since OFCO first reported on this topic in 2009. In our 2011 report, OFCO noted that few recommendations were implemented on a statewide level; in contrast, to date there have been several major law, policy and practice changes made in response to recommendations made by fatality review committees. The centralized fatality review process, recommended by OFCO in 2011 and that CA established in mid-2012 should improve the quality of reviews as well as the resulting recommendations. Most importantly, the process for transferring knowledge learned from fatality reviews to the field is improving every year, with the ongoing "Lessons Learned" trainings, to collaboration between the CA Critical Incident Case Review Specialists and the newly established Training Alliance for Child Welfare Excellence. One suggestion that OFCO made in 2011 that has not yet been implemented is to make the "Lessons Learned" training available on the intranet and accessible to all staff. We reiterate this practical and effective step in 2013.

The areas of progress noted in this report provide some affirmation regarding the important question of whether implementation of fatality recommendations actually improves casework practice or indeed, the child welfare system as a whole. Broader questions of how maltreatment–related child fatalities are counted[54] and reviewed, the outcomes of these reviews (i.e. the findings, recommendations, and their implementation), and whether this helps evaluate the overall effectiveness of our child protection system, could be the subject of a broader public policy study. The improvements underway in the fatality review process and record keeping about the findings and recommendations of these reviews, are steps in the right direction.

[54] See *How Effective is Child Protection? Part 1* in Sounding Board, op cit.

APPENDIX A

COMMON THEMES OF CHILD FATALITY RECOMMENDATIONS

The following tables show the issues addressed by specific recommendations within the nine main themes identified by OFCO in the recommendations.

RECOMMENDATION THEME 1: PROVIDE TRAINING

Training Topic	Target Participants	Number of Recommendations
Practice area:		
Domestic violence training	CA staff	4
Comprehensive improvements to CA Training Academy curriculum, including cross-training across DCFS functions, and improved supervisor training	CA staff	4
Intake screening	DCFS staff, tribal staff	2
Safety planning/risk assessment	DCFS staff	2
Resources for relative caregivers	CA staff	1
Premature infants	CA staff	1
Lessons learned from fatality reviews	CA staff	1
Refresher training on CPS investigations	CPS staff	1
Medication usage by foster parents	DLR staff	1
Child mental health, behavior management	CA staff, foster care providers	1
Safe Sleep, SIDS/SUID[55]	Child care providers, child care licensors, DLR staff	6
Mandated reporting of child maltreatment:		
Provide locally	Law enforcement officers, hospital staff, Head Start staff	3
Require annually	All mandated reporters	1
Technical training:		
Accessing database systems such as Barcode	CA staff	1
Searching for family history in FamLink	DCFS staff	1
Obtaining out-of-state CPS history	DCFS staff	1
Conducting a Diligent Search Process	CPS supervisors	2
Using the MODIS[56] system	DCFS staff	2

[55] Sudden Infant Death Syndrome/Sudden Unexpected Infant Death

Safety planning	Court officials	1
TOTAL		**36**

RECOMMENDATION THEME 2: CASEWORK PRACTICE

Area for improvement	Number of recommendations
Improve worker compliance with existing policy	8
Improve documentation	8
Improve case transfer process	3
Improve information sharing	1
Improve quality of monthly health and safety visits	1
Take corrective action to address poor practice by worker	4
Ensure effective supervision by supervisors	1
Take corrective action to address backlog of open inactive cases	1
Take corrective action to address mandated reporting requirement of CA staff	1
Convene multidisciplinary team staffings in complex cases	1
TOTAL	**29**

RECOMMENDATION THEME 3: PARTNERSHIPS WITH COMMUNITY PROFESSIONALS

Area Needing Strengthening	Participating Partners	Number of Recommendations
Coordinate efforts, collaborate	CA, Law enforcement	4
Coordinate and collaborate in domestic violence cases	CA, Law enforcement, DV professionals	2
Amend law to require Law enforcement to notify CPS when child is present in DV incident	CPS, Law enforcement	1
Co-locate domestic violence advocates in CA offices	CA, domestic violence advocates	1
Collaborate with schools in engaging families	CA, school staff	1
Collaborate with tribal judges to address child safety	CA, tribal court judges	1
Collaborate with chemical dependency providers to maximize limited resources	CA, chemical dependency providers	1
Consult with CPMC[57] to clarify physical abuse diagnoses	CA, CPMC consultants	1
Ensure collateral contacts by contracted service	CA, contracted service	

[56] Management Operations Document Imaging System, an electronic database used by CA to archive records.
[57] CA's contracted medical consultant group, Child Protection Medical Consultants.

providers	providers	2
Improve partnership with CPS referents	CA, child abuse reporters	1
Improve case transfer process to tribal child welfare workers	CA, tribal child welfare staff	1
Review protocols for coordination of CPS investigations with the military	CPS, military	1
Strengthen relationships with hospitals	CPS, Hospital staff	1
TOTAL		**18**

RECOMMENDATION THEME 4: EFFECTIVE CPS INVESTIGATIONS

Area for improvement	Number of recommendations
Take corrective action to address poor practice by worker	5
Complete investigations within timelines per policy	3
Follow existing policy re investigation procedures	2
Improve information gathering on family history	1
Increase staffing levels for foster home investigations	1
Make collateral contacts to verify information reported by family	1
Contact referrer for additional information	1
Take corrective action to address inaccurate records	1
Obtain photographic evidence in physical neglect cases	1
Other "good practice" recommendation	1
TOTAL	**17**

RECOMMENDATION THEME 5: SAFETY PLANNING AND RISK ASSESSMENT

Area for improvement	Number of recommendations
Use Child Protection Teams more effectively	4
Reassess/improve Structured Decision Making tool	3
Improve safety assessments of children in home	2
Conduct global assessment of safety	2
Improve quality of consultations with CPMC	1
Limit expungement of CPS records	1
Reassess policy re medication use by foster parents	1
Reassess risk at case closure	1
Share case history with service providers	1
Improve safety planning for medically fragile children	1
TOTAL	**17**

Recommendation Theme 6: Effective Interventions with Families

Intervention Type	Number of recommendations
Engage families in needed services	3
Reassess FRS program eligibility and services	1
Use assessment tools as directed by tool developer	1
Ensure referrals and access to needed services	1
Improve collaboration with service providers	1
Improve expertise of workers working with military families	1
Improve use of existing resources to serve chemically dependent clients	1
Other "good practice" recommendations	2
TOTAL	**11**

Recommendation Theme 7: Intake Screening Decisions

Area for improvement	Number of recommendations
Review screening decisions and develop consensus/consistency	4
Take corrective action to address incorrect screening decisions	1
Implement new policy regarding screening of referrals made by medical providers	1
Improve consistency of intake procedures for reports of fatalities	1
Reevaluate criteria for screening of FRS intakes	1
TOTAL	**8**

Recommendation Theme 8: Child Fatality Investigations and Reviews

Area for improvement	Number of recommendations
Increase CA access to autopsy and death scene investigation reports	2
Create intake following a child fatality	1
Improve fatality investigation protocol	1
Review child death notification protocol	1
Ensure access to expunged CPS records for child fatality reviews	1
Develop statewide protocol for covering funeral expenses of children in CA care	1
Improve support for CA staff impacted by a child fatality	1
TOTAL	**8**

RECOMMENDATION THEME 9: EDUCATION, SERVICES, AND OTHER RECOMMENDATIONS

Service/Education Needed	Target population	Number of Recommendations
Provide education about safe sleep environments/SUID	Child care providers, consumers	2
Increase public health services	Families in child welfare system	1
Increase level of services for medically vulnerable children	Medically vulnerable children & caregivers	1
Strengthen mandated reporting law	Mandated reporters of child maltreatment	1
Strengthen legal protection of medically fragile, legally free children	Medically fragile, legally free children	1
Increase frequency of checks on napping infants in child care facilities	Child care providers	1
Amend DEL licensing requirements to promote safe sleep environments for infants	Child care providers	1
TOTAL		**8**