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

Patterns in Mandated Reporter Referrals 2006-2008

2SSB 6206 — Chapter 211, Sec. 6, Laws of 2008

Office of the Family and Children's Ombudsman
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www.governor.wa.gov/ofco
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I. Background

A. Federal and State Law

Every state, including Washington, has enacted a mandatory child abuse and neglect reporting law.[1] This qualifies states for Federal funding under the Child Abuse Prevention and Treatment Act (CAPTA), 42 U.S.C. 5101, et seq.,[2] a law designed to assist states in preventing, investigating, treating, and prosecuting child abuse and neglect.

RCW 26.44.030 requires designated professionals to report[3] to law enforcement or the Department of Social and Health Services (DSHS) if they have "reasonable cause to believe that a child has suffered abuse or neglect."[4] "Abuse or neglect" means "sexual abuse, sexual exploitation, or injury of a child by any person under circumstances which cause harm to the child's health, welfare, or safety, excluding conduct permitted under RCW 9A.16.100[5]; or the negligent treatment or maltreatment of a child by a person responsible for or providing care to the child."[6] State law defines "Negligent treatment or maltreatment" as "an act or a failure to act, or the cumulative effects of a pattern of conduct, behavior, or inaction, that evidences a serious disregard of consequences of such magnitude as to constitute a clear and present danger to a child's health, welfare, or safety, including but not limited to conduct prohibited under RCW 9A.42.100.[7] When considering whether a clear and present danger exists, evidence of a parent's substance abuse as a contributing factor to negligent treatment or maltreatment shall be given great weight. . . ."[8]

[1] RCW 26.44.030.
[2] CAPTA was amended and reauthorized in 2003 by the Keeping Children and Families Safe Act of 2003 (P.L. 108-36). See http://dc.mandatedreporter.org/pages/docs/About-CAPTA.pdf
[3] Throughout this report, OFCO uses the terms "referent" and "reporter" interchangeably to refer to individuals making a referral or report to CPS alleging concerns of child abuse or neglect.
[4] RCW 26.44.030(1)(a). Non-mandated reporters, such as a neighbor or relative, may make a referral if they have reasonable cause to believe a child has suffered abuse or neglect. RCW 26.44.030(3).
[5]RCW 9A.16.100 provides that: "the physical discipline of a child is not unlawful when it is reasonable and moderate and is inflicted by a parent, teacher, or guardian for purposes of restraining or correcting the child. Any use of force on a child by any other person is unlawful unless it is reasonable and moderate and is authorized in advance by the child's parent or guardian for purposes of restraining or correcting the child." RCW 9A.16.100 also sets forth use of force presumed unreasonable: "(1) Throwing, kicking, burning, or cutting a child; (2) striking a child with a closed fist; (3) shaking a child under age three; (4) interfering with a child's breathing; (5) threatening a child with a deadly weapon; or (6) doing any other act that is likely to cause and which does cause bodily harm greater than transient pain or minor temporary marks. The age, size, and condition of the child and the location of the injury shall be considered when determining whether the bodily harm is reasonable or moderate. This list is illustrative of unreasonable actions and is not intended to be exclusive."
[6] 26.44.020(12); WAC 388-15-009.
[7] RCW 9A.42.100 provides that "[a] person is guilty of the crime of endangerment with a controlled substance if the person knowingly or intentionally permits a dependent child or dependent adult to be exposed to, ingest, inhale, or have contact with methamphetamine or ephedrine, pseudoephedrine, or anhydrous ammonia, including their salts, isomers, and salts of isomers, that are being used in the manufacture of methamphetamine, including its salts, isomers, and salts of isomers. Endangerment with a controlled substance is a class B felony."
[8] RCW 26.44.020(15).

B. LEGISLATIVE HISTORY OF 2SSB 6206 IN RELATION TO THE OFFICE OF FAMILY AND CHILDREN'S OMBUDSMAN

In 2007 and 2008, the Office of the Family and Children's Ombudsman (OFCO) engaged in a series of informal conversations with legislators and staff about the current mandated reporter law and what we viewed as some potential areas that needed further assessment and possible strengthening. These conversations ranged from the need to designate guardians ad litems as mandated reporters[9], the need for improved training of mandated reporters, possible barriers to persons reporting, to concerns about referrals from mandated reporters being screened out from investigation.

The issues OFCO brought to the attention of legislators arose, in part, from our investigative work on complaints from citizens. In OFCO's 2007 & 2008 Annual Report, we made 13 adverse findings of failure by DSHS Children's Administration (CA) to screen in a CPS referral for investigation or other screening errors.[10] These findings included failure to screen in referrals from mandated reporters, but also included referrals from non-mandated reporters. The following example provides OFCO's investigative findings on a complaint alleging failure to investigate a report from a mandated reporter:[11]

> CPS failed to screen in a referral for investigation from a mandated reporter alleging physical abuse of an 11-year-old non-dependent child by the parent. The Ombudsman found that the referral was poorly documented (the referent reported providing a good deal more information than was documented), but even so could have been screened in for investigation based on the allegations as well as the chronic history of similar referrals. A new referral from a different mandated reporter was then screened in for investigation after the child reported being hit with a belt causing a welt on his back. OFCO reviewed the investigation on the new referral, and found the child had been seen and interviewed four days after the referral had come in. This was a violation of policy; and by that time, the "red 5 - inch welt" described by the referent was a faint mark. CPS was preparing to close the investigation. OFCO determined that the agency should gather more information to better assess the child's need for protection, given the family's history of CPS involvement. **After OFCO intervention, CPS arranged a Family Team Decision Making Meeting and the parent agreed to multiple services, including wraparound services in the home.**

More recently, in the context of investigating a complaint on a different issue in a dependency case, OFCO had concerns about CPS screening out the following referral[12] from a mandated reporter as "information only": [13]

[9] In 2008, OFCO participated in a workgroup convened by Senator Debbie Regala to examine issues related to CASAs and GALS under title 13 (dependency) cases and title 26 (family court) cases. In 2009, the legislature passed SSB 5285 (whose original primary sponsor was Senator Regala) designating CASAs and GALs as mandated reporters. RCW 26.44.030(1)(e)(Effective 07/26/09).

[10] OFCO 2007 & 2008 Annual Report at p. 20. See http://www.governor.wa.gov/ofco/reports/ofco_07-08_annual.pdf

[11] OFCO 2007 & 2008 Annual Report at p. 28. See http://www.governor.wa.gov/ofco/reports/ofco_07-08_annual.pdf

[12] OFCO requested an explanation from DSHS CA about its screening decision rationale. In a 07/16/09 conversation between OFCO and the CA Kelso Area Administrator (AA), CA asserted that that the referral was appropriately screened out pursuant to the policy in effect at the time the referral was received in July 2008. The AA stated that since the implementation of FamLink, CA's new computerized database, in February 2009 (see fn 35), CA has a "risk only" option for screening intakes, and this referral would now

Mother delivered a baby and her urinalysis tested positive for METH. The referent stated that the mother did not receive any prenatal care and 'she lost three other children to CPS' . . . The referent indicated that the child's behaviors are jittery, irritable with high-pitched screams, and fussy. Prior to this referral, the mother had a FOUNDED finding . . . for Physical Neglect. The referent stated that the mother and father have substance abuse histories (METH). The mother's last address listed was homeless.

In follow up calls from referent to the CPS intake unit, referent reported that the urinalysis results for the baby are positive for METH. . . 'the doctor was surprised that CPS was not going to get involved.' Referent also reported that the mother did not know her address, did not have a phone, a car or car seat, but says she does not need a car seat and that she plans to walk to appointments. The referent stated 'we are all worried about this baby' and do not understand why CPS is not opening a case**.**

CPS did not screen in this referral for investigation.

During the 2008 Washington State legislative session, Senator Zarelli and other legislators sponsored legislation (2SSB 6206) in response to a variety of concerns including OFCO's interest in further study of DSHS CA's handling of CPS referrals. 2SSB 6206 became Chapter 211, Sec. 6, Laws of 2008, effective June 12, 2008 (hereafter referred to as "2SSB 6206"). This report fulfills OFCO's reporting requirements under 2SSB 6206. It requires OFCO to:

- Analyze a random sampling of child abuse and neglect referrals made by mandated reporters to the Children's Administration during 2006 and 2007 and report the results to the Legislature no later than June 30, 2009.
- Include in the report:
    - The number and type of referrals,
    - The disposition of each referral by category of mandated reporter,
    - Any patterns established by DSHS in how it handled the referrals,
    - Whether the history of deaths in 2006 and 2007 showed referrals by mandated reporters and any other information OFCO deems relevant.

screen in as "risk only" based on the family's history including parents' drug use, prior termination of parental rights, and the mother's homeless status. See DSHS CA Practices and Procedures Guide, Chapter 2552. Intakes on Newborns Identified by a Medical Practitioner as Substance Exposed and/or Substance Affected Newborns by Substances (Not Medically Prescribed) or Has Withdrawal Symptoms Resulting from Prenatal Substance Exposure. See http://www.dshs.wa.gov/ca/pubs/mnl_pnpg/chapter2_2500.asp

[13] Significant portions of the allegations text are verbatim. Some text has been edited to delete identifying information or shorten the text without altering the meaning or context of the referral.

II. Scope of Review

A. Analysis of Child Abuse and Neglect Referrals

2SSB 6206 provides that OFCO may contract to have all or some of these tasks completed by an outside entity. OFCO contracted with the Washington State Institute for Public Policy (WSIPP)[14] to analyze child abuse and neglect referrals from mandated reporters and the outcomes of these referrals.[15] Due to WSIPP's analytical capacity, it was able to broaden its analysis beyond the "*random sampling of child abuse and neglect referrals made by mandated reporters to the Children's Administration during 2006 and 2007"* required by 2SSB 6206. WSIPP analyzed 96,000 referrals received by CPS between January 2006 and February 2008. This represents virtually **all** referrals received by the agency over this time period, not merely a random sampling from mandated reporters.

WSIPP examined the significance of referral outcomes by referent type. The results of WSIPP's analysis, analytical approach, and methodology are set forth in the section of this report entitled: **Outcomes of Referrals to Child Protective Services: Comparing Reporters (WSIPP).**

B. Presence of Mandated Reporter Referrals in Child Deaths

In compliance with 2SSB 6206, OFCO examined whether there were mandated reporter referrals present in the history of the caretakers of 241 children who died in 2006, 2007, and 2008 (2008 is one year beyond the required scope of 2SSB 6206) by collecting and analyzing additional data as part of its routine review of child fatalities.[16] These 241 children met OFCO's criteria for review[17], which means that they were either in the care of, or had received child welfare services[18] from, DSHS CA within one year of their death, or died while in state-licensed care. When OFCO receives notice of a

[14] The Washington Legislature established WSIPP in 1983 to provide non-partisan research at legislative request. http://www.wsipp.wa.gov/

[15] WSIPP analyzed data from the Children's Administration Management Information System.

[16] OFCO receives notice of child deaths known to DSHS from an automated critical incident notifier via e-mail from the Children's Administration's Administrative Incident Reporting System (AIRS) and reviews these fatalities. Prior to January 2009, OFCO received notification of fatalities and critical incidents via a CAMIS alert. 2SSB 6206 also requires CA to notify OFCO of near fatalities and of cases with three founded findings within the last 12 months and provide the disposition. According to DSHS CA, "the Headquarters CPS Program Manager will track these cases and notify OFCO until FamLink (Release 2) provides automatic notification. OFCO has been receiving required notification of cases with three founded findings. See http://www.dshs.wa.gov/ca/pubs/mnl_pnpg/chapter2_2500.asp

[17] To put the 241 child deaths reviewed by OFCO in the context of total child deaths in Washington State, there were 831 child deaths aged 0-19 in 2006 and 821 deaths in 2007. 2008 figures are not yet available publicly. Also note that the overall deaths reported by the Department of Health include children up to age 19 (one year beyond the age range examined by OFCO). http://www.doh.wa.gov/EHSPHL/CHS/chs-data/death/dea_VD.htm Mortality Table B2. Autopsy by Age and Manner of Death for Residents, 2007.

[18] This refers to the child and/or the child's family receiving services from DSHS CA.

child death known to DSHS CA, it reviews the child welfare case and circumstances of the death and then records the death in an internal database if OFCO's criteria for review are met.[19]

OFCO paid particular attention to whether the referral history included referrals from mandated reporters within one year of the child's death; and also to DSHS CA's screening decision made on the last referral the agency received (regardless of reporter type) prior to the child's death.

OFCO does not draw conclusions in this report as to whether investigation of the screened out ("information only") referrals by DSHS CA would have made a difference in the survival of a child. Although this is an obvious question to ask, it is a highly speculative and emotionally charged question with too many unknown factors to answer. However, Section VII of our report features excerpts from 11 child death cases in which the last referral received by DSHS CA (prior to the child's death) was screened as "information only" (see section: Child Fatality Reviews, page 33). These are included to provide readers with a view of the landscape of "information only" referrals that were screened out by DSHS CA. It may give readers a sense of the enormity of the task and the responsibility involved in making appropriate screening decisions.

[19] OFCO attempts to reconcile the fatalities it records in its database with CA's records. Sometimes there is a discrepancy between the number of child fatalities due to a variety of factors. For example, OFCO includes in its database expected deaths of children (e.g. a child with a terminal illness), while CA typically does not, if they meet our criteria. i.e. they were in the care of, or receiving child welfare services from DSHS CA within one year of their death, or died while in state licensed care.

III. Child Protective Services Screening of Referrals

A. A Referral Must Meet Sufficiency Criteria to Screen in for Agency Intervention

When Child Protective Services (CPS)[20] receives a referral, it evaluates whether to screen it in for investigation. CPS intake workers use assessment tools to evaluate the level of risk presented by the referral and determine the appropriate agency response. The agency's referral assessment process has changed over time. As discussed, this report examines referrals from 2006 through 2008. In 2006, CPS intake workers used a standardized CPS intake risk assessment procedure, which is part of the Washington Risk Assessment model. In determining whether a referral could be "accepted" for agency action, it needed to meet the CPS sufficiency screen.

This consisted of four questions:

1. Can the child be located?
2. Is the alleged subject the parent/caregiver of the child?
3. Does the allegation of child abuse or neglect meet the legal definition?
4. Do risk factors exist that place the child in serious and immediate harm? [21]

If a referral met the sufficiency criteria, then it was assigned a risk tag based upon how serious the allegations of abuse or neglect were[22], which determined the agency's investigative response.[23] If the referral did not meet the threshold for sufficiency criteria for intervention by CPS, then it was categorized as "information only," which means the referral would not be investigated by CPS.

DSHS CA has further modified its CPS intake process. The current CPS sufficiency screen[24] consists of three criteria, all of which must be met, to screen in a referral for agency intervention: 1) the victim is under age 18; 2) if the allegation were true, it would minimally meet the WAC definition[25] of child abuse or neglect; and 3) the alleged subject has the role of parent/caregiver,[26] acts in loco parentis,[27] or is unknown.

[20] Child Protective Services (CPS) is the agency within DSHS CA responsible for receiving and assessing child abuse and neglect referrals/reports.

[21] A referral met the sufficiency screen if questions one, two, and three are answered "yes"; questions one, two and four are answered "yes"; or all four questions are answered "yes."

[22] According to Christine Robinson, former Acting Director of CA Division of Program and Practice Improvement, CPS also considered the factor of "the likelihood of repeat maltreatment" in screening decisions.

[23] Risk tags from "0" (no risk) to "5" (high risk) were assigned to referrals. Depending upon the risk tag, this determined the investigative standard and triggered varying response times by CPS. A referral with a risk tag of 3 or above was accepted for investigation.

[24] See Children's Administration Practice Guide to Intake and Investigative Assessment. See also DSHS CA Practices and Procedure Guide. Chapter 2500 (includes Investigative Assessment) at http://www.dshs.wa.gov/ca/pubs/mnl_pnpg/chapter2_2500.asp

[25] WAC 388-15-011

B. ALL SCREENING DECISIONS ARE REVIEWED BY A CPS INTAKE SUPERVISOR

All screening decisions continue to be reviewed by an intake supervisor. The role of the supervisor is to ensure that all intake screening decisions are appropriate; that referrals are sent to law enforcement that involve physical injury, sexual abuse, death or other crimes against children; that a family's intake history is reviewed for patterns; and that on all referrals that are screened out but indicate "chronicity"[28], that the history is carefully reviewed to determine if cumulative harm exists and to assess whether it is necessary to make additional calls back to the referent or other collateral contacts to make a final screening decision.[29]

C. PRE-NATAL REFERRALS ARE AUTOMATICALLY SCREENED OUT

In addition to needing to meet sufficiency screening criteria to warrant intervention, there are other factors that may affect whether a referral is screened in for agency response.[30] For example, CPS automatically screens out pre-natal referrals. State law does not specifically authorize DSHS CA to screen in a referral or initiate court action on an unborn child.[31] Consequently, if DSHS CA receives a referral alleging substance abuse by a pregnant woman, the agency documents this information and may make a referral to First Step services.[32]

[26] Thus, if a "third party" (i.e. a non-parent/non-caregiver)(e.g. a neighbor who was not given permission to care for the child) is identified as the perpetrator, this would be screened out for investigation.
[27] This includes persons providing care for a child in a facility licensed by DSHS or the Department of Early Learning such as a licensed foster parent, child care provider, or group home.
[28]Research supports the importance of identifying families that have a CPS history when making intake decisions and assessing caregiver risk to the child. In Famlink, there is a "chronicity indicator" that is automatically checked when a participant in a case meets the following criteria: 1) 3 accepted CPS or DLR/CPS intakes (i.e. referrals) in the prior year; 2) 4 accepted CPS or DLR/CPS intakes in the prior 2 years; 3) 5 accepted CPS or DLR/CPS intakes in the prior 3 years; or 4) 2 or more founded allegations in the past 2-6 CPS referrals.
[29]For additional information on CPS intake supervisor's duties, including authority to change screening decisions, see DSHS CA Practices and Procedures Guide, Chapter 2220, Guidelines. http://www.dshs.wa.gov/ca/pubs/mnl_pnpg/chapter2.asp
[30] Agency response means investigation of the referral or referral to the Alternate Response System so that families can be provided community services to address their problems.
[31] See RCW 26.44.020 for pertinent definitions related to dependency law and reporting of abuse and neglect. RCW 26.44.020 (6) defines "child" or "children" as "any person under the age of eighteen years of age." See also RCW 74.13.020, which pertains to providing child welfare services. "[C]hild" means a "person less than 18 years of age."
[32] First Steps is a program that assists low-income pregnant women get health and social services to help themselves and their baby. Women qualify once they are pregnant. For a summary of state laws (current through August 2006), that address the issue of substance abuse by parents in relation to causing harm to children, see http://www.childwelfare.gov/systemwide/laws_policies/statutes/drugexposedall.pdf

D. TRANSITION TO FAMLINK

In February 2009, DSHS Children's Administration (CA) transitioned from its former case management system (CAMIS) to FamLink.[33] CA has implemented further changes to the intake process. Instead of assigning a risk rating to a referral as was done previously, workers answer a series of questions on the "Intake Decision Tree matrix", which guides intake staff in determining the response time and program that will respond to a screened in referral. OFCO anticipates that screening of referrals will be affected by the transition to FamLink. The referrals reviewed in this report by both OFCO and WSIPP were referrals that were received by CA prior to implementation of FamLink.

E. NEW LAW PURGING RECORDS

Effective, October 2008, new law went into effect providing that DSHS will destroy all of its records concerning:

1. A screened-out report,[34] within three years from the receipt of the report; and
2. An unfounded or inconclusive report, within six years of completion of the investigation, unless a prior or subsequent founded report has been received regarding the child who is the subject of the report, a sibling or half-sibling of the child, or a parent, guardian, or legal custodian of the child, before the records are destroyed.

RCW 26.44.031(2) (a) & (b)

This new law could have implications for reviewing child fatalities, if record purging has occurred or is occurring simultaneous with a case file review of a child who has died. Access to full and accurate information could be compromised if prior referrals are purged from the DSHS CA data base. OFCO has recently made DSHS CA aware of some of its concerns about information being deleted from the agency's computerized database on child deaths that OFCO has reviewed. DSHS CA is looking into this issue further at OFCO's request and it is premature to address this in any greater detail here.

[33] http://www.dshs.wa.gov/ca/about/imp_famlink.asp
[34] i.e. an "information only" referral.

IV. Outcomes of Referrals to Child Protective Services: Comparing Reporters (WSIPP)

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OUTCOMES OF REFERRALS TO CHILD PROTECTIVE SERVICES: COMPARING REPORTERS

Background

State law requires certain professions to report to the Department of Social and Health Services (DSHS) Child Protective Services (CPS) suspected child abuse and neglect.[1] The Children's Administration database sorts these mandated reporters into the following categories:

- Corrections personnel
- DSHS employees
- Medical professionals
- Law enforcement
- Mental health professionals
- Foster care providers
- Social service professionals
- Educators
- Child care providers

Reports are also received from non-mandated reporters who may be neighbors, relatives, or other citizens, including persons choosing to remain anonymous.

In 2008, the legislature required a study of the outcomes of these child abuse and neglect reports.[2] Legislators wanted to know whether the source of the referral influenced the response by CPS at DSHS' Children's Administration.

Suggested citation: Marna Miller (2009). *Outcomes of referrals to Child Protective Services: Comparing reporters.* Olympia: Washington State Institute for Public Policy, Document Number 09-06-3901.

[1] RCW 26.44.030.
[2] 2SSB 6206, Chapter 211, Laws of 2008.

Summary

In 2008, the Legislature directed the Office of the Family and Children's Ombudsman (OFCO) to analyze referrals of child abuse and neglect to find out whether the source of the referral influenced the response by the Child Protective Service at the Department of Social and Health Services (DSHS).

OFCO contracted with the Washington State Institute for Public Policy to perform the study. A total of 96,000 referrals made between January 2006 and February 2008 were examined.

State law requires certain professions to report suspected child abuse or neglect. The data system at DSHS sorts these professionals into nine categories: corrections personnel, DSHS employees, medical professionals, law enforcement personnel, mental health professionals, foster care providers, social service professionals, educators, and child care providers. Referrals also come from friends, neighbors, and other citizens who are not mandatory reporters.

The study found that educators and social services professionals make more reports to CPS than other types of reporters. This is true nationally as well as in Washington.

The study also found variations in the outcomes of referrals from the various types of reporters. The proportion of referrals accepted for investigation ranged from 47 percent for mental health professionals to 69 percent for law enforcement. Referrals from law enforcement were both more likely to be accepted for investigation, and result in removal of a child from his or her home.

The largest variation in outcomes, however, was not determined by reporter type. Rather, DSHS region and the history of the individual intake worker were the stronger predictors of the initial risk assigned to a referral. Intake workers with a history of assigning higher levels of risk than their peers (which results in investigation and intervention) were more likely to continue to assign higher levels of risk.

It is possible that this phenomenon may have changed since February 2009, when Children's Administration modified its intake procedures. Further analysis would be necessary to learn whether the new procedures have changed the worker and regional variations we observe here.

The study assignment is set out in 2SSB 6206:

> *The ombudsman shall analyze a random sampling of referrals made by mandated reporters during 2006 and 2007 and report to the appropriate committees of the legislature on the following: The number and types of referrals from mandated reporters; the disposition of the referrals by category of mandated reporters; how many referrals resulted in the filing of dependency actions; any patterns established by the department in how it dealt with such referrals; whether the history of fatalities in 2006 and 2007 showed referrals by mandated reporters; and any other information the ombudsman deems relevant. The ombudsman may contract for all or a portion of the tasks essential to completing the analysis and report required under this section. The report is due no later than June 30, 2009.*

The Office of the Family and Children's Ombudsman contracted with the Washington State Institute for Public Policy (Institute) for this research and analysis. Because the Institute has the analytical capacity to do so, all referrals during the period of interest were studied rather than a random sample.

The analysis focused on referrals and subsequent outcomes. Exhibit 1 shows a generalized series of events that may ensue when a report is made to CPS. When a referral is made to CPS, the intake worker gathers information and, based on that information, referrals are placed in one of the following five decision categories:

1) ***Third Party Report.*** Referrals are assigned to this category if the alleged abuser is not the parent or legal guardian. Such cases must be referred to law enforcement by CPS.

2) ***Information Only.*** If the report does not meet the threshold for any intervention, the report is categorized as "information only."

Referrals not categorized as Third Party or Information Only are assigned a risk tag, ranging from zero (no risk) to 5 (very high risk). Based on risk, a referral may be:

3) ***Low risk.*** In cases of low risk, caregivers generally receive a letter or phone call from the department that may state the concern about care giving, cite law, and/or provide referrals to contracted or community resources, if available.

4) ***Referred to Alternative Response Services (ARS).*** If a report indicates that there is a problem that can be solved outside the child protection system, it is referred to a community service provider that may provide public health services, counseling, or other family services, if available.

5) ***Accepted.*** If a report warrants CPS investigation, it is "accepted."

Based on the CPS investigation, the social worker may have the child removed from home. If DSHS intends to keep the child out of the home, it must either obtain a voluntary placement agreement signed by the child's parents or legal custodian, or obtain a court order supported by a dependency petition and other documentation alleging that the child is dependent and is at risk of imminent harm. A shelter care hearing must be held within three business days of removing the child to determine the ongoing need for state custody and out-of-home placement. In most cases, the child is declared dependent, which grants the state control, custody, and supervision of the child, until the parents can correct the conditions in the home that resulted in removal.

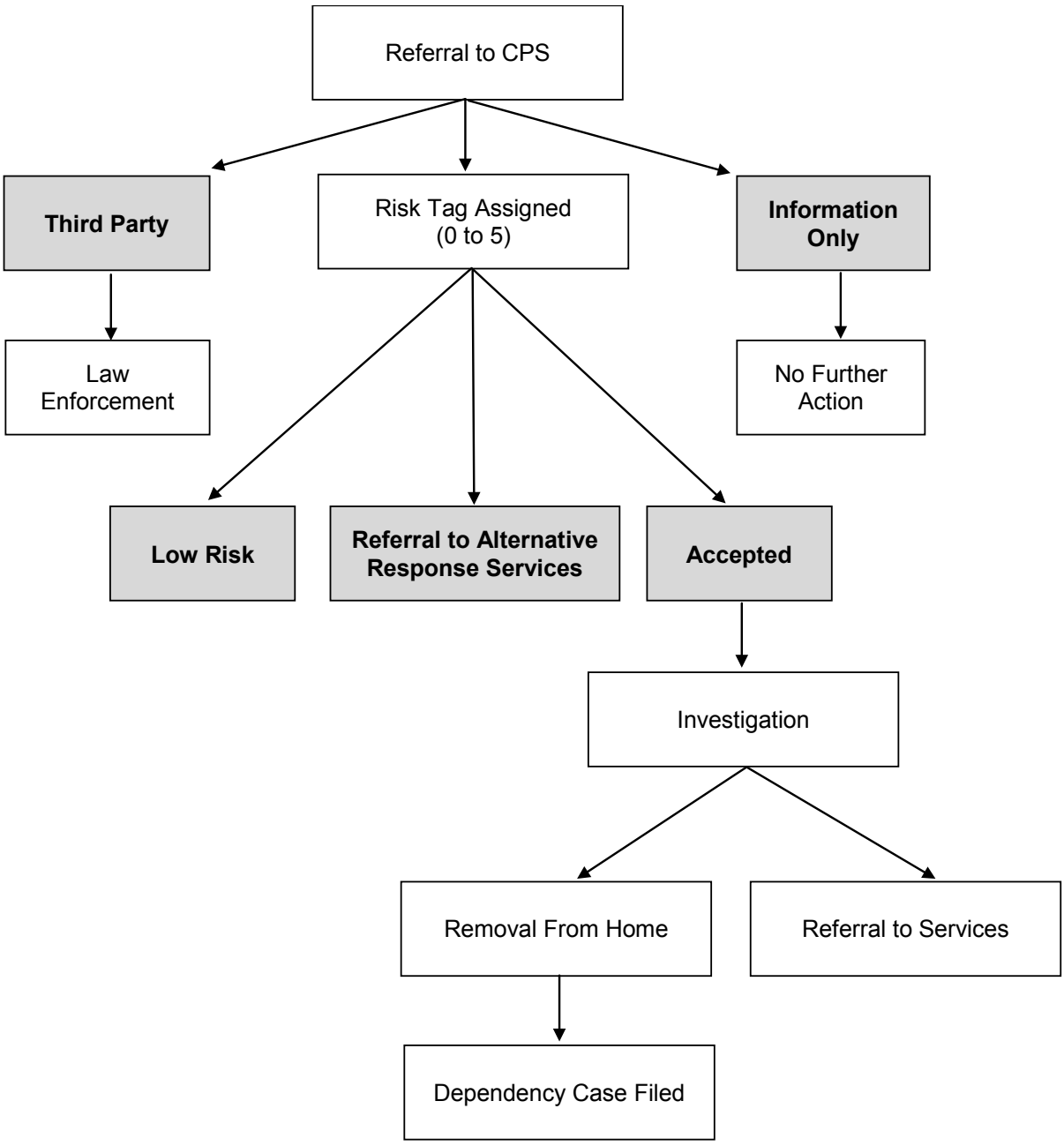
In this report, we focused on outcomes of the 96,000 referrals to CPS filed between January 2006 and February 2008.[3] Filings for dependencies in Washington's Superior Courts were examined, for referrals filed between January 2006 and November 2006.[4]

The following outcomes were examined:

- The intake decision (for example, was the referral accepted?)
- Was the child removed from home?
- Was a dependency petition filed in court?

[3] More than one child may be included on a referral to CPS. In this study, the referral was the unit of the analysis.
[4] We excluded referrals after November 2006, because we found that legal data in the Children's Administration data system were incomplete after that date.

Exhibit 1
Possible Outcomes of Referrals to Washington State Child Protective Services



Note: Shaded boxes indicate intake decisions.

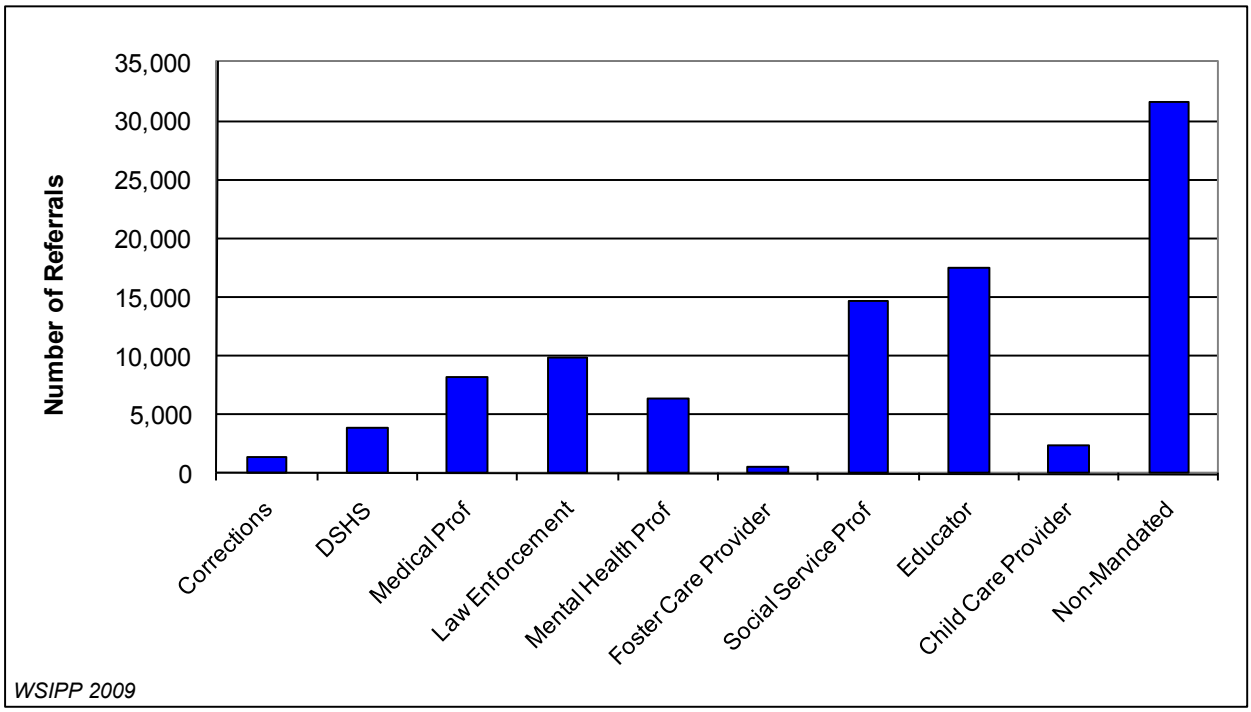
WSIPP 2009

Findings

Who refers?

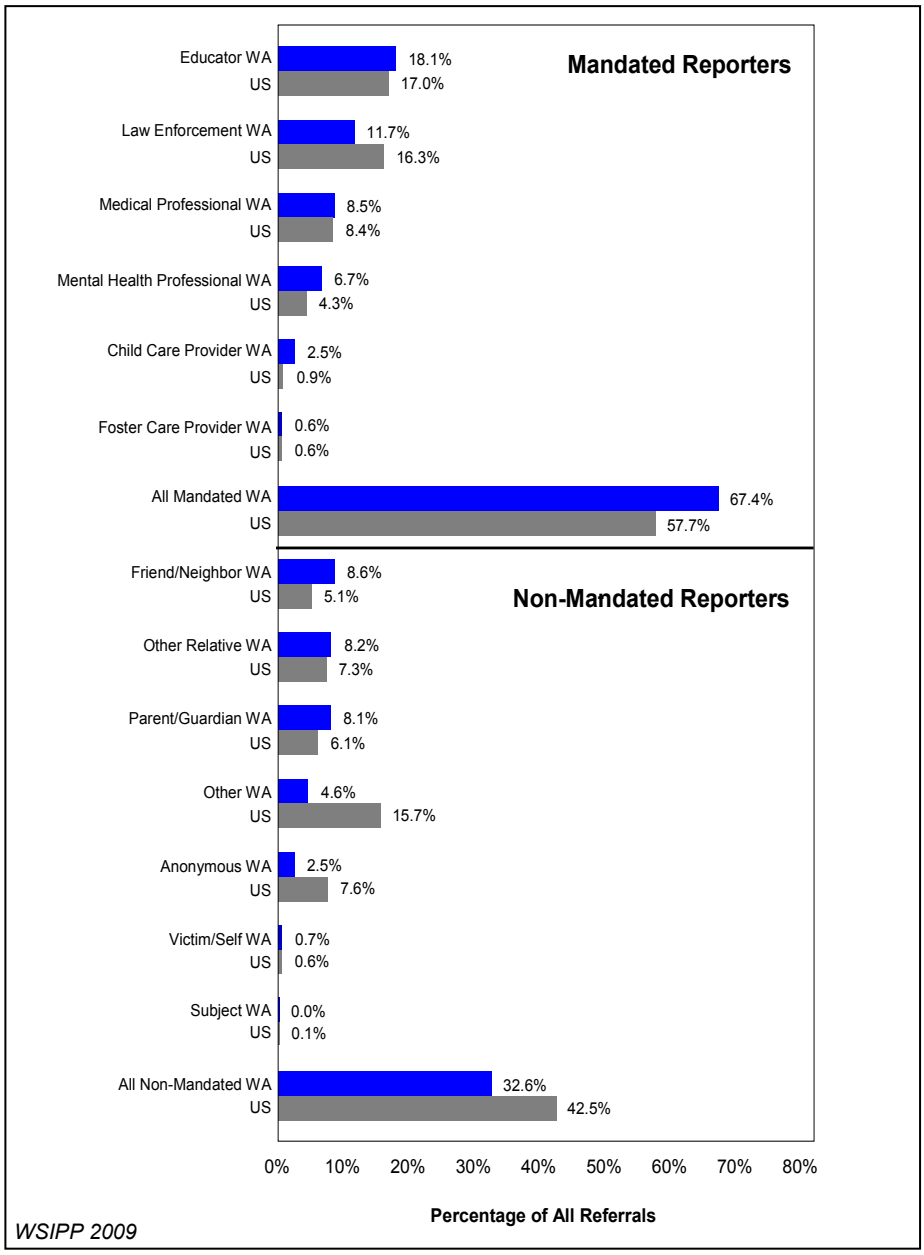
Exhibit 2 displays the number of reports from various categories of reporter types. More reports are received from non-mandated reporters than from any single class of mandated professionals. Educators and social service professional make more referrals than the other types of mandated reporters.

Exhibit 2
Referrals to Child Protective Services by Type of Reporter
(Referrals Received January 2006 through February 2008)



The pattern of CPS referrers in Washington is similar in most respects to what is observed nationally. Exhibit 3 shows the percentage of all referrals by type of reporter in Washington State and nationally.[5] Washington has a higher percentage of reports from mandated reporters than most other states. This pattern may reflect differences between Washington's reporting requirements and the majority of other states.

Exhibit 3
CPS Referrals in Washington and Across the United States

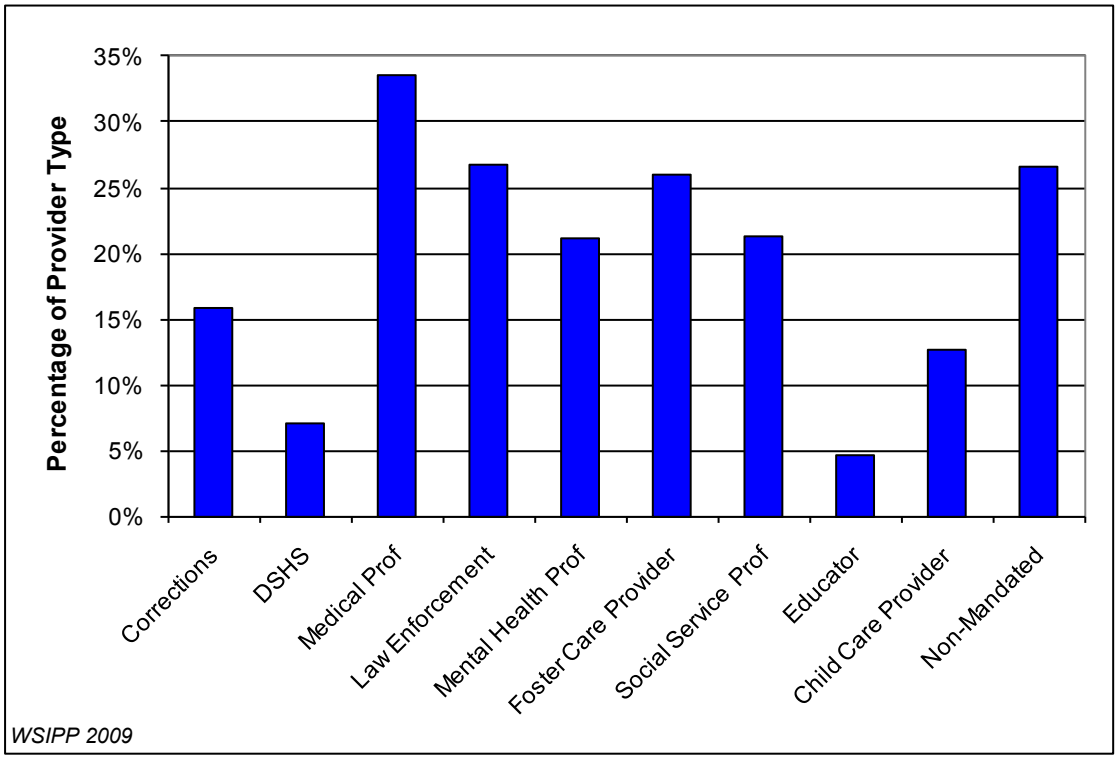


[5] Source for national data: Administration for Children and Families (2007). *Child Maltreatment 2007.* Washington DC: Health and Human Services. http://www.acf.hhs.gov/programs/cb/pubs/cm07/insidecover.htm

When do they refer?

A total of 20 percent of all referrals are made outside of regular business hours. A central, statewide phone service handles these calls. The Central Intake takes 94 percent of all after-hours calls.[6]

Exhibit 4
CPS Referrals Received After Regular Business Hours

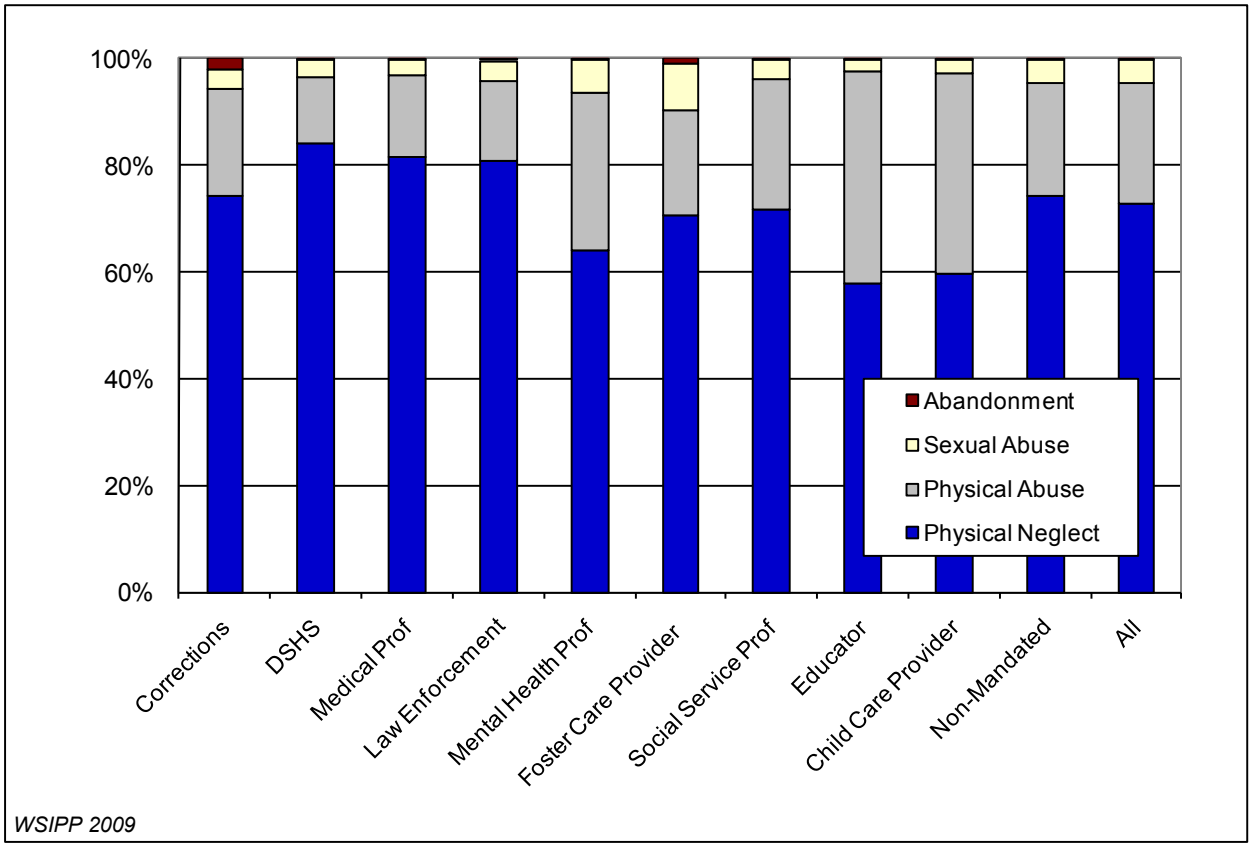


[6] In this analysis, calls were identified as after hours if they occurred before 8 a.m., after 5:00 p.m., on weekends, or on state holidays.

Who reports various types of child maltreatment?

Exhibit 5 shows the type of maltreatment reported. The most common alleged maltreatment, regardless of reporter type, is physical neglect. Educators, child care providers, and mental health professionals are more likely to report physical abuse than other reporters.

Exhibit 5
Type of Alleged Maltreatment



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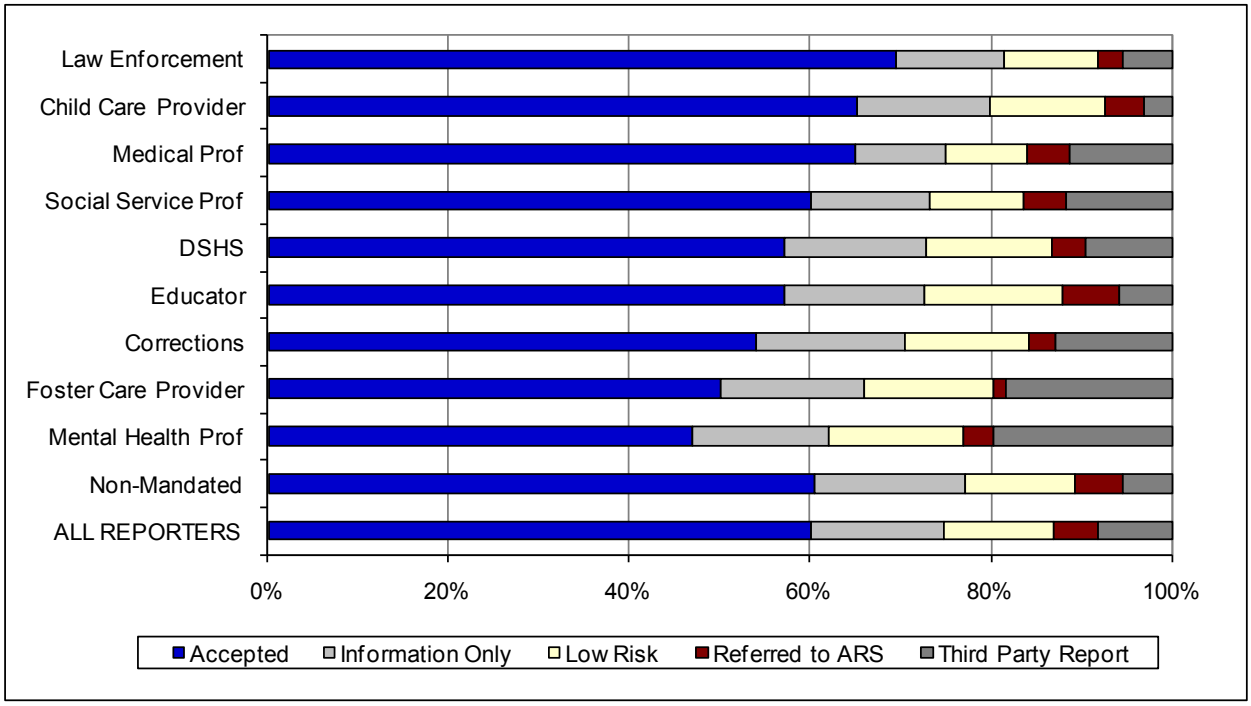
Do intake decisions vary by reporter type?

Sixty percent of all referrals are accepted for investigation. As shown in Exhibit 6, referrals from law enforcement are significantly more likely to be accepted than referrals from other reporters. This is probably because law enforcement officers are more likely to be involved in acute family crises.

Exhibit 6
Intake Decisions Vary by Type of Reporter



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Do subsequent outcomes vary by reporter type?

After referrals are accepted, there continues to be variation in the reporter type and case outcomes. Referrals from law enforcement are the most likely to result in a child's removal from the home, and educator referrals are the least likely to have this result. However, the initial difference in home removal is probably due to the crisis intervention nature of law enforcement involvement. While reporter-related differences persist after a child is removed from home, significantly fewer law enforcement referrals result in the filing of a dependency case.

Exhibit 7
Outcomes of Accepted Referrals

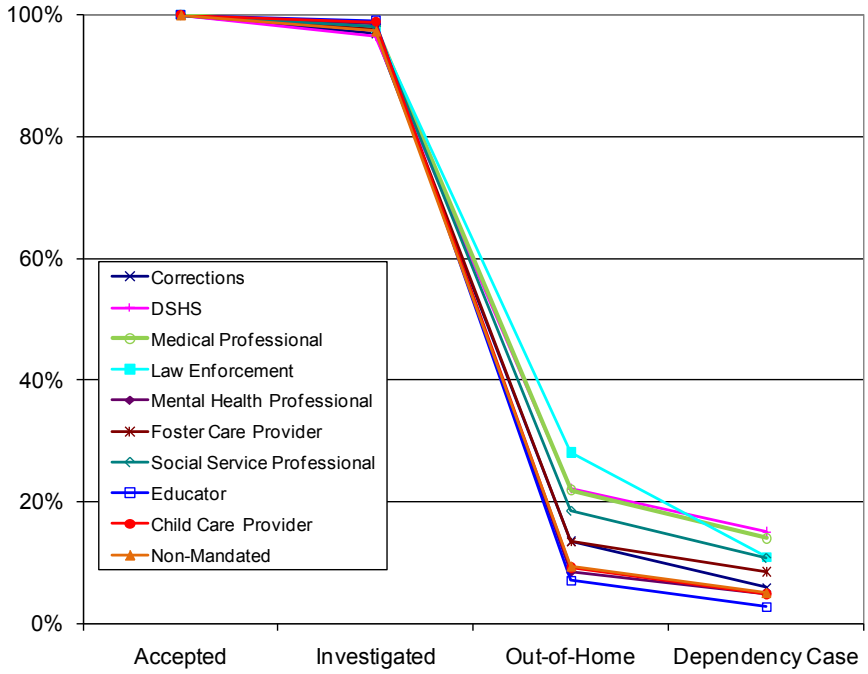

Chart Data: Percentage of Accepted Referrals

Reporter Type	Investigated	Removed From Home	Dependency Filed
Corrections	97%	14%	6%
DSHS	97%	22%	15%
Medical Professional	98%	22%	14%
Law Enforcement	98%	28%	11%
Mental Health Professional	98%	8%	5%
Foster Care Provider	98%	13%	9%
Social Service Professional	98%	19%	11%
Educator	99%	7%	3%
Child Care Provider	99%	9%	5%
Non-Mandated	97%	9%	5%
Total	98%	14%	7%

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These variations in outcomes are likely to be the result of differences in the role of various reporter types.

Law enforcement crisis intervention may result in prompt removal of a child, but following the child's removal from home, issues with the family may be quickly resolved and the child returned home. This may explain that although children referred by law enforcement are removed from home at a relatively higher rate than those reported by others, the proportion of law enforcement-accepted referrals that result in filing of a dependency petition is about the same as referrals from social service professionals.

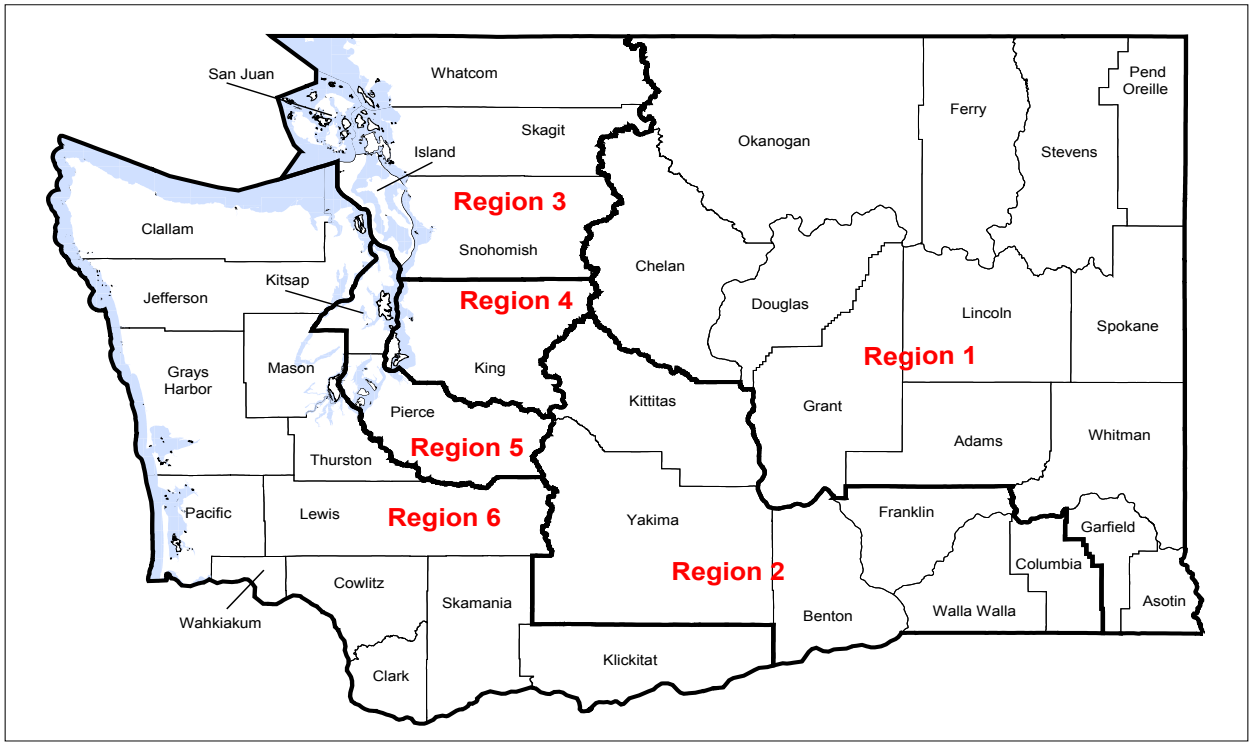
Medical professionals can also hold children, and call law enforcement and Child Protective Services to intervene. This too may result in interventions other than long-term out-of-home placement.

When a DSHS employee refers a family to CPS, the employee is likely to have information on prior family involvement with the child welfare system. DSHS referrals may also follow unsuccessful attempts to engage families in voluntary services. These factors would lead to a higher rate of out-of-home placement and dependency filings.

Are there regional differences in rates of referral or outcomes?

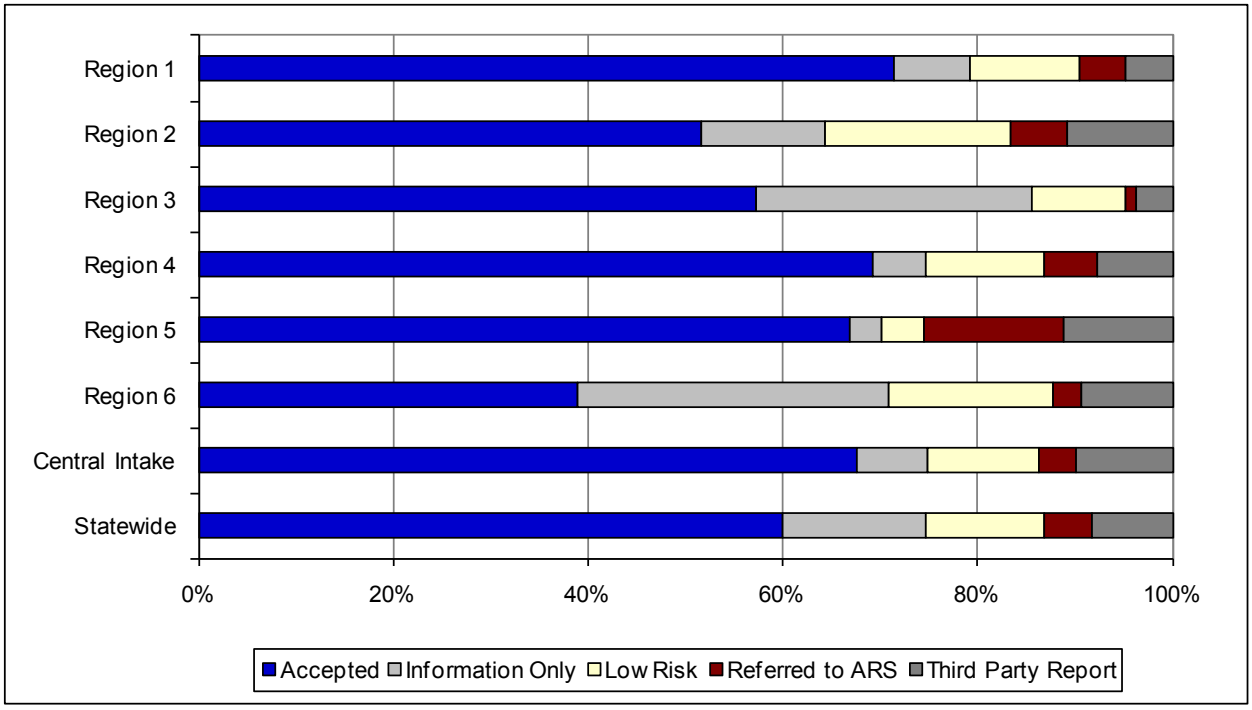
For administrative purposes, DSHS divides the state into six geographical regions, as shown in Exhibit 8, below.

Exhibit 8
DSHS Administrative Regions



Initial intake decisions vary markedly by region. Compared with referrals received in other regions and at Central Intake (statewide call center for after-hours calls), those in Region 6 are much less likely to be accepted and significantly more likely to be classified as Information Only.

Exhibit 9
Intake Decisions Vary by Region



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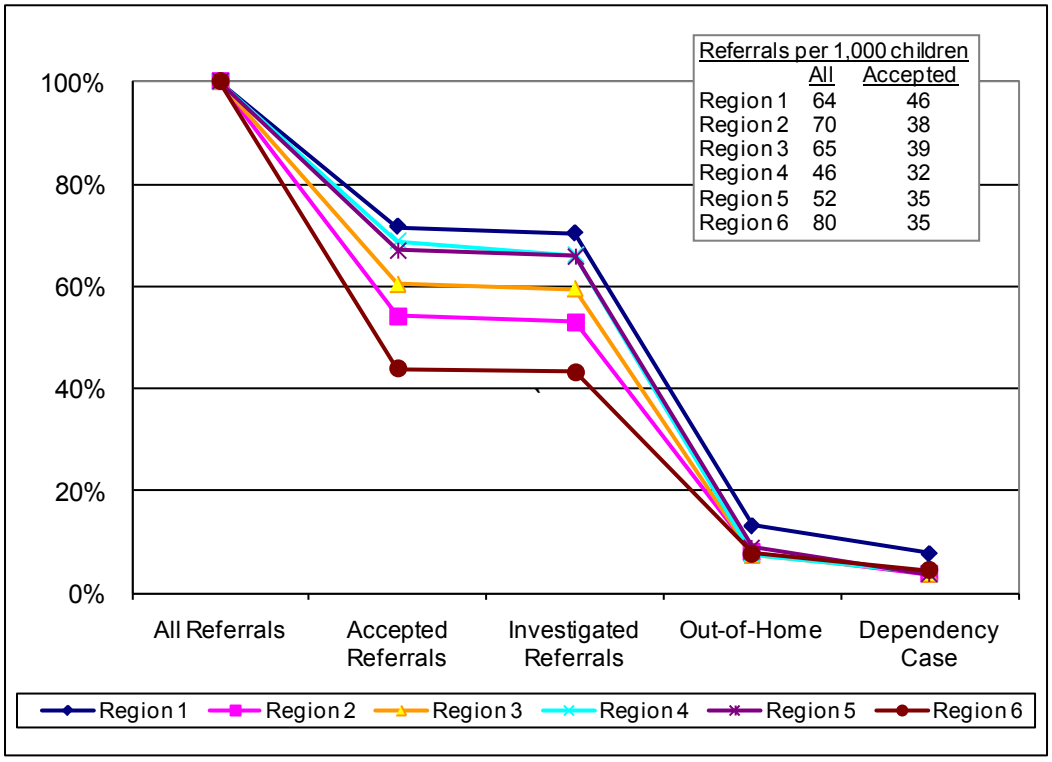
To determine whether outcomes of accepted referrals vary by region, referrals to the statewide Central Intake were included in the geographic regions where the cases originated and were investigated see Exhibit 10).

The percentage of referrals accepted for investigation varies widely by region. In general, regions with higher referral rates tend to have the lowest rates of accepted referrals. In Region 6, where there are 80 referrals per 1,000 children, only 43 percent of referrals (including those through Central Intake) are accepted. By contrast, the referral rate is lowest in Region 4, where 69 percent of referrals are accepted.

Region 1 is an exception. Its referral rate of 64 per 1,000 puts it in the middle of the regions. However, this region has the highest percentage of accepted referrals—over 70 percent.

The variation in the percentage of referrals accepted by the six regions has the effect of decreasing the difference among regions in terms of accepted referrals per 1,000 children.

Exhibit 10
Referral Outcomes Vary
by Administrative Regions



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Do differences among reporter types remain when we control for all known case characteristics?

Up to this point, we have examined discrete aspects of referrals—type of reporter, alleged maltreatment, time of day when reports are made, etc. Because we know these factors all might relate to the outcome of a referral, we also conducted multivariate analyses to determine whether differences by reporter type can be explained by other case characteristics. Our analysis controlled for age, race, and gender of the youngest child on the referral, DSHS region, type of maltreatment, number of prior referrals the family has received, number of victims on the referral, after hours reports, and the intake worker.

Many of these characteristics affected the three outcomes we considered:

- Referral accepted
- Child removed from home
- Dependency case filed with the court

Even after controlling for these characteristics, we still see significant differences in outcomes, depending on the type of reporter. In particular, referrals from law enforcement are more likely to be accepted and associated with removal of the child from home. However, law enforcement referrals are significantly less likely to result in dependency cases of children removed from home than all other referrals.[7]

[7] See Exhibit A4 in the Appendix.

Do intake workers differ in their assignment of risk?

When a report of suspected abuse or neglect is received that is not coded "Third Party Report" or "Information Only," the intake worker assigns a "risk tag" based on the information she or he hears. This level of risk scale ranges from 0 to 5, with 5 being very high risk and 0 being no risk. Any report with a risk tag of 3 or above is accepted for investigation.

The risk tags assigned by individual intake workers were examined across all regions. As shown in Exhibit 11, the average risk assigned by workers varies by region. Workers in Region 1 assign the highest risk to referrals; workers in Region 6 assign the lowest risk.

Exhibit 11
Average Risk at Intake Varies by Region

Region	Average Risk at Intake	Number of Referrals
Region 1	3.51	9,328
Region 2	3.10	7,228
Region 3	3.44	9,301
Region 4	3.27	12,493
Region 5	3.19	8,511
Region 6	2.86	10,320
Central Intake	3.44	17,251

Further, we observed that the individual intake workers vary in the risk level they assign to referrals. This variation among workers has a significant effect on outcomes. The screening decision history of the intake worker was the strongest predictor of the level of risk the worker would assign. That is, intake workers with a history of assigning higher than average risk tags continue to assign higher risk tags and, thus, have higher than average rates of accepting referrals. Thus, controlling for other known case characteristics, the historical average risk assigned by the intake worker has the greatest influence on the initial risk assigned,[8] and hence, on whether the referral is accepted.

It is not known whether this variation is affected by workers' level of tenure or experience.

Among the 190 intake workers who handled at least ten referrals, the average risk assigned was 3.27. Overall, the average risk assignment by individual intake workers ranged from 1.6 to 4.9.[9]

This result is based on data collected between January 2006 and February 2008. Since then, the Children's Administration has modified its intake procedures. Future analysis would be necessary to learn if the new procedures have affected the worker-to-worker variation in risk assessment and subsequent outcomes following referrals.

[8] See Exhibit A5 in the Appendix.
[9] For this analysis, we excluded workers logging in using generic worker codes and workers with fewer than ten referrals.

Conclusions

Similar to national trends, this study found that Washington State educators and social service professionals make more referrals than other types of mandated reporters.

Further, outcomes following CPS referrals vary by reporter type. The variation can be largely explained by the nature of reporters' professional contact with children and the circumstances in which they report. Referrals from law enforcement were more likely to be accepted for investigation and to result in removal of a child from home. The proportion of referrals accepted by DSHS ranged from 47 percent for mental health professionals to 69 percent for law enforcement. Further, after the referrals are accepted, those from law enforcement are more likely than other referrals to result in removing a child from home.

For the period of this study, the responses to reported child abuse and neglect, and the outcomes for children, varied as much by region and by screening decision history of individual intake workers as they did by type of reporter. These regional and worker differences may warrant further examination.

V. Presence of Mandated Reporter Referrals in Child Fatalities

A. OFCO Findings of Mandated Reporter Referrals in Child Deaths

The following section provides data gathered and reviewed by OFCO regarding the presence of mandated reporter referrals in the 241 child deaths of children ages 0-18 that OFCO reviewed from 2006, 2007 and 2008. As stated earlier in this report, this data set includes children who meet OFCO's criteria for review, i.e. those children who were in the care of, or whose families received child welfare services from, DSHS CA within one year of their death, or who died while in state licensed care.

Important factors to consider in reviewing this data:

- Not all of the child fatalities are caused by child abuse and neglect. Some are accidental or the result of natural or medical causes.
- Mandated reporters make the majority of referrals to CPS, so it follows that most of the deaths have a mandated reporter referral in their history.[35]
- The mandated reporter referral on the caretaker does not necessarily mean the referral pertained to the child who died. The referral could relate to abuse or neglect of a sibling.
- The referral history pertains to the "caretaker's" history.[36] The caretaker is defined as the caretaker at the time of the child's death. The child may have had various caretakers throughout his or her life.

OFCO's findings are summarized as follows:

- A large majority of the 241 child deaths OFCO reviewed had a mandated reporter referral present in the deceased child's caretaker's total history.
- Less than one-half of the deaths had one or more mandated reporter referrals screen in for agency response within one year of the child's death.
- Close to one-third of the deaths had one or more mandated reporter referrals screened out as "information only" within one year of the child's death.
- Nearly half of the children who died were infants less than one year old. About one-third of these infants had a screened out "information only" referral prior to their death, with close to three-fourths of these made by mandated reporters. Close to one-quarter of the "information only" referrals on infants were pre-natal referrals with almost 90 percent made by mandated reporters.

[35] See discussion of referrals in WSIPP section of this report, starting on page 9.
[36] Total caretaker history includes any referral that names the caretaker at the time of death as the subject of the referral. It includes referrals on the caretaker even if the deceased child is not an identified victim. It does not include referrals that list the caretaker as a victim, i.e. when the caretaker was a minor.

1. **How many child deaths reviewed in the years 2006, 2007 and 2008 had a referral from a mandated reporter within the caretaker's total history?**

   83 percent (or 199) of the 241 child deaths reviewed by OFCO had a mandated reporter referral present in the deceased child's caretaker's total history.

Year of Death	Mandated Reporter Referral Present on Caretaker	Total Deaths Reviewed
2006	59	61
2007	61	75
2008	79	105
Total	**199**	**241**

2. **How many child deaths had a mandated reporter referral on the caretaker "screened in"[37] for DSHS CA response within one year prior to death of the child?**

   46 percent (112) of the 241 deaths reviewed had at least one mandated reporter referral "screen in" for DSHS CA response within a year of the child's death.

3. **How many child deaths had a mandated reporter referral screened out as "information only" within one year prior to death of the child?**

   32 percent (76) of the 241 deaths reviewed had at least one mandated reporter referral screened out as "information only" within a year of the child's death.

4. **How many child deaths had both "information only" and "screened in" referrals on the caretaker from a mandated reporter within one year prior to death of the child?**

   14 percent (34) of the 241 deaths reviewed had both "information only" and "screened in" referrals from mandated reporters present in the caretaker's history within the year prior to death.

5. **How many child deaths had referrals that were "third party"[38] reports within one year of the child's death?**

   30 percent (7) of the child deaths had referrals that were "third party" reports within one year of the child's death.

[37] OFCO uses "screened in" to mean a referral that is investigated by DSHS CA or sent to Alternative Response Services so that the family is provided services in the community to address problems or meet their needs.

[38] See footnote 26 for explanation of "third party."

6. **How many of the children among the 241 deaths were infants (defined as birth to 1 year of age)?**

   48 percent (116) of 241 of the children who died were infants less than one year of age.

7. **How many of the 116 infants who died had a final referral that was screened out as "information only" prior to death?**

   33 percent (38) of 116 of the infants who died had a final referral that was screened out as "information only" prior to death. The **manner of death**[39] for the 38 infants who had "information only" referrals was:

   - Accidental: 2
   - Homicide: 3
   - Natural/Medical: 20
   - Unknown/Undetermined: 13

8. **Of the 38 infants who had a final referral screened out as "information only" prior to their death how many of these were from a mandated reporter?**

   74 percent (28) of the 38 "information only" referrals were from a mandated reporter. The **manner of death** for the 28 infants whose "information only" referrals were from a mandated reporter was:

   - Accident: 2
   - Homicide: 3
   - Natural/Medical: 15
   - Unknown/Undetermined: 8

9. **Of the 38 referrals screened out as "information only" how many were pre-natal referrals**[40]**?**

   24 percent (9) of 38 referrals screened out as "information only" were pre-natal referrals.

10. **Of the 9 pre-natal referrals on infants that were screened as "information only" how many were from mandated reporters?**

    89 percent (8) of the 9 pre-natal referrals screened as "information only" were from mandated reporters.

[39] Infants who died of Sudden Infant Death syndrome (SIDS) or Sudden Unexplained Infant Death (SUID) are included in either the natural/medical or unknown/undetermined categories depending upon how the coroner or medical examiner recorded the death.
[40] These are referrals that DSHS CA received when the mother was pregnant.

B. Discussion of Infant Deaths

OFCO's review of child fatality data shows that nearly half of the children who died were infants less than one year old. This data may invite an opportunity to improve screening of CPS referrals related to infants with the goal of adopting preventive measures to improve safety.

Preliminary data gathered through the Child Death Review (CDR) process[41] on 2008 child deaths from Sudden Infant Death Syndrome[42] in King County was provided to OFCO.[43] This preliminary data shows an increase in infant deaths over the last year and identifies the presence of well-established risk factors, such as use of loose bedding, sharing a bed (co-sleeping), and the use of drugs and/or alcohol, in infant deaths.[44] This data also suggests that gestational age may be a factor in SIDS death, even when the baby is born just a few weeks ahead of full term (40 weeks).[45]

OFCO recommends that DSHS CA coordinate with the Northwest Infant Survival Alliance (NISA), medical examiners and coroners, the Department of Health, and other appropriate professionals to consider these risk factors in further refining its intake protocol on referrals pertaining to infants. When questioning referents or collateral contacts, it is appropriate for intake workers to gather information about the sleeping environment (to determine if there is a safe sleeping arrangement)[46],

[41] In 1997, the process for reviewing unexpected deaths of children was formalized and expanded through the establishment of the Child Death Review (CDR) system. In an executive directive, then Governor Gary Locke established the CDR system and provided funding to the Department of Health (DOH) to develop and implement a statewide child death review system to collect and analyze death review data utilizing local community based teams. During the 1997-99 biennium, the legislature appropriated money for these reviews. DOH compiled aggregate data based on the reviews from local communities facilitated by local health jurisdictions. IN 2003, DOH lost its funding to conduct these reviews, but the law authorizing CDRs remained in effect. Since then, partial funding has been restored. Some local health jurisdictions continue to conduct these reviews, while others do not due to insufficient funding.

[42] Sudden Infant Death Syndrome (SIDS) is defined as the sudden death of an infant less than one year of age that cannot be explained after a thorough investigation is conducted, including a ***complete autopsy, examination of the death scene***, and ***review of the clinical history.*** Sudden unexplained infant deaths (SUID) are defined as infant deaths that occur suddenly and unexpectedly, and whose manner and cause of death are not immediately obvious prior to investigation. See http://www.cdc.gov/sids/index.htm. For additional information on child death reviews and SIDS/SUID, see http://www.childdeathreview.org/home.htm and http://www.sidscenter.org/

[43] Deborah Robinson, an Infant death Investigation Specialist with the Northwest Infant Survival Alliance (NISA) brought this information to the attention of OFCO.

[44] This data was analyzed by David S. Jardine, M.D. from the SIDS Research Project at the University of Washington. Dr. Jardine is an Associate Professor of Pediatrics, Pediatrics, Division of Critical Care, at Seattle Children's Hospital, Seattle, Washington.

[45] In the deaths analyzed in this data set, the highest frequency of SIDS occurred among babies whose gestation was in the range of approximately 34 to 38 weeks. This data is in the preliminary stages and is not yet available publicly. Pre-maturity and associated low birth weight have long been identified as high-risk factors for SIDS. Babies are considered pre-mature if they are born earlier than 37 weeks. However, this 2008 data is significant because it shows SIDS occurring at a greater frequency among babies who are born as little as a few weeks earlier than 40 weeks gestation. Data regarding gestational age is based on the SUIDI (Investigation) reporting form, which establishes a standard death scene investigation protocol for all sudden, unexplained deaths. For more information on the SUIDI form, see http://cdc.gov/sids/SUIDAbout.htm

[46] According to experts on SIDS and SUID, ensuring safe sleeping requires more than determining that a family has appropriate bedding (e.g. a crib with a firm mattress) for their infant. In the majority of cases

the mother's substance abuse history even when an infant is not born with a positive toxicology screen for drugs, and the gestation of the infant.[47]

The need to improve collection of data on SIDS and SUID has been recognized at the Federal level. On July 14, 2009, Senator Frank Lautenberg and Congressman Frank Pallone introduced the Stillbirth and SUID Prevention, Education, and Awareness Act.[48] The bill would:

- Expand current data collection activities to additional states to identify the causes of stillbirth and ways to prevent it in the future.
- Create a national public awareness and education campaign to educate parents and caregivers about known risk factors for sudden unexpected death in infancy and childhood.
- Expand support services, such as grief counseling, for families who have experienced stillbirth or SUID.
- Establish a national database to track SUID deaths and identify risk factors to prevent them in the future.
- Expand successful child death review programs to track and analyze the circumstances surrounding infants' and children's deaths in their community.

The bill has been endorsed by numerous non-profit organizations around the country working to end infant mortality, including NISA, as well as the National Association of Medical Examiners, International Association of Coroners and Medical Examiners and the National Sheriffs' Association.

where co-sleeping occurs, the family has a crib or equivalent bedding available, but is choosing to have the infant share the parents' bed. This highlights the importance of education on the dangers of co-sleeping.

[47] In April 2009, OFCO was notified by Christine Robinson, then Acting Director of CA Division of Program and Practice Improvement, that changes would be made to the curricula of caseworker Academy and Post Academy training to place greater emphasis on infant safety issues. This was in response to safety concerns that OFCO brought to CA's attention related to safe sleep and the home environment (over-heating) for this age group. CA has modified its safety training to now include: identification of protective factors in families; information about shaken baby syndrome; the importance of safe sleeping arrangements and the risks of SUID; and developmental issues. April 29, 2009, email communication from Chris Robinson to Mary Meinig, Director Ombudsman, OFCO.

[48] For more information, see http://lautenberg.senate.gov/newsroom/record.cfm?id=315708.

VI. Last Screening Decision Prior to Each Child's Death

The chart below shows the screening decisions made by DSHS, by reporter type, on the last referral prior to each child's death in 2006-08.

A. Referral from a Mandated Reporter Prior to Death[49]

Childcare Provider	**2**
Information Only	1
Other, non CPS (i.e. Family Reconciliation Services, Child Welfare Service, referrals to Licensing[50])	1
DSHS	**21**
Information Only	7
Accepted for CPS Investigation	6
Low Risk	1
Third Party Report	1
Other, non CPS	6
Educator	**14**
Information Only	5
Accepted for CPS Investigation	6
Low Risk	2
Referred to Alternative Response Services (ARS)	1
Foster Parent	**1**
Other, non CPS	1
Law Enforcement	**23**
Information Only	7
Accepted for CPS Investigation	14
Third Party Report	1
Other, non CPS	1

[49] The screening terms used in this chart, such as "information only", "third party report," etc. are explained on page 11 of the WSIPP section of this report entitled "Outcome of Referrals to Child Protective Services: Comparing Reporters."

[50] "Licensing" means the Division of Licensed Resources, which licenses foster homes.

Medical Professional	**30**
Information Only	12
Accepted for CPS Investigation	16
Low Risk	1
Referred to Alternative Response Services (ARS)	1
Mental Health Professional	**9**
Information Only	3
Accepted for CPS Investigation	4
Low Risk	1
Other, non CPS	1
Social Services Professional	**69**
Information Only	15
Accepted for CPS Investigation	29
Low Risk	6
Third Party Report	5
Other, non CPS	14
TOTAL Referrals by Mandated Reporter	**169**

B. Referral from a Non-Mandated Reporter Prior to Death

Anonymous	**7**
Information Only	3
Accepted for CPS Investigation	3
Other, non CPS	1
Child's Relative	**20**
Information Only	7
Accepted for CPS Investigation	11
Other, non CPS	2
Friend/Neighbor	**16**
Information Only	2
Accepted for CPS Investigation	12
Low Risk	1
Referred to Alternative Response Services (ARS)	1

Other, Not Mandated Reporter	**4**
Accepted for CPS Investigation	3
Other, non CPS	1
Parent	**22**
Information Only	4
Accepted for CPS Investigation	6
Low Risk	1
Third Party Report	2
Other, non CPS	9
Victim	**2**
Information Only	1
Other, non CPS	1
Total Non-Mandated Reporters	**71**[51]

C. Presence of "Information Only" Referrals Among Deaths Regardless of Reporter Type

OFCO found that in less than one-third of the deaths, the last referral received by CPS was screened out as "information only" and thus not investigated.

1. Of the 241 deaths reviewed, how many had the final referral prior to the child's death, regardless of reporter type, screened out as "information only?"

In 28 percent of the 2006-08 deaths (67 out of 241) reviewed by OFCO, the final referral prior to the child's death, regardless of reporter type, was screened out as "information only", and therefore did not receive a response from DSHS.

[51] One fatality occurred in a licensed facility that had no prior referrals.

VII. Child Fatality Reviews

A. State Law Requires DSHS Review of Unexpected Child Deaths

State law requires DSHS to review all unexpected deaths of children who have been in the care of or receiving child welfare services from the department within one year of the child's death:

> *The Department of Social and Health Services shall conduct a child fatality review in the event of an unexpected death of a minor in the state who is in the care of or receiving services described in chapter 74.13 RCW from the department or who has been in the care of or received services described in chapter 74.13 RCW from the department within one year preceding the minor's death.*
>
> *Upon conclusion of a child fatality review required pursuant to subsection (1) of this section, the department shall within one hundred eighty days following the fatality issue a report on the results of the review, unless an extension has been granted by the governor. Reports shall be distributed to the appropriate committees of the legislature, and the department shall create a public website where all child fatality review reports required under this section shall be posted and maintained.*[52]

RCW 74.13.640

The purpose of a child fatality review is to take a critical look at the child protection system in relation to the child's death. The team focuses on the history of the case, including referrals and screening decisions, to identify risk factors that may have contributed to the child's death, and to determine ways in which the system could be improved so as to prevent other deaths and keep children safe. The fatality review teams make recommendations with these goals in mind.

There are two different types of fatality review: Child Fatality Review (CFR) and Executive Child Fatality Review (ECFR).[53] CFRs are used most frequently. The CFR is participated in by local/regional staff and/or others appointed by the regional administrator (RA). DSHS CA may invite members of the community who had involvement with and/or provided services to the child's family. An ECFR may be convened by the CA Assistant Secretary in select cases when it appears the child died of abuse by their parent or caretaker and the case was actively receiving services at the time of the child's death. This process involves an independent review by participants who are appointed by the CA Assistant Secretary. They are individuals who had no involvement in the case, but whose professional expertise would be useful in the case.

[52] The requirement that child fatality review reports be posted on a public website is the result of 2008 amendments to RCW 74.13.640 contained in 2SSB 6206. For additional guidance on CA practice and procedure on Child Fatality Reviews, see Chapter 5200 of DSHS CA Operations Manual at http://www1.dshs.wa.gov/ca/pubs/mnl_Ops/Chapter5.asp.

[53] See Chapter 5000, Health and Safety of the DSHS Children's Administration Operations Manual. http://www.dshs.wa.gov/CA/pubs/mnl_ops/chapter5.asp. For more information about a Child Fatality Review and Executive Child Fatality Review, see DSHS CA Operation Manual 5200 Child Fatality Review and 5220 Fatality Review Matrix at http://www.dshs.wa.gov/CA/pubs/mnl_ops/chapter5.asp.

B. Examples of Final "Information Only" Screening Decisions in Child Deaths

OFCO reviewed all 67 of the final referrals[54] screened out as "information only" preceding the child's death. The following provides a selection of these 2006 – 2008 referrals. In each of these referrals profiled, the child who died is the same as the subject child in the referral.[55] A fatality review was convened by DSHS CA on each of the children associated with these referrals. OFCO participated in ECFRs as well as several regional CFRs. On all child fatalities, OFCO conducted an independent internal review.

For each of these referrals, we have provided the type of referent, the age of the child who died, a case overview,[56] the cause and manner of death, the time elapsed between the final referral and the date of death, the allegations in the final referral, and excerpts from DSHS CA's CFR to the extent it addressed intake or screening decisions. All the information provided in these case examples is taken directly from the DSHS CA CFR team's summary which is available on the public website indicated after each case overview. In many of these cases, CFR teams identified concerns regarding the final "information only" screening decisions and OFCO has provided excerpts of the CFR team's concerns. CA's response also may identify "Action Taken" or "Recommendations." OFCO will be reporting on the status of DSHS CA actions and fatality review recommendations in its future report to the Legislature on the status of CFR recommendations.[57]

Case 1

Referent: Social Services Professional

Age of Child at time of death: 2 months

Case Overview: On March 22, 2007, the father of this two-month old fell asleep on a sofa with the child in his arms. When he awoke a few hours later, the father found the infant unresponsive. Medics were called to the home and transported the child to the local emergency room where death was pronounced upon arrival.

Child Fatality Review #07-51, Region 5, http://www1.dshs.wa.gov/pdf/ca/CFR2qtr2008.pdf at page 179.

Manner of Death: Unknown/Undetermined

Cause of Death: No identifiable cause

Days between Referral[58] and Death: 9 days

Finding regarding fatality: Founded for physical abuse, injuries did not cause death

[54] OFCO uses "final referral" to mean the last referral received by CPS before the child died.
[55] For many of these cases, there may have been an additional referral made after the child died. The section "Case Overview" may include selected information from referrals after death.
[56] The Case Overview is derived from CA's Child Fatality Review (CFR). The text of most of the case overviews is largely verbatim but has been edited in some instances to delete unnecessary details, without changing the accuracy. Each case overview is followed by a link to the full child fatality review. In addition to providing details about the family history and circumstances of the child's death, the child fatality review typically identifies practice issues and corresponding recommendations,
[57] OFCO must issue an annual report to the Legislature on the status of CFR recommendations pursuant to 2SSB 6206.
[58] Referral is discussed under "Allegations" section that follows.

Allegations: *On March 13, 2007, Children's Administration (CA) intake received a report from a Maternity Support Services (MSS) worker about the general care of the twins (including the deceased child) by their parents. A relative told the MSS worker that the children are missing doctor appointments and the father has mental health issues. The MSS worker had last been to the home on February 26, 2007, and the children looked fine and the home appeared clean and safe. This referral was screened as information only.*[59]

DSHS CA Child Fatality Review of Screening Decision: The decision to screen out the referral appears to have been based on the fact that the children had recently been seen by the Maternity Support Services (MSS) worker and they appeared fine and the plan was for on-going MSS involvement. There were no prior CPS reports. The father had Family Reconciliation Services (FRS) involvement as a child, although this was not identified by the intake worker during the person search of CAMIS. It is unknown as to why that history was not identified at intake.

An argument could be made that there was sufficient information for the referral to be accepted low risk and possibly sent to Alternative Response Services (ARS) for services, although the family was already receiving MSS services. Such argument to accept the report for an alternate intervention would be based on the reported lack of supervision for the one-year-old child and the missed medical appointments. The lack of specific information regarding the supervision may have played a role in the screening decision (screen out). At intake, contact information for the relative was not provided, so there was no opportunity for a collateral contact to that person. It is unknown if the missed doctor appointments were for routine check-ups or necessary appointments specific to the respiratory problems. CPS had received no reported concerns from any medical providers. The intake worker did receive the name of the pediatrician but did not do a collateral call with that medical provider. It is possible that additional information might have resulted in a different screening decision.

Recommendations: None

Action Taken: A special intake focused "Lessons Learned from Region 5 Fatality Reviews" is tentatively planned for September or October at which time the issue about contacting medical care providers will again be discussed and emphasized as a best practice expectation for any referral involving young children.

CASE 2

Referent: Social Services Professional

Age of Child at time of death: 3 months

Case Overview: On November 15, 2008, CA Central Intake received a report that a three-month old baby was brought to the hospital by her parents with no pulse and not breathing. Medical staff was able to revive the child, however, prognosis was poor. On November 16, 2008, hospital staff notified CA that the baby was diagnosed with bilateral retinal hemorrhages and was brain dead. Medical consultation at the time confirmed the injury was consistent with shaken baby syndrome.

Executive Child Fatality Review, Region 4,
http://www1.dshs.wa.gov/pdf/ca/LeingangECFR.pdf.

[59] Italicized text indicates the allegations text is quoted from CA's CFR. It is not a direct quote from the referral history in CAMIS, but rather is a quote from CA's CFR which summarizes the referral. However, OFCO reviewed the original referral history in CAMIS as well.

Manner of Death: Unknown/Undetermined

Cause of Death: anoxic encephalopathy of unknown etiology

Time between Referral and Death: 5 ½ weeks

Finding regarding fatality: Founded for physical abuse and neglect. Criminal investigation remains open.

OFCO Attended Child Fatality Review

Allegations: *In October 2008, an information-only intake was received reporting several vehicles at the family's residence, though no one answered the door when knocked. The referent was concerned as she could hear a child crying for about 10 minutes. The referent called to report her concerns as the mother had recently disclosed a prior drug problem and had two children removed from her care in the past. It was reported three children were now living in the home, ages 3½ years, 18-months, and 2-months (S.L.).*

DSHS CA Executive Child Fatality Review of Screening Decision: Executive Child Fatality Review committee stated taking into consideration the family's CA history when screening more recent intakes[60] (including above intake) warranted assignment of the intake based on high-risk factors alone.

The Executive Fatality Review Committee made Findings and a Recommendation related to screening decisions:[61]

Findings:

- A family's complete alleged child abuse and neglect (CA/N) history, including Information-Only intakes were not considered when intake screening decisions were made. Considering the complete alleged CA/N history, regardless of previous intake screening decisions, ensures a comprehensive review of all information available to assess risk and child health and safety. Attention to chronicity (recurrent episodes of alleged abuse or neglect over time) and severity (degree of abuse) helps to identify if there is a pattern of alleged child maltreatment over time rather than assessing an isolated incident.
- A family's history in which parental rights had been terminated in the past should elevate the standard by which a new intake is assessed and subsequently screened for investigation.

Recommendation: 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 [of child abuse or neglect] or the presence of risk factors.

[60] The term "intakes" is interchangeable with "referrals." Since Famlink went into effect, DSHS CA is using the term "intakes" in lieu of "referrals."

[61] The ECFR made other recommendations and findings not related to screening/intake that are not included here.

CASE 3

Referent: DSHS

Age of Child at time of death: 4 months

Case Overview: On November 5, 2006, the Fire Department and Police Department unsuccessfully attempted life saving measures on a four-month-old found not breathing. The parents reported they fed the child around 6:00 a.m. They woke at approximately 9:20 a.m. and the child was not breathing. On November 7, 2006 an autopsy was conducted and it was determined that the probable cause of death was Sudden Infant Death Syndrome.

Child Fatality Review #06-50, Region 6, http://www1.dshs.wa.gov/pdf/ca/CFR2qtr2008.pdf at page 18.

Manner of Death: Natural/Medical

Cause of Death: Sudden Infant Death Syndrome (SIDS)

Time between Referral and Death: 2 weeks

Finding regarding fatality: Inconclusive

Allegations: *On October 26, 2006, a referral was made to CA intake alleging the mother gave birth to a premature child at the University of Washington Hospital. The urinalysis was negative. The mother has a history of using methamphetamines regularly and was recently asked to move from her home because of her drug use. The mother was reported to have "meth sores." This referral was information only*

DSHS CA Child Fatality Review of Screening Decision:

Issue: Based on the allegations, this referral was screened as "information only". There were no additional collateral calls conducted to learn more about the allegations in the referral. Additional collaterals may have provided additional information as to the concerns from the hospital staff about the lack of parent involvement and lack of visitations.

Recommendation: The supervisor will review with the intake staff the need to make collateral calls when referrals of this nature are received.

CASE 4

Referent: Medical Professional

Age of Child at time of death: 3 months

Case Overview: The child's 16-year-old mother was placed by the Tribal Nation in the home of a relative. On November 21, 2006, the mother left for several hours one evening leaving her baby in the care of two teenage girls who also lived in the home. At one point one of these teenagers found the child not breathing. An ambulance was summoned and CPR was performed but was unsuccessful. There was no evidence at the scene that the death was suspicious. The cause of death after autopsy was determined to be acute pulmonary bronchial pneumonia due to a bacterial infection.

Child Fatality Review #06-46, Region 3, http://www1.dshs.wa.gov/pdf/ca/CFR2qtr2008.pdf at page 8.

Manner of Death: Natural/Medical

Cause of Death: acute pulmonary bronchial pneumonia due to bacterial infection.

Time between Referral and Death: 6 weeks

Finding regarding fatality: No investigation

Allegations: *There was one prior referral on this mother. Her baby (then 6 weeks old) was hospitalized to correct an intestinal birth defect. She developed an infection while in the hospital. Medical staff questioned the mother's ability to care for her infant. The mother had difficulty waking to the baby's cries and had to be repeatedly prompted to hold bottles upright to prevent the baby from swallowing air. There was also a concern that the mother was feeding the child enough formula for the infant to make adequate weight gain. This referral was not screened in for investigation.*

DSHS CA Child Fatality Review of Screening Decision:

Issue: When infants are born to women who have dependent children or born to young women who are dependent themselves, there is currently no system in place in this DCFS office to alert the unit supervisor of the birth and the need to assess the safety of the infant. In this case, although the assigned social worker did address the issue of the safety of the newborn with the Tribe, there is no documentation that the unit supervisor was aware of the birth and concurred with the decision.

Recommendation: The review team, including the Area Administrator of this office agreed that such a system would be helpful in ensuring that these situations receive the attention they need. The office intends to direct its intake staff, when they receive information of a birth to a young woman who is dependent herself, or who has other children that are dependent, to document that according to policy and provide a written copy to the assigned worker and to the supervisor of that unit.

CASE 5

Referent: Mental Health Professional

Age of Child at time of death: 7 months

Case Overview: On January 29, 2007, the Police Department contacted Child Protective Services to report the death of a seven-month-old child in the family home. The infant was said to have been found deceased by the mother. Per law enforcement reports, the mother had placed the infant in an infant "bouncy chair" the night before. The child had been ill for several days with a runny nose and diarrhea. Upon discovery of the child the father performed Cardio Pulmonary Resuscitation prior to the arrival of emergency medical services (EMS). EMS transported the infant to the hospital where the child was pronounced dead. The police reported the deceased infant was found with a bleeding diaper rash and a small bruise on the forehead which may have occurred during resuscitation efforts.

Child Fatality Review #07-56, Region 5, http://www1.dshs.wa.gov/pdf/ca/CFR2qtr2008.pdf at page 195.

Manner of Death: Unknown/Undetermined

Cause of Death: Death during infancy; no identifiable cause

Time between Referral and Death: 6 ½ months

Finding regarding fatality: Not stated in Child Fatality Review

Allegations: *It was not until a year and a half later (June 2006) CPS received a report from a hospital social worker reporting the decedent's mother had given premature birth to a child, the now deceased child. At the time of the report, it was not known whether a toxicology screen had been done on the child at delivery. The mother did not appear to have had any prenatal care. Given no allegations, the report was taken as Information Only.*

DSHS CA Child Fatality Review of Screening Decision:

Recommendation: [A]s the review panel discussed the recurring issue of intake workers not asking clarifying questions, it was suggested that a desk top resource guide with suggested clarifying questions be developed for intake workers with "templates" designed for a multitude of categories. This might include templates for asking clarifying questions when there is a reported injury to a child, when there are concerns for lack of general medical care of a child, for reported domestic violence situations where children may be present, for when a child has been left to be watched by a relative and the parent has not returned to retrieve the child, etc. The Tacoma intake supervisor offered to begin developing such a resource/desk guide, and will contact other regional intake leads across the state regarding such a project.

CASE 6

Referent: Social Services Professional

Age of Child at time of death: 2 months

Case Overview: On July 20, 2008, the 19-year-old mother of the deceased child called 911 to report her infant daughter was not breathing. An ambulance was dispatched and took the baby to the hospital. The cause of death is unknown, and there were no signs of abuse. The mother reported she checked on the baby at 6:00 a.m. and changed her diaper. Around noon, she checked on the child and found her not breathing. When the child arrived at the hospital, staff made attempts to revive her. They reported her prognosis was not good. Attempts to revive the child ceased. There were no signs of trauma or abuse.

Child Fatality Review #08-39, Region 1, http://www1.dshs.wa.gov/pdf/ca/08-39.pdf

Manner of Death: Unknown/Undetermined

Cause of Death: Sudden Unexplained Infant Death (SUID)

Time between Referral and Death: 2 months

Finding regarding fatality: Founded for neglect

Allegations: *On March 13, 2008, a social worker reported to CPS intake that the three-year-old sister of the deceased child was placed with her grandmother on a dependency due to the mother's lifestyle and substance abuse issues. The social worker said the mother was trying to have her daughter placed back with her. The mother was six-months pregnant with the deceased child. On March 12, 2008, the mother had a party with underage juveniles involved. The mother was drinking alcohol. The police went to the home and broke up the party. This referral was screened as information only.*

DSHS CA Child Fatality Review of Screening Decision: Child Fatality Review team did not address the appropriateness of the screening decision or make any recommendations related to screening or intake.

CASE 7

Referent: Educator

Age of Child at time of death: 3 months

Case Overview: The mother reported to law enforcement that she had gone to bed with her infant sometime around 10:30 the evening of November 27, 2008. The infant, mother and her boyfriend (presumed father) were all sleeping in the same bed. The boyfriend awoke around 4:30 a.m. and went to back to sleep in another room in the house. The mother fed the infant at around 6:30 a.m., burped her, and then laid her across the mother's stomach in the prone position (on stomach with face turned towards mother). They both went back to sleep. The mother said she later awoke with the infant in the same position as when they fell asleep, but the child was blue and cold to the touch. Fire and Rescue was dispatched to the scene as the parents attempted to revive their daughter. The child was pronounced dead at 9:44 a.m. Law enforcement was notified and arrived on scene around 10:00 a.m. There is a reported discrepancy in the events. A responding fireman told police that the mother went back to sleep with the boyfriend around 6:30 that morning and both adults were in same bed when the baby was found not breathing and blue in color. This information conflicts with the mother's later statement to law enforcement that the baby's father was sleeping elsewhere at the time the baby was discovered unresponsive.

Child Fatality Review #08-72, Region 5, http://www1.dshs.wa.gov/pdf/ca/08-72.pdf

Manner of Death: Natural/Medical

Cause of Death: Interstitial pneumonia

Time between Referral and Death: 19 days

Finding regarding fatality: No investigation

Allegations: *On November 6, 2008, a teacher called CPS intake and reported that the deceased child's mother had relapsed on methamphetamine. The mother told the referrer she and her children had lost their housing and were going to live in a car. The family moved around to various friends' homes. The deceased child's 8-year-old brother has Attention Deficit Hyperactivity Disorder (ADHD) and is developmentally delayed. The referrer reported he was not in school for three weeks. This referral was screened as Information Only.*

DSHS CA Child Fatality Review of Screening Decision:

The decision to screen out this referral appears reasonable. There were no specific allegations being reported. While there were identified risk factors, none singularly or cumulatively appear to have represented imminent risk of serious harm at the time of the intake. Just over two weeks later CPS intake received by mail the hardcopy school report from the original call made to intake. The same intake worker who processed the call-in also reviewed the mail-in report. The worker noticed information on the hardcopy school report that had not been originally presented at the time of the call-in, and the worker documented the additional information in a Service Episode Report (SER) case note. The panel was unable to review the hardcopy school report. According to the SER by the intake worker, the school report was discarded due to there being no previous CA case file. This was an error as there had in fact been a CPS investigation conducted previously and a case file for the family existed at the time of this intake.

The worker did document in SER that according to the school the mother admitted to drug use. Additionally, it was being reported that an unnamed live-in boyfriend was involved with making and selling methamphetamine (not specified if such was occurring at the home or elsewhere). The fact

that the intake worker compared the details from the hardcopy school report with what had been documented in CAMIS-GUI reflected good practice. However, the panel review members were in full consensus that the additional information found in the mailed-in school report should have generated at least further discussion with the intake supervisor about a possible screening revision or generating a new referral based on the additional information of the methamphetamine manufacturing and selling. Minimally, the intake worker might then have been directed to re-contact the referent to find out who was the primary source of the information being reported.

Recommendation: None

Action Taken: The Area Administrator overseeing regional intake has agreed to address with the intake supervisor and intake worker for general feedback the specific intake issues discussed during the Child Fatality Review.

Regarding this referral, it will be used as a training opportunity during the next scheduled DCFS intake unit meeting. Primary focus will be on discussing consultation and shared decision making following additional information received on an already completed intake.

CASE 8

Referent: Social Services Professional

Age of Child at time of death: 3 months

Case Overview: On June 3, 2008, law enforcement was dispatched to the family home of this deceased child on a report that she was not breathing. Officers attempted CPR. Officers spoke to the mother who said that she found her husband sleeping on the couch, her daughter lying on his body with her face toward his arm. The deceased child's mother pulled her from her husband and noticed that she was not breathing. She called 911.

Child Fatality Review #08-27, Region 6, http://www1.dshs.wa.gov/pdf/ca/08-27.pdf

Manner of Death: Unknown/Undetermined

Cause of Death: Probable positional asphyxia

Time between Referral and Death: 3 months

Finding regarding fatality: Inconclusive

Allegations: *On March 13, 2008, staff at a hospital reported to Child Protective Services (CPS) intake concerns about the behavior of the father toward his newborn daughter (the deceased child). The referrer reported the father was seen feeding the deceased child and said, "Come on, just eat the food!" The father's affect at the time was impatient and not playful. The father handled the baby roughly. The child's mother told hospital staff she had a baby die of SIDS about one year prior. The parents had good family support at the hospital. The baby was fine medically. There was no suspicion of drug or alcohol use by either parent. The Women, Infants, and Children (WIC) program was already involved with this family. The parents refused referrals to other local services. This referral was screened as Information Only.*

DSHS CA Child Fatality Review of Screening Decision:

Issue:[62] This referral was screened appropriately based on the information received at intake. The review team felt that further questioning of the caller may have provided more specific information regarding the parent's apparent rough handling of his infant. The Area Administrator has talked with the intake supervisor regarding follow up questions by intake when given vague information.

CASE 9

Referent: Law Enforcement

Age of Child at time of death: 12 months

Case Overview: This 12-month-old Native American child was ill for several days prior to her parents taking her to be seen by a doctor on January 12, 2008. She was given an antibiotic for an ear infection. She vomited and had diarrhea after taking the antibiotic. On January 15, 2008, she became very lethargic. Her parents called 911 and she was taken to a local hospital. She died of septic shock. There was an open CPS case on the deceased child at the time of her death.

Child Fatality Review #08-02, Region 1, http://www1.dshs.wa.gov/pdf/ca/08_02final.pdf

Manner of Death: Natural/Medical

Cause of Death: hypoxic encephalopathy with cerebral infarcts (stroke) due to septic shock brought on by an ear infection and pneumonia.

Time between Referral and Death: 2 ½ months

Finding regarding fatality: Not addressed in Child Fatality Review.

OFCO Attended Child Fatality Review

Allegations: *On October 26, 2007, law enforcement responded to the family home on a domestic disturbance call. The deceased child's mother reported her husband knocked her to the ground and punched her twice. The deceased child's father reported that his wife got knocked down while he was trying to prevent her from hurting the child. He reported having seen the mother shake the child. The deceased child's father was arrested for domestic violence. Law enforcement reported the incident to CPS on October 30, 2007. The CPS referral was screened as information only. The child was placed in protective custody on October 31, 2007. At a Local Indian Child Welfare Advisory Committee (LICWAC) meeting held in November 2007, it was recommended to return the deceased child to her parents' care with a safety plan. This placement was approved in court on December 3, 2007.*

DSHS CA Child Fatality Review of Screening Decision:

Issue: Four days passed from the date of the deceased child's father's DV arrest and when CPS was notified by law enforcement. The incident led to a protective custody placement.

Recommendation: A meeting with law enforcement to discuss delays in reporting to CPS.

[62] This discussion of DSHS Child Fatality Review of Screening Decision is taken from an AIRS Fatality Review, which is not accessible on a public website. See fn 16.

CASE 10

Referent: Medical Professional

Age of Child at time of death: 2 ½ months

Case Overview: This 2 ½ month old baby was brought to the hospital ER by an EMT. He was non-responsive and could not breathe on his own. It appeared he had suffered a brain injury; however, no trauma to the head was visible. There was bruising to the child's buttocks of unknown origin. The baby was diagnosed with anoxic brain injury (results from a lack of oxygen to the brain) and placed on life supports. The baby died the next day from his injuries. An individual in whose care the mother left the baby admitted he shook and spanked the baby leaving bruises. He was charged with 2nd degree murder.

Executive Child Fatality Review, Region 1,
http://www1.dshs.wa.gov/pdf/ca/DenisonECFR.pdf

Manner of Death: Homicide

Cause of Death: blunt force head injury

Time between Referral and Death: 1 month

Finding regarding fatality: Founded for physical abuse by father. Unfounded for physical abuse and neglect by mother.

OFCO Attended Executive Child Fatality Review

Allegations: *It was in November 2008, CA received the first of only two referrals regarding this family. The first referral received states the following: 'The referent stated she is involved with the family and the parents are engaged. The referent stated the children look good and the home is in good condition except for the fact numerous people live there or come and go. The referent stated both children are sleeping in the same bed as the parents. A neighbor reported to the referent that [mother] is smoking pot with a 16-year old…he has an open CPS case and is on probation. The referent stated there are a lot of people in the home and they all discipline the 3-year old.' This referral was screened as information only.*

DSHS CA Executive Child Fatality Review of Screening Decision: The above referral screened as "information only" as allegations did not meet the Washington Administrative Code 388-15-009 definition of child abuse or neglect.

The review team discussed at length the screening decision regarding the above intake. The screening decision was based on the following factors: no specific allegations of child abuse and/or neglect were identified, the family had no previous CPS history, the family was engaged in services to support caring for their infant, and both children in the home appeared healthy and doing well. The review committee agreed based on the information provided at the time of intake the screening decision, information only was appropriate.

The review committee did discuss intakes received from mandated reporters in general warrant close scrutiny. They noted the above intake screening decision was reviewed and approved by an Intake supervisor. In reviewing FS [First Steps] notes not all the information in the notes were captured in the intake received by CA. It was suggested when intakes are received from mandated reporters that may not support assignment for investigation, it is prudent to ask the mandated reporter what intervention if any they are expecting or if they have additional information related to safety or risk. Documentation of this additional information should be recorded in the intake along with discussion regarding expectation of CA's intervention.

Finding: Review of the First Steps provider notes appears some information may not have been captured in the above intake. Whether this is a result of CA not recording information received or the referent not including the information their initial report is unknown.

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.

At the recommendation of the Office of Family and Children's Ombudsman, CA should consider contacting the law enforcement when information in an intake alludes to possible criminal activity at a residence (e.g. smoking marijuana with a 16-year old). Currently, CA is required to notify law enforcement regarding referrals if its investigation reveals that crime against a child has been committed (RCW 74.13.031(3)) or if a child is alleged to have died or had physical injury inflicted as a result of alleged child abuse or neglect or has been subject to alleged sexual abuse (RCW 26.44.030(4)). While such contact may provide additional insights into possible risk factors if law enforcement is aware of any previous criminal activity or intervention associated with the family, CA should weigh this against the possibility that such reports may deter people from voluntarily seeking or participating in services through DSHS or other agencies.

CASE 11

Referent: DSHS

Age of Child at time of death: 1 month

Case Overview: On April 3, 2008, this one-month old Hispanic female was brought to a hospital in cardiac arrest. The mother told law enforcement she fell asleep with the infant on her lap and when her boyfriend woke up, he found the child face down on the floor not breathing. The deceased child's aunt and mother's boyfriend started CPR and called 911. Detectives reported there was probable cause the death resulted from possible neglect issues. In the autopsy report, it was reported that the infant was found on the floor after co-sleeping between her mother and her mother's boyfriend on a twin bed.

Child Fatality Review #08-12, Region 2, http://www1.dshs.wa.gov/pdf/ca/08-12.pdf

Manner of Death: Unknown/Undetermined

Cause of Death: Sudden Infant Death Syndrome or overlay asphyxia are both reasonable possibilities.

Time between Referral and Death: 4 months

Finding regarding fatality: Unfounded for negligent treatment or maltreatment.

Allegations: *On December 4, 2007, the deceased child's mother disclosed to a CA social worker that she was six months pregnant and over the past year used methamphetamine on an ongoing basis during her pregnancy. The mother admitted using methamphetamine on December 2, 2007. The mother said she received prenatal care through a private doctor and did not receive care or services through the Public Health Department.*

DSHS CA Child Fatality Review of Screening Decision: The referral was screened as information only according to CA intake policy and a referral to First Steps was made by CA staff.

VIII. Recommendations

The following are OFCO's recommendations. Please note that in OFCO's review of the child fatality review reports associated with the "information only" final referrals, there were a number of excellent recommendations made by the fatality review teams. Many of these seem meritorious, but we have largely resisted including these in our list of recommendations until we have an opportunity to determine their status. This will occur as part of our additional reporting obligation under 2SSB 6206, which requires us to report on the status of fatality recommendations.

FOR AGENCY OFFICIALS AND POLICYMAKERS:

- **Authorize WSIPP to further study the effect of intake worker and regional variations (identified by WSIPP as the strongest predictors of risk assigned to a referral) in screening decisions on outcomes for families and children.** Specifically, examine what effect new intake procedures adopted with the implementation of Famlink has had on these variations.
- **Ensure strong quality assurance through improved training and review:**
    - Increase collateral contacts and active questioning by intake workers so that information necessary to make appropriate screening decisions is obtained.
    - Require review at a higher level by two supervisors or more if a referral is to be downgraded.
- **Train intake workers not to rely on mandated reporters (e.g. educator at school) as a safety factor that justifies screening out a referral** when the mandated reporter who is presumed to be the "safety factor" is alleging concerns about abuse or neglect.
- DSHS CA should coordinate with Northwest Infant Survival Alliance, medical examiners and coroners, the Department of Health, and other appropriate professionals to **consider risk factors identified by statewide child death reviews in further refining CPS intake protocol on referrals pertaining to infants**. Require intake workers to gather information about the sleeping environment (to determine if there is a safe sleeping arrangement), the parent's substance abuse history even when an infant is not born with a positive toxicology screen for drugs, and the gestation of the infant to help determine the risk the caregivers pose to the child.

IX. Conclusion

OFCO's data collection and analysis was facilitated by the work of many. We wish to thank WSIPP for its significant contribution to this report by analyzing outcomes of referrals to CPS. We also want to acknowledge that DSHS CA has made steady improvements over the past several years in its record keeping and documentation of data on child fatalities. We drew heavily from this data in preparing this report. We commend the Legislature's work toward making the child fatality review process more transparent and accessible to the public by requiring that reports of the child fatality review team be posted on a public website. Greater transparency will lead to necessary improvements in the child protection system.

It is our hope that OFCO's report will be a first step toward providing the Legislature, DSHS CA, and the public with data to support a further look at worker and regional variations in screening decisions; closer examination of characteristics to consider when CPS screens referrals on infants; and revised training of intake workers to ask more clarifying questions and make collateral contacts more frequently. We look forward to reporting on the implementation of existing fatality recommendations.

Technical Appendix

Regression Analyses. The exhibits in this section display statistics from logistic regression analyses described in the report. The regression analyses model the likelihood of a decision or outcome that retains a child in the child welfare system, controlling for reporter type and other factors. We include all the children with a CPS referral in modeling the likelihood that a referral will be accepted. We model placement (removal from home) and the filing of a dependency case only for children with an accepted referral. Thus, the number of children decreases as we model later points in the system.

How to read these tables. The first four tables provide the standardized logistic regression parameters for each reporter type and case characteristic. Except when factors are numbers, we omit the variable for one group to serve as a comparison. Then the standardized estimates in the table provide the magnitude and direction of an effect. For example, in these models, we omit the variable that codes for social service professionals. Looking at the results of the likelihood of an accepted referral, we see that referrals from corrections personnel are significantly more likely to result in an accepted referral than referrals from social service professionals. The standardized estimate is greatest for law enforcement. We also see that referrals from mental health professionals are significantly less likely to be accepted than those from social service professionals.

We also list the statistic, Area Under the Receiver Operating Characteristic (AUC). This statistic provides a measure of how well the model predicts an outcome. AUC can vary between 0 and 1. A value of 0.5 indicates the model does not predict the outcome. Values of 0.7 or greater indicate that the model does a good job of predicting the outcome.

The decision to accept a referral is made at the intake. For this reason, in the analysis of accepted referrals, we include the Central Intake Office.

Exhibit A.1 provides regression results for the population of children with a CPS referral between January 1, 2006 and March 1, 2008. Exhibit A.2 shows the regression results for the likelihood of placement, given an accepted referral. Exhibit A.3 provides information on the likelihood that an accepted referral results in the filing of a dependency case. For this last analysis, we restricted the referrals to those made prior to November 2006, because the legal data were incomplete for later filings. The fourth table, A.4, shows the likelihood of a dependency case after the child is removed from home.

Exhibit A.5 displays the results of a linear regression model predicting the initial risk tag assigned at intake. For this analysis, we eliminate those worker codes that allow numerous workers to log in to the computer, and we exclude workers who handled fewer than ten referrals. Controlling for other variables, we observe that the variable with the strongest influence on the initial risk tag assigned to a referral is the historical worker risk; that is, the average of the risk tags assigned by the individual intake workers over the 26-month period of this study.

Exhibit A1
Referral Accepted
N=96,656 AUC=0.738

	Standardized Estimate
Type of Reporter (Compare to Soc Svc Prof)	
Corrections	ns
Anonymous	0.0095
DSHS Personnel	ns
Medical Professional	0.0277
Law Enforcement	0.0920
Mental Health Prof	-0.0427
Friend/Neighbor	0.0746
Educator	0.0356
Other Relative	0.0309
Parent/Guardian	-0.0642
Foster Care	-0.0200
Victim	0.0227
Child Care Provider	ns
Other	0.0155
Alleged Abuser	ns
Type of Maltreatment (Compare to Neglect)	
Sex abuse	0.1824
Physical abuse	0.2713
Abandon	0.0488
Child's Age (Compare to Ages 3 to 5)	
Infant	0.1645
Ages 1 to 2	0.0784
Ages 6 to 9	-0.0674
Ages 10 to 13	-0.0888
Ages 14 and older	-0.1639
Number Prior Referrals	0.1375
Number of Victims	0.0596
After Hours Call	ns
Male	0.0309
Race (Compare to White)	
Indian	0.0269
Black	0.0183
Asian	0.0090
Hispanic	ns
DSHS Region (Compare to Region Central Intake)	
Intake Region 1	0.0387
Intake Region 2	-0.0956
Intake Region 3	-0.0646
Intake Region 4	0.0344
Intake Region 5	ns
Intake Region 6	-0.2352

Exhibit A2
Placement Given an Accepted Referral
N=57,906 AUC=0.771

	Standardized Estimate
Type of Reporter (Compare to Soc Svc Prof)	
Corrections	ns
Anonymous	-0.0948
DSHS Personnel	0.0256
Medical Professional	-0.0233
Law Enforcement	0.095
Mental Health Prof	-0.0704
Friend/Neighbor	-0.1158
Educator	-0.1159
Other Relative	-0.0645
Parent/Guardian	-0.172
Foster Care	ns
Victim	ns
Child Care Provider	-0.0514
Other	-0.0525
Alleged Abuser	ns
Type of Maltreatment (Compare to Neglect)	
Sex abuse	-0.0422
Physical abuse	-0.0619
Abandon	0.0363
Child's Age (Compare to Ages 3 to 5)	
Infant	0.2223
Ages 1 to 2	0.0552
Ages 6 to 9	ns
Ages 10 to 13	0.0219
Ages 14 and older	0.0543
Number Prior Referrals	0.1451
Number of Victims	0.019
Male	-0.0174
Race (Compare to White)	
Indian	0.035
Black	0.0362
Asian	ns
Hispanic	ns
DSHS Region (Compare to Region 4)	
Region 1	0.0967
Region 2	0.0491
Region 3	0.0251
Region 5	0.0552
Region 6	0.1425
Risk Tag at Intake	0.3004

Exhibit A3

Likelihood that a Dependency Case Is Filed
Given an Accepted Referral
Prior to November 2006
N=22,395 AUC=0.786

	Standardized Estimate
Type of Reporter (Compare to Soc Svc Prof)	
Corrections	ns
Anonymous	-0.0845
DSHS Personnel	0.0293
Medical Professional	ns
Law Enforcement	ns
Mental Health Prof	-0.0546
Friend/Neighbor	-0.1391
Educator	-0.1411
Other Relative	-0.0859
Parent/Guardian	-0.1399
Foster Care	ns
Victim	ns
Child Care Provider	-0.0538
Other	-0.0568
Alleged Abuser	ns
Type of Maltreatment (Compare to Neglect)	
Sex abuse	-0.0593
Physical abuse	-0.1513
Abandon	0.0225
Child's Age (Compare to Ages 3 to 5)	
Infant	0.2332
Ages 1 to 2	0.0521
Ages 6 to 9	ns
Ages 10 to 13	-0.0763
Ages 14 and older	-0.0561
Number Prior Referrals	0.1217
Number of Victims	ns
Male	ns
Race (Compare to White)	
Indian	ns
Black	ns
Asian	ns
Hispanic	-0.0352
DSHS Region (Compare to Region 4)	
Region 1	0.0893
Region 2	ns
Region 3	ns
Region 5	ns
Region 6	0.1327
Risk Tag at Intake	0.2614

Exhibit A4

Likelihood that a Dependency Case Is Filed
After Removal From Home
Referrals Prior to November 2006
N=3,404 AUC=0.666

	Standardized Estimate
Type of Reporter (Compare to Soc Svc Prof)	
Corrections	ns
Anonymous	ns
DSHS Personnel	ns
Medical Professional	ns
Law Enforcement	-0.1089
Mental Health Prof	ns
Friend/Neighbor	ns
Educator	ns
Other Relative	ns
Parent/Guardian	ns
Foster Care	ns
Victim	ns
Child Care Provider	ns
Other	ns
Alleged Abuser	NA
Type of Maltreatment (Compare to Neglect)	
Sex abuse	ns
Physical abuse	-0.0856
Abandon	ns
Child's Age (Compare to Ages 3 to 5)	
Infant	0.1221
Ages 1 to 2	ns
Ages 6 to 9	ns
Ages 10 to 13	-0.1197
Ages 14 and older	-0.1171
Number Prior Referrals	ns
Number of Victims	ns
Male	ns
Race (Compare to White)	
Indian	-0.0421
Black	-0.0682
Asian	ns
Hispanic	ns
DSHS Region (Compare to Region 4)	
Region 1	ns
Region 2	ns
Region 3	ns
Region 5	-0.0594
Region 6	ns
Risk Tag at Intake	ns

Exhibit A5

Predicting Initial Risk of Referrals

N= 61,352 R-Square=0.3748

	Standardized Estimate
Type of Reporter (Compare to Soc Svc Prof)	
Corrections	ns
Anonymous	0.0329
DSHS Personnel	-0.0092
Medical Professional	0.0375
Law Enforcement	0.0745
Mental Health Prof	-0.0177
Friend/Neighbor	-0.0165
Educator	ns
Other Relative	-0.0253
Parent/Guardian	-0.0510
Foster Care	-0.0114
Victim	ns
Child Care Provider	ns
Other	-0.0151
Alleged Abuser	ns
Type of Maltreatment (Compare to Neglect)	
Sex abuse	0.0488
Physical abuse	0.0207
Abandon	0.0163
Child's Age (Compare to Ages 3 to 5)	
Infant	0.1265
Ages 1 to 2	0.0416
Ages 6 to 9	-0.0520
Ages 10 to 13	-0.0498
Ages 14 and older	-0.0563
Number Prior Referrals	0.02905
Number of Victims	-0.01588
After Hours Call	0.0308
Male	ns
Race (Compare to White)	
Indian	0.00709
Black	0.01349
Asian	0.00709
Hispanic	ns
DSHS Region (Compare to Region Central Intake)	
Intake Region 1	-0.01696
Intake Region 2	-0.02826
Intake Region 3	ns
Intake Region 4	ns
Intake Region 5	-0.02937
Intake Region 6	-0.05805
Historical Worker Risk	0.52181

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