# 2019 REPORT ON CHILD FATALITIES AND NEAR FATALITIES IN WASHINGTON STATE

OFFICE OF THE FAMILY AND CHILDREN'S OMBUDS

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# Executive Summary

The Office of the Family and Children's Ombuds (OFCO) was established to ensure that government agencies respond appropriately to children in need of state protection, children residing in state care, and children and families under state supervision due to allegations or findings of child abuse or neglect. As part of its oversight of the state child welfare system, OFCO examines critical incidents, such as child fatalities, near fatalities and cases of recurrent child maltreatment. OFCO also participates in executive child fatality and near fatality reviews and reports on the implementation status of recommendations produced from these executive reviews. Through this process, OFCO identifies issues related to these critical incidents and facilitates systemic improvements.

The Department of Children, Youth and Families (DCYF) notifies OFCO when a critical incident occurs.[1] OFCO then conducts an independent preliminary review of the circumstances surrounding the incident and the Department's involvement. Critical incidents include:

- **Child Fatalities:** When the family was involved in the child welfare system within the preceding 12 months of the child's death, including "information only" referrals; or when the fatality occurred in a DCYF licensed, certified, or state operated facility.[2]

- **Child Near Fatalities:**[3] When the near fatality is a result of alleged child abuse and/or neglect and the family was involved in the child welfare system within the preceding 12 months, including "information only" referrals; or the near fatality occurred in a DCYF licensed, certified, or state-operated facility. A near fatality is defined as an act that, as certified by a physician, places the child in serious or critical condition.[4]

- **Recurrent Maltreatment:**[5] When children in the same family experience three founded reports of alleged abuse or neglect within the preceding 12 months.

- **Other Critical Incidents:** The Department notifies OFCO of other critical incidents including child abuse allegations in licensed foster homes or residential facilities, high-profile cases, incidents involving DCYF clients (such as dangerous behavior by foster youth), or incidents affecting DCYF staff safety. OFCO briefly reviews each of these cases to assess whether there is any unaddressed safety issue, and if so, may conduct a more thorough review.

**Section I** of this report describes OFCO's critical incident review activities from January 1, 2018 to December 31, 2018. The critical incidents discussed in this report include: child fatalities, child near fatalities, and recurrent maltreatment.

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[1] OFCO receives notice through DCYF's Administrative Incident Reporting System (AIRS).
[2] When a report does not meet the legal definition of child abuse or neglect intake staff documents this information as an "Information Only" intake in the DCYF database.
[3] RCW 74.13.640(2) requires the Department to promptly notify the Ombuds in the event of a near fatality of a child who is in the care of or receiving services from the Department or a supervising agency or who has been in the care of or received services from the Department or a supervising agency within one year preceding the near fatality. The Department may conduct a review of the near fatality at its discretion or at the Ombuds' request.
[4] RCW 74.13.640(2)(c).
[5] RCW 26.44.030(15).

Over this one year period, OFCO conducted:

- **87** administrative examinations of child fatalities involving both child abuse or neglect and cases unrelated to child maltreatment;
- **21** examinations of child near fatalities; and
- **117** reviews of cases of recurrent maltreatment.

Of these, OFCO considered **47** child fatalities and **13** child near fatalities to be related to child maltreatment. Through this process OFCO identifies common factors and systemic issues regarding these critical incidents.

Child neglect continues to constitute the largest number of the founded reports in recurrent maltreatment cases and is more likely to recur than physical or sexual abuse.

DCYF conducts a child fatality review when the death of a child was suspected to be caused by abuse or neglect, and the child received services from DCYF at the time of death, or in the preceding 12 months. The review committee consists of individuals with no prior involvement with the case, and typically includes DCYF staff, OFCO staff, and community professionals with expertise relevant to the case, such as law enforcement, chemical dependency, domestic violence, mental health, child health, or social work practice. The purpose of reviewing child fatalities and near fatalities is to increase understanding of the circumstances around the child's injury or death, evaluate practice and programs and make recommendations to prevent future child fatalities or near fatalities and improve the health and safety of children. OFCO is required to issue an annual report on the implementation of recommendations issued by fatality review committees.

**Section II** of this report describes the implementation status of recommendations made in child fatality and near fatality reviews conducted between **October 1, 2017 and December 31, 2018.** During this period, DCYF conducted **27 child fatality reviews and 6 near fatality reviews.** These reviews produced **57 recommendations**. OFCO found that 19 recommendations (33.3%) were completely implemented and 32 (56.1%) were in the process of implementation. The majority of recommendations addressed statewide issues (89.5%) as opposed to regional or local office concerns. Recommendations generally addressed increased training, improving casework practice, and enhancing partnerships with community professionals.

# Child Fatalities Examined by OFCO

OFCO conducts a preliminary review of all fatalities in which the child's family was involved with Washington's child welfare system within 12 months of the fatality, regardless of whether the subject child received services from the Department, and regardless of whether the child's death was suspected to be caused by child abuse or neglect.[6]

OFCO examines these fatalities to:

- identify current safety issues for any children remaining in the home;
- determine whether the fatality appears to have resulted from abuse or neglect, thus requiring DCYF to conduct an executive child fatality review OR whether ongoing child maltreatment concerns in the child's family may have contributed to the fatality;
- identify any problematic casework practice or decisions by the agency, to ensure more effective protection of any other children in the family OR to improve agency services and case management in similar cases in the future; and
- assist policymakers in developing stronger policies to protect children.

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

OFCO examined **87 child fatalities in 2018**.[8] Not all fatalities OFCO receives notice of are related to maltreatment. For example, OFCO may receive notice of an expected medical death of a child whose family has had contact with the Department in the past 12 months.

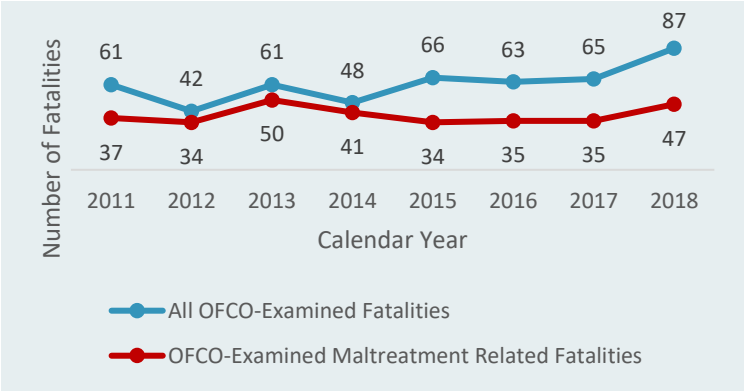
OFCO defines **maltreatment-related fatalities** to be those in which:

- the child's death was directly caused by abuse or neglect; or
- the child's death was not a direct result of maltreatment, but the family has a history of abuse or neglect of that child and/or other children in the family that may have contributed to the child's death.

Of the 87 child fatalities examined by OFCO in 2018, OFCO considered **47** to be related in some way to child maltreatment. The following data describes the profile of these 47 maltreatment-related child fatalities. While this report primarily focuses on incidents that occurred in 2018, four years of demographic data is available in Appendix A in order to contextualize these incidents and show year-to-year differences.

[6] "DCYF history" may include reports to CPS that were not screened in for investigation.
[7] State law requires DCYF to conduct an executive child fatality review when the child's death is suspected to be caused by child abuse or neglect, and the child was either in the Department's custody or receiving services in the 12 months before the death.
[8] Calendar year.

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




## Fatality Case Examples By Maltreatment Type

***Clear Physical Abuse***

A six-month-old infant died as a result of physical injuries inflicted by the mother. The mother admitted to throwing the infant face down into her crib then striking the infant multiple times on the back of the head, which fractured the infant's skull. At the time of the incident, the mother had an open CPS case. The CPS investigation into the fatality resulted in a founded finding of physical abuse by the mother. The mother was charged with second-degree murder.

***Clear Neglect***

A five-month-old was found unresponsive in the morning by the mother. The Medical Examiner's office determined the cause of death to be bronchitis and chronic methamphetamine exposure as a significant condition contributory to the child's death. The mother had an extensive CPS history including a founded finding due to substance abuse and leaving the children without adequate supervision and without a safe and healthy living environment. The investigation resulted in a founded finding of neglect by the mother.

***Child Maltreatment Concerns***

A sixteen-year-old was shot and killed in an incident that was believed to be gang-related. The youth's mother was present at the scene, heavily intoxicated. The youth's grandparents had legal custody but reported that they were unable to keep the youth from leaving the home and the youth spent most of their time living with the mother in her car or moving from couch-to-couch. The mother was involved in gang activity and did not have legal custody of her children. There were no findings made as the intake screened in for a CPS Risk Only investigation.

## OFCO CHILD MALTREATMENT DEFINITIONS

**Clear Physical Abuse**: A CPS investigation concluded that physical abuse by a caretaker caused the child's death. Law enforcement reports, medical records, and/or an autopsy report may also have concluded that intentionally inflicted physical injuries caused the child's death.

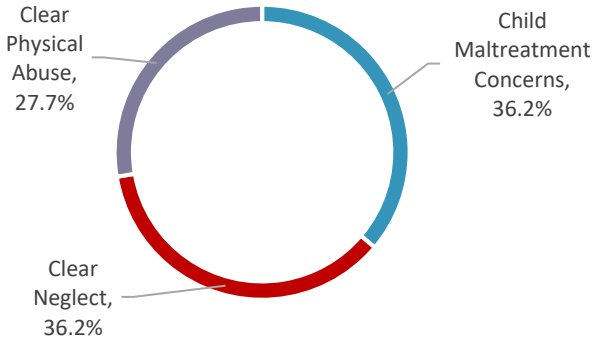
**Clear Neglect**: A CPS investigation concluded that neglect by a caregiver (e.g. an infant or toddler left unattended) caused the child's death. Law enforcement reports, medical records, and/or an autopsy report may also have concluded that negligent treatment/maltreatment caused the child's death.

**Child Maltreatment Concerns**: Factors associated with child abuse or neglect were present in the family's history and while not a direct cause, may have contributed to the child's death. These factors include: substance abuse; domestic violence in the presence of children; mental health issues that impair a parent's ability to appropriately care for a child; and prior substantiated abuse or neglect of the deceased child or of other children in the family.

## Maltreatment-Related Child Fatalities

Figure 2: **Type of Maltreatment in Child Fatalities, 2018**

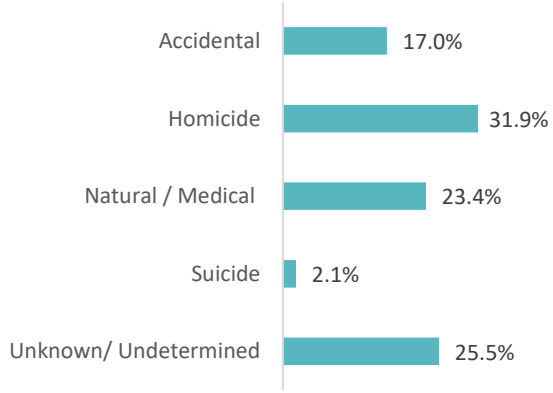
Of the 47 child fatalities related to maltreatment, 17 children died as a direct result of neglect and 13 died from physical abuse. OFCO found that child abuse or neglect concerns were present and may have contributed to the child's death in another 17 cases.




- Of the 47 maltreatment-related deaths examined during this period, 21 deaths resulted in a "**founded**" finding of neglect and/or physical abuse.
- Investigations into **8** deaths were "**unfounded**".
- In the remaining **18** deaths, **no findings** were made.
  Findings may not have been made for many reasons, including the intake may have screened out, the death may have occurred out of state and was investigated by another state's child welfare agency, or there may have been a "risk only" CPS investigation.

## Manner of Death

Figure 3: **Manner of Death, 2018**




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

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

The cause of death details how the death occurred. For example, the manner of death is determined as natural or medical when the cause of death is pneumonia, or the manner of death is determined as accidental when the cause of death is a drug overdose. Based on the scene investigation and other factors, a death caused by drug overdose could also be determined to be suicide.

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

| Manner of Death | Fatality and Case Status Summary |
|---|---|
| **Accidental** | A four-month-old infant died after the mother rolled over on top of the infant while co-sleeping. The Medical Examiner determined that the infant most likely passed from asphyxia. Toxicology results revealed the infant was positive for methamphetamines but the manner of death was ruled as an accident.<br><br>***Case History*:** The family had an open CPS case at the time of the infant's death. The mother's rights to two other children were terminated within the past two years.<br>***Placement*:** The child was in the care of the parents.<br>***Fatality CPS Investigation:*** The investigation resulted in a founded finding of neglect by the mother. |
| **Homicide** | Two siblings, ages one and two, were found deceased in their home alongside their mother and father. Law enforcement believed that the father killed the children and mother before killing himself.<br><br>***Case History*:** The family had an open dependency case.<br>***Placement*:** The children were placed with their parents under an in-home dependency.<br>***Fatality CPS Investigation*:** There was no CPS investigation as both parents were deceased. |
| **Natural or Medical** | A six-month-old infant was found deceased after being wrapped in a heavy blanket and placed to sleep with a bottle in a Rock 'n Play.[9] The Medical Examiner determined the manner of death was natural and the cause of death was SIDS.<br><br>***Case History:*** The family was receiving Child Family Welfare services and the child was placed in out-of-home care.<br>***Placement*:** The child was placed with an unlicensed, suitable person.<br>***Fatality CPS Investigation*:** There was a CPS risk-only investigation opened on the suitable person caregivers. No findings are made in a risk-only case. |
| **Suicide** | A sixteen-year-old died by suicide after running from her group home placement. The youth had a history of prior suicide attempts.<br><br>***Case History*:** The youth was dependent.<br>***Placement*:** The youth was placed in a group home but was missing from care at the time of death.<br>***Fatality CPS Investigation:*** DLR conducted a licensing investigation into the group home and there were no valid licensing findings. |
| **Unknown or Undetermined** | A nine-month-old infant was found unresponsive in the father's bed. The father slept next to the infant in a cluttered bed. The Medical Examiner certified the death as undetermined and the cause of death as Sudden Unexplained Infant Death.<br><br>***Case History***: The family had an open CPS case at the time of the infant's death. The infant's twin sibling passed away from SUIDs four months prior.<br>***Placement*:** The child was in the care of the parents.<br>***Fatality CPS Investigation*:** The investigation resulted in a founded finding of neglect by the father. |

[9] A Rock 'n Play is an inclined padded baby seat. This equipment does not qualify for DCYF's definition of a safe sleep environment. In 2019, there was a recall of Rock 'n Plays due to at least 30 infant deaths related to the product but the recall was not in effect at the time of this child's death.

## Child Fatalities and Racial Disproportionality

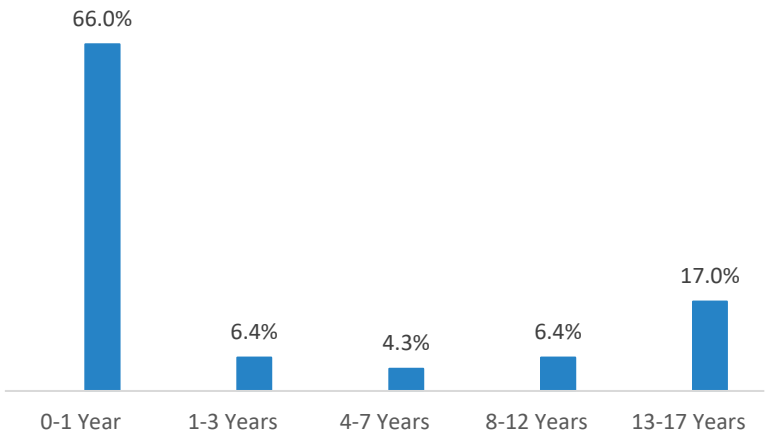
As in previous years, maltreatment-related child fatalities continue to be disproportionally higher for children of color. While African American or Black children make up 4.8% of Washington children and 9.2% of Washington children in out-of-home care, 19.1% of maltreatment-related child fatalities examined by OFCO in 2018 were those of African American or Black children.

Table 1: **Child Race and Ethnicity, 2018**

| | OFCO-Examined Maltreatment-Related Child Fatalities | | WA Children in Out of Home Care[10] | WA State Children[11] |
|---|---|---|---|---|
| | # | % | | |
| **African American or Black** | 9 | 19.1% | 9.2% | 4.8% |
| **American Indian or Alaska Native** | 4 | 8.5% | 4.9% | 2.4% |
| **Asian or Pacific Islander** | 1 | 2.1% | 2.3% | 9.1% |
| **Caucasian** | 24 | 51.1% | 62.9% | 73.3% |
| **Other** | 1 | 2.1% | -- | -- |
| **Multi-Racial** | 8 | 17.0% | 20.4% | 10.4% |
| **Latino / Hispanic** | 6 | 12.8% | 19.7% | 21.7% |

## Child's Age at Time of Death

Figure 4: **Age of Child at Time of Death, 2018**




A majority of maltreatment-related fatalities (72.4%) involved children under the age of three. Infants (birth to 12 months) accounted for 66% of the fatalities. Infants are the most vulnerable to risk of fatal harm from their caregivers.

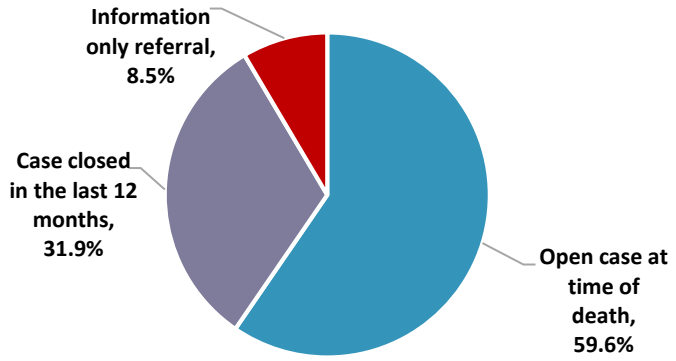
[10] Partners for Our Children Data Portal Team. (2019). [Graph representation of Washington state child welfare data 10/20/2019]. Children in Out-of-Home Care (Count). Retrieved from http://www.vis.pocdata.org/graphs/ooh-counts.
[11] Office of Financial Management. Estimates of April 1 population by age, sex, race and Hispanic origin. 2019. http://www.ofm.wa.gov/pop/asr/default.asp

## Family Contact with the Department of Children, Youth, and Families

OFCO examines child fatalities when there is an open case with the family at the time of death or any DCYF history or contact in the preceding 12 months. This includes referrals made to DCYF that were screened as "information only" and did not meet the criteria for investigation or services. OFCO also examines fatalities that occur in a DCYF licensed, certified, or state operated facility.

Nearly 60% of the families involved in the maltreatment-related fatalities examined by OFCO had an open case with DCYF at the time of death. Thirty-two percent of families had cases that closed in the previous 12 months.

Figure 5: **DCYF Case Status within 12 Months of Fatality, 2018**




*Of the 28 fatalities with open cases at the time of death, 11 were open for CPS investigation; 8 families were receiving Child and Family Welfare Services; 5 were open to the FAR program; and 4 were participating in FVS.*

Table 2: **Program Type for DCYF Cases Open at Time of Death, 2018**

| Program Type | Program Description[12] | Number of Fatalities | Percent |
|---|---|---|---|
| **Child Protective Services (CPS) – Investigation Pathway** | Investigates screened in reports of child maltreatment. | 11 | 39.3% |
| **Child and Family Welfare Services (CFWS)** | Case management and permanency planning for children and youth in out-of-home placement. | 8 | 28.6% |
| **Family Assessment Response (FAR)** | A CPS alternative pathway to investigate low to moderate risk screened in reports of child maltreatment and offer any needed services. | 5 | 17.9% |
| **Family Voluntary Services (FVS)** | Cases transfer to FVS after a CPS investigation, AND the parent requests services OR the family was determined to be at moderately high or high risk for abuse or neglect. Participation is voluntary. | 4 | 14.3% |

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

Table 3: **Placement at Time of Death, 2018**

| Program Type | Parental Care | Relative Care (Not Facilitated by DCYF) | Unlicensed Suitable Other | Residential Care Facility (Medical) | Missing from Care |
|---|---|---|---|---|---|
| **Child Protective Services (CPS) – Investigation Pathway** | 10 | 1 | -- | -- | -- |
| **Child and Family Welfare Services (CFWS)** | 3 | 1 | 1 | 2 | 1 |
| **Family Assessment Response (FAR)** | 5 | -- | -- | -- | -- |
| **Family Voluntary Services (FVS)** | 4 | -- | -- | -- | -- |

*Of the 28 fatalities with open cases at the time of death, majority of the children were in the care of their parents (78.6%).*

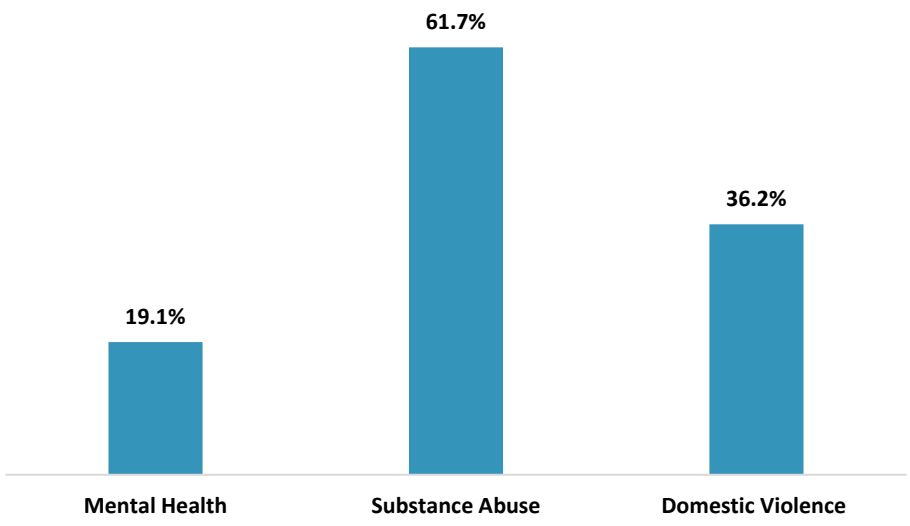
## Substance Abuse, Domestic Violence and Mental Health are Risk Factors for Child Fatalities

Parental substance abuse is a major risk factor for child fatalities, maltreatment and involvement with the child welfare system. Children removed from their home as a result of parental substance abuse are likely to remain in foster care longer and have significantly higher rates of adoption than those in foster care for other reasons.[13]

The majority of children who died came from families with a history of drug or alcohol abuse (61.7%). Of the families with known drug or alcohol abuse, 41.4% (12 families) had documented histories of prenatal drug use and in many cases this was what led to a referral to CPS at the time of a child's birth. A history of opiate use was documented in 38% of these families (11 families); 48.3% had documented methamphetamine use (14 families); and 89.7% of families were noted to use some "other substance", most commonly alcohol or marijuana.

Domestic violence and mental health disorders were also identified as significant risk factors in many of these fatalities. At least one of these three risk factors was present in 72.3% of the fatalities examined by OFCO.

Figure 6: **Family Risk Factors in Child Maltreatment-Related Fatalities, 2018**




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

## Majority of Infant Deaths are Related to Unsafe Sleep Environments

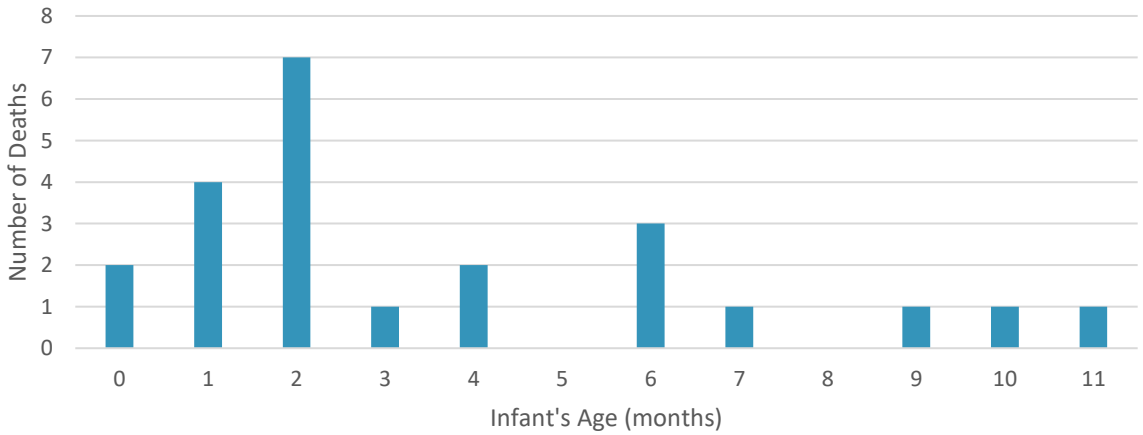
Approximately 3,500 infants in the United States die each year from sleep-related deaths.[14] To reduce the risk of infant deaths the American Academy of Pediatrics recommends several infant care strategies, including:

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

Bed-sharing or co-sleeping is particularly dangerous for babies born prematurely or with a low birth weight; if a caregiver is a smoker or the mother smoked during pregnancy; an adult has used any medications that make it harder to wake up; an adult has consumed any alcohol or drugs; or the surface has soft bedding on it or is soft like an armchair or couch.[15] One study found the chance of a baby dying of SIDS while bed-sharing is substantially higher when the baby is of low birth weight, the parent(s) smoke and the mother consumes more than two alcoholic drinks regularly than for families who have none of those risk factors.[16]

In 2018, OFCO examined the deaths of **23 infants** that occurred when the child was in an unsafe sleep environment. These deaths comprise the vast majority of infant fatalities examined by OFCO (74.2%). Most of these infants were under the age of six months and over half of these infants were Caucasian.

Figure 7: **Infant's Age at Time of Death, 2018**




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

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

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

Table 4: **Infant's Race and Ethnicity, 2018**

| | Number | Percent |
|---|---|---|
| **African American or Black** | 4 | 17.4% |
| **American Indian or Alaskan Native** | 2 | 8.7% |
| **Asian or Pacific Islander** | 1 | 4.3% |
| **Caucasian** | 12 | 52.2% |
| **Other** | 1 | 4.3% |
| **Multi-Racial** | 3 | 13.0% |
| **Latino Hispanic** | 3 | 13.0% |

**DCYF Policies Addressing "Safe Sleep"**

DCYF staff must conduct a safe sleep assessment when placing a child under one year in a new placement setting and when completing a CPS intervention with a family that has a child under one. When licensing or approving home studies with families that accept infants for placement, the home study worker must assess the sleeping environment and educate the family on safe sleep practices.[17] Assessing and discussing safe sleep is particularly important for children and families with the risk factors of substance abuse, alcohol use, smoking, premature births or low birth weights, and babies with medical complications.

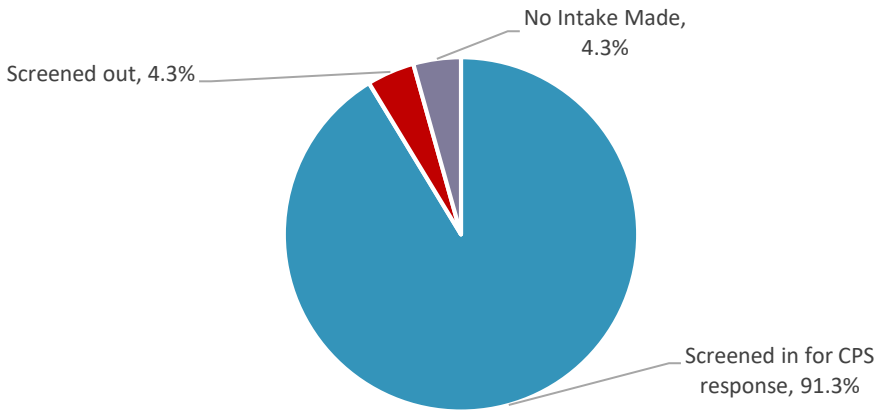
**Are Unsafe Sleep Environments Neglectful?**

There is a wide range of CPS responses and outcomes to an infant death that occurs while co-sleeping or in another unsafe sleep environment. This variance is expected based on differing family histories, circumstances, and results from the autopsy or death investigation. Though a baby may have died while co-sleeping or while in another unsafe environment, it is not always clear if the sleeping environment was a causal factor in the death. In many of these kinds of deaths there are other risk factors present as well, such as exposure to illicit substances or a parent who is under the influence.

[17] DCYF Practices and Procedures Guide. 1135. Infant Safety Education and Intervention.

Of the 23 infant fatalities examined by OFCO that occurred in an unsafe sleep environment, 21 screened in for some type of CPS response and one screened out as it did not meet the criteria for a CPS response ("information only").[18] Of the reports that were accepted for a CPS response, 11 were founded for negligent treatment or maltreatment, 6 were unfounded, and there were no findings made in 4.

Figure 8: **CPS Response to Referrals of Infant Deaths in Alleged Unsafe Sleep Environments, 2018**




[18] In one fatality no CPS referral was made.

# Child Near Fatalities Examined By OFCO

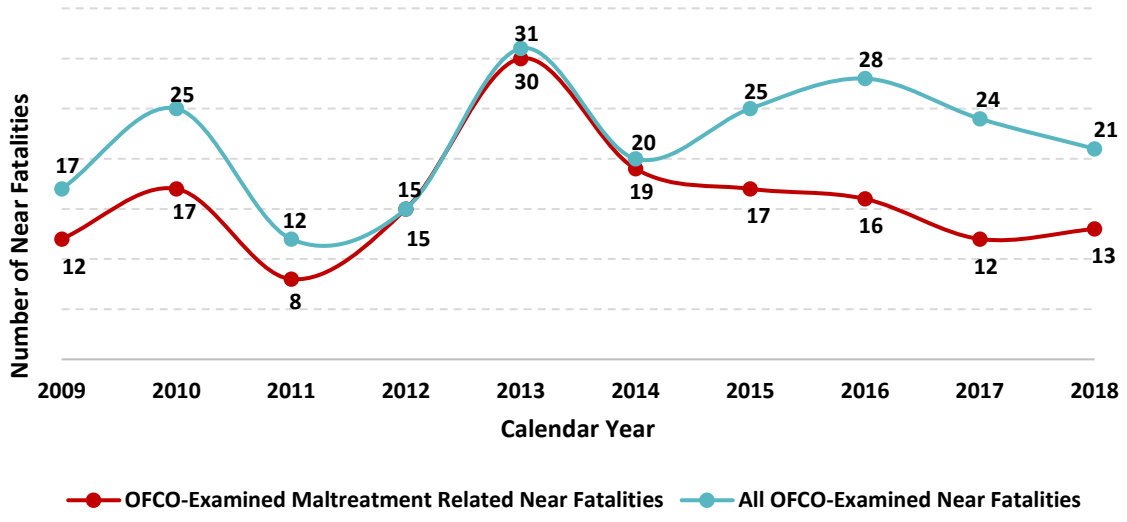
State law requires DCYF to notify OFCO of the near fatality[19] of any child who has been in the Department's custody, or receiving services, within the last 12 months.[20] OFCO conducts a preliminary review of all near fatalities involving alleged child abuse or neglect when the family had an open case with DCYF at the time of the near fatality or in the preceding 12 months, even if the subject child was not the recipient of Department services and including "information only" referrals.

OFCO examined **21 near fatalities in 2018**. OFCO considered 13 of the near fatalities to be related to child maltreatment.

OFCO examines these cases to:

- identify any safety issues regarding the child and any other children remaining in the home;
- determine whether the near fatality appears to have resulted from abuse or neglect, thus requiring a DCYF near fatality review, or whether ongoing child maltreatment concerns in the family may have contributed to the near fatality;
- identify any problematic casework practice or decisions by the agency to ensure more effective protection of the children in the family, as well as improve agency services in similar cases in the future; and
- assist policymakers in developing strategies to avoid near fatalities.

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



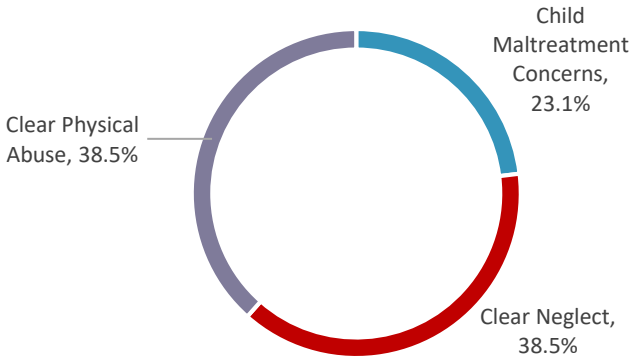

[19] RCW 74.13.500 defines "near fatality" as "an act that, as certified by a physician, places the child in serious or critical condition."
[20] RCW 74.13.640(2).

## Maltreatment-Related Near Fatalities

*OFCO identifies child near fatalities reported to CPS that were directly caused by child abuse or neglect, as well as those in which abuse or neglect concerns may have contributed to the incident, and the family had DCYF history in the preceding 12 months.*

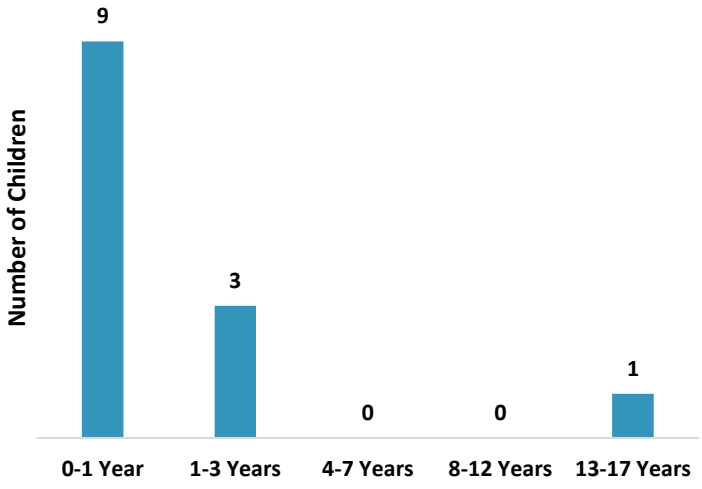
*Of the 21 near fatalities examined by OFCO in 2018, thirteen were determined to either be caused by abuse or neglect, or abuse or neglect concerns were present.*

Figure 10**: Maltreatment-Related Child Near Fatalities, 2018**




## Child Age at Time of Near Fatality

Figure 11: **Child Age at Time of Near Fatality, 2018**




*The vast majority of the maltreatment-related near fatalities in 2018 involved children under the age of three years. There was only one maltreatment-related near fatality of a child over four years of age in 2018.*

## Examples of Maltreatment-Related Near Fatalities

### Infant Attacked by Family Dog

A one-month-old infant with multiple lacerations and scratches all over their body was brought to the hospital by the parents in critical condition. The father reported that he placed the baby in a baby swing in the living room then went to the bedroom down the hallway and fell asleep. About an hour later, the father woke up to the infant screaming. The father went into the living room and found the baby laying on the living room floor, covered in multiple scratches and possible bite marks from the family dog.

Although the injuries were found to be consistent with the explanation, there was some concern about the father's delay in responding to the infant's crying. The CPS investigation into the incident was unfounded.

### Infant Exposed to Multiple Drugs

An eleven-month-old infant was transported to the hospital in respiratory distress. The infant tested positive for cocaine, cannabis, and opiates. Medical personnel administered CPR twice and gave multiple doses of Narcan. The parents did not keep the drugs out of reach and the child was able to get ahold of the drugs. The CPS investigation resulted in founded findings of neglect for both parents.

### Toddler Abused by Mother's Partner

During a traffic stop, a two-year-old child was found by law enforcement with the parents. Law enforcement observed that the child was severely malnourished, extremely dehydrated, had a broken leg, and a brain bleed. At the hospital, the child tested positive for cannabinoids and was observed to have multiple old scars all over the body.

An intake was made to CPS a few days prior to the child's hospital admission that alleged the mother and the child were physically assaulted by the mother's partner. The intake also alleged that the mother did not get the child medical care following the injuries. The CPS investigation into this incident resulted in a founded finding of physical abuse by the mother's partner and a finding of neglect by the mother.

# Recurrent Maltreatment

DCYF is required to notify OFCO of all families or children who experience three or more founded reports[21] of abuse or neglect in the last 12 months.[22] This notification enables OFCO to review cases involving chronic child maltreatment and intervene as needed. A close review of recurrent maltreatment cases can indicate whether Washington's child welfare system is effectively reducing the recurrence of child maltreatment, and inform practice to further reduce this problem.[23]

In 2018, OFCO received **117 notifications** of families or children who experienced three or more founded reports in a 12 month period. **Neglect is by far the most common type of recurrent maltreatment experienced by children**, comprising 74.6% of all founded reports reviewed by OFCO in 2018. Approximately 16% of the founded reports were physical abuse allegations, and 9% were sexual abuse allegations.

Figure 12: **Number of Recurrent Maltreatment Notifications Made to OFCO, 2010-2018**

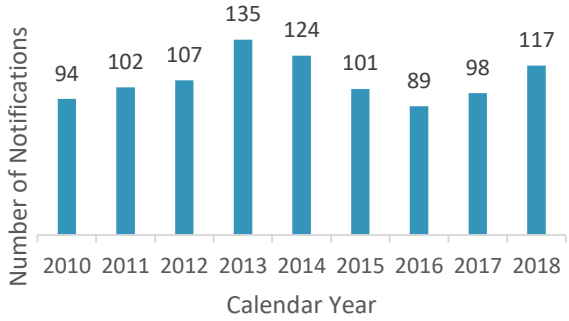
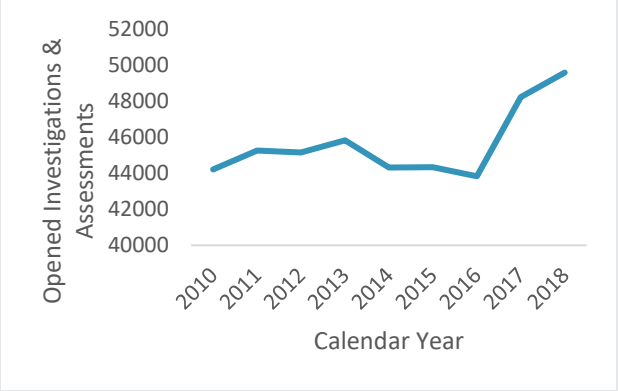



Figure 13: **Opened Investigations and Assessments, Department of Children, Youth, and Families**[24]




Some factors may affect the recurrence rates. If the number of intakes made to CPS or the number of opened investigations and assessments increase, the number of founded allegations of abuse or neglect would be expected to increase as well. As shown in Figure 13, the number of opened investigations and assessments matches the trend seen in OFCO's recurrent maltreatment reviews. Investigations and assessments increased from 2010 through 2013, dropped from 2014 to 2016, and increased in both 2017 and 2018.

[21] "Founded" means the determination following an investigation by the Department that, based on available information, it is more likely than not that child abuse or neglect did occur - see RCW 26.44.020(8). In this context, "report" means a "referral" to Child Protective Services, which DCYF calls an "intake."

[22] RCW 26.44.030(13)

[23] "Repeat Maltreatment" was identified as an area needing improvement in the 2010 Washington State Child and Family Services Review (CFSR). The CFSR also noted that there has been a significant drop in re-victimization rates since 2005. *July 2010 State Assessment.*

[24] Partners for Our Children Data Portal Team. (2019). [Graph representation of Washington state child welfare data 4/25/2019]. Investigations & Assessments (Count). Retrieved from http://www.vis.pocdata.org/graphs/ia-counts.

# Implementation Status of Recommendations

The Department of Children, Youth, and Families (DCYF) conducts a child fatality review when the death of a child was suspected to be caused by abuse or neglect, and the child was in the care of or receiving services from DCYF at the time of death, or in the preceding 12 months.[25] If it is not clear whether a child's death was the result of abuse or neglect, the Department must consult with OFCO to determine if a review should be conducted. The Department must also review any near fatality of a child[26] who was in the care of or receiving services from the Department at the time of the incident or in the preceding 12 months.[27] Even if these criteria are not met, DCYF may conduct a review of any fatality or near fatality at its discretion, or at the request of OFCO.[28]

The purpose of reviewing child fatalities and near fatalities is to increase the agency's understanding of the circumstances around the child's injury or death and to evaluate practice, programs and systems to improve the health and safety of children.[29] These reviews of the Department's services and community response to concerns about child abuse and neglect help identify areas for increased education and training, as well as potential policy or legislative changes.

The committee reviewing a child fatality or near fatality is made up of individuals with no prior involvement with the case, and typically includes DCYF staff, OFCO staff, and community professionals with expertise relevant to the case, such as law enforcement, chemical dependency, domestic violence, mental health, child health, or social work practice. The review committee has full access to all relevant records and files regarding the child and family that have been produced or retained by the supervising agency.[30]

DCYF must issue a report on child fatality review results within 180 days following the fatality, unless granted an extension by the Governor.[31] These reports are subject to public disclosure and must be posted on the Department's public website. The Department is required to redact confidential information contained in these reports to protect the child's privacy, as well as the privacy of siblings and any other information protected by law (e.g., HIPPA protected information).[32]

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[25] See RCW 74.13.640. Prior to the passage of SHB 1105 in 2011, DCYF was required to review any unexpected deaths of children who were in the care of or receiving services from CA, or had received care or services in the last year. As amended, DCYF must only review those deaths that are "suspected to be caused by child abuse or neglect." This eliminates fatality reviews of a child's accidental or natural death, even if the child had been receiving child welfare services in the year prior to the fatality.

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

[27] RCW 74.13.640(2). A review is also required if the child was receiving services from a supervising agency at the time of the incident or in the prior three months.

[28] Id. The Department also conducts internal fatality or near fatality reviews when a case does not meet the statutory requirements that mandate an executive review, but the Department and/or OFCO believe a review could aid in evaluating the agency's practice. Because these reviews do not meet the statutory requirements for public release, internal review reports remain confidential in order to protect the privacy of the child and family.

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

[30] RCW 74.13.640(3).

[31] Id.

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

In order to promote accountability and the consistent implementation of recommendations from fatality reviews, OFCO is required to issue an annual report to the Legislature on the implementation of recommendations issued by fatality review committees.[33] This report also includes recommendations from near fatality reviews.

This section of the report describes the implementation status of recommendations made in child fatality and near fatality reviews conducted by DCYF between **October 1, 2017 and December 31, 2018.**[34] During this period, DCYF conducted reviews in the **deaths of 27 children and 6 near fatalities**. These reviews produced **57 recommendations**. OFCO reviewed information provided by DCYF and found that 19 recommendations (33.3%) were already completed and 32 (56.1%) were still in the process of implementation. The majority of recommendations addressed statewide issues (89.5%). Local office concerns were addressed in 8.8% of recommendations and one recommendation was tailored to remedy a regional concern.

Table 5: **Child Fatality and Near Fatality Review Recommendations by Implementation Status and Targeted Organizational Level, October 2017 – December 2018**

| | Number of Recommendations | Percent | Statewide (#) | Region (#) | Office (#) |
|---|---|---|---|---|---|
| **Implemented** | 19 | 33.3% | 14 | -- | 5 |
| **In Process** | 32 | 56.1% | 31 | 1 | -- |
| **Considered, Not implemented** | 6 | 10.5% | 6 | -- | -- |

**Topic areas identified by fatality recommendations:**

**Training**

- 40.4% of recommendations

**Casework Practice**

- 57.9% of recommendations

**Partnering with Community Professionals**

- 1.8% of recommendations

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

[34] The implementation status of recommendations from fatality reviews occurring before October 1, 2017 are included in past OFCO reports and can be found at: http://ofco.wa.gov/reports/.

# Major Themes of Recommendations

Table 6: **Child Fatality and Near Fatality Review Recommendations by Topic, 2017-2018**

| | Number | Percent | Percent of Topic Completed | Percent of Topic in Process | Percent of Topic Considered but Not Implemented |
|---|---|---|---|---|---|
| **Training** | 23 | 40.4% | 43.5% | 56.5% | -- |
| *Chemical Dependency* | (8) | | | | |
| *Safety* | (7) | | | | |
| *Casework Practice* | (6) | | | | |
| *Domestic Violence* | (2) | | | | |
| **Casework Practice** | 33 | 57.9% | 24.2% | 57.6% | 18.2% |
| *Operations and Administration* | (17) | | | | |
| *Policy/Rule Change* | (7) | | | | |
| *Multidisciplinary Collaboration* | (5) | | | | |
| *Safety Assessment & Planning* | (2) | | | | |
| *Other Casework Practice* | (2) | | | | |
| **Partnerships with Community Professionals** | 1 | 1.8% | 100% | -- | -- |

# APPENDICES

## APPENDIX A:

2015-2018 Maltreatment-Related Child Fatality and Near Fatality Data

## APPENDIX B:

Child Fatality and Near Fatality Review Recommendations

# Appendix A: 2015-2018 Maltreatment-Related Child Fatality and Near Fatality Data

This appendix includes additional data regarding maltreatment-related fatalities and near fatalities examined by OFCO each year from 2015 to 2018. During this four year period OFCO examined 151 maltreatment-related fatalities and 59 maltreatment-related near fatalities.

Table 7: **Number of Maltreatment-Related Child Fatalities per Year**

(n = 151)

| | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|
| Clear Physical Abuse | 5 | 3 | 4 | 13 |
| Clear Neglect | 8 | 10 | 8 | 17 |
| Child Maltreatment Concerns | 21 | 22 | 23 | 17 |

Table 8: **Manner of Death per Year**

(n = 151)

| | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|
| Accidental | 8 | 11 | 6 | 8 |
| Homicide | 5 | 4 | 4 | 15 |
| Natural / Medical | 14 | 7 | 11 | 11 |
| Suicide | 2 | 3 | 0 | 1 |
| Unknown / Undetermined | 5 | 10 | 14 | 12 |

Table 9: **Child Age at Time of Death per Year**

(n = 151)

| | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|
| 12 Months or Less | 24 | 21 | 29 | 31 |
| 1-3 Years | 3 | 7 | 5 | 3 |
| 4-7 Years | 3 | 0 | 1 | 2 |
| 8-12 Years | 1 | 1 | 0 | 3 |
| 13-17 Years | 3 | 6 | 0 | 8 |

Table 10: **Child Race and Ethnicity in Maltreatment-Related Fatalities per Year**

(n = 151)

| Race and Ethnicity | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|
| African American or Black | 3 | 2 | 5 | 9 |
| American Indian or Alaska Native | 1 | 7 | 2 | 4 |
| Asian or Pacific Islander | 3 | 1 | 2 | 1 |
| Caucasian | 21 | 23 | 18 | 24 |
| Multi-Racial | 6 | 2 | 6 | 8 |
| Other or Unknown | 0 | 0 | 2 | 1 |
| Latino / Hispanic | 3 | 2 | 2 | 6 |

Table 11: **Maltreatment-Related Child Near Fatalities per Year**

(n = 59)

| | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|
| Clear Neglect | 11 | 9 | 4 | 5 |
| Clear Physical Abuse | 5 | 3 | 4 | 5 |
| Child Maltreatment Concerns | 2 | 4 | 4 | 3 |

Table 12: **Child Age at Time of Near Fatality per Year**

(n = 59)

| | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|
| 12 Months or Less | 3 | 8 | 5 | 9 |
| 1-3 Years | 7 | 6 | 4 | 3 |
| 4-7 Years | 4 | 0 | 2 | 0 |
| 8-12 Years | 2 | 1 | 1 | 0 |
| 13-17 Years | 2 | 1 | 0 | 1 |

Table 13: **Child Race and Ethnicity in Maltreatment-Related Near Fatalities per Year**

(n = 59)

| Race and Ethnicity | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|
| African American or Black | 1 | 3 | 0 | 0 |
| American Indian or Alaska Native | 2 | 1 | 2 | 4 |
| Asian or Pacific Islander | 0 | 0 | 0 | 1 |
| Caucasian | 12 | 10 | 9 | 6 |
| Multi-Racial | 3 | 2 | 0 | 2 |
| Other or Unknown | 0 | 0 | 1 | 0 |
| Latino / Hispanic | 5 | 5 | 2 | 1 |

# Appendix B: Child Fatality and Near Fatality Review Recommendations

The recommendations made by representatives from the community, OFCO, and DCYF participating in child fatality and near fatality reviews are forwarded to a DCYF administrator or DCYF's Continuous Quality Improvement Committee for review and prioritization. At regular intervals, administrators are required to report on the progress of implementing a recommendation or provide a written response when a specific recommendation is not implemented.

Listed below by topic are the **57 recommendations** made in child fatality and near fatality reviews conducted from **October 1, 2017 through December 31, 2018** and the implementation status for each recommendation.

| **Training**<br>***Casework Practice*** | |
|---|---|
| The Committee encourages the Department to provide the regional adoption units with an annual half-day refresher training on ICPC. This would require direct collaboration with the state ICPC unit in facilitating discussions with adoption workers about communicating with the ICPC unit, strategies for communicating with workers in other states (e.g., courtesy supervision and home study workers), and consulting with ICPC staff particularly at case transfer and shared planning meetings. Furthermore, the Committee encourages the Department to share previous ICPC cases that involved child fatalities or near-fatalities with field staff as opportunities to learn. | Completed<br>Level: Statewide |
| CA headquarters and the AAG's headquarters office should consider creating a training regarding communication between the staff of each agency when staffing cases for legal sufficiency, preparing for testimony and presentation and expectations at dependency hearings. | Completed[35]<br>Level: Statewide |
| CA should make training available to staff regarding the importance of connections with DDA, available information systems within DSHS including navigation, as well as provide CA staff with periodic reminders of such trainings and local resources or liaisons. The Committee believed that CA should continue to be allowed access to all DSHS computer systems and information for thorough safety assessments. | Completed<br>Level: Statewide |

[35] DCYF cannot dictate what trainings are provided to the AG's office but DCYF will pass the recommendation on to the AG's office.

| Training<br>*Casework Practice* | |
|---|---|
| Based on concerns that Department field staff may be unware of available information from the Family Court System, the Committee suggests that DCYF consider developing and making available cross-training opportunities that include participation by county family court staff. | In process<br>Level: Statewide |
| CA should make training available to all CA staff regarding the importance of connections and partnering in the field with DDA and assessing safety of children with developmental disabilities. | In process<br>Level: Statewide |
| DCYF should also create or obtain a training for staff that work with or may work with ASL speaking clients. The Committee discussed that when department staff assess child safety for clients that are deaf, there may be additional areas to consider as it relates to parenting and daily functions based on many differing aspects for that family (i.e. who is deaf, were they born deaf, is there exposure for children of deaf parents to spoken language, etc.). The Committee's intent is to make available to staff a voluntary, easy to access such as an e-learning training. | In process<br>Level: Statewide |

| Training<br>*Safety* | |
|---|---|
| The King Southeast and Southwest offices should receive training regarding safety throughout the life of a case to include informal placements, safety framework and safety threshold. | Completed<br>Level: Local |
| The local area administrator should address clinical supervision with the local supervisor in hopes to amplify timely and more accurate safety assessments, case planning and to improve supervisory case reviews and collaboration with collateral contacts. The local area administrator might consider encouraging local staff to attend the variety of available trainings for gathering information and safety assessments throughout the region. | Completed<br>Level: Local |
| The King Southwest and King Southeast offices should receive training regarding the Practices and Procedures policy 1135 Infant Safety Education and Intervention. This training should include (but not be limited to) a virtual walkthrough of assessing infant sleep, discussing developmentally appropriate care such as when to stop swaddling an infant/when to drop the crib's mattress level, intervening in unsafe sleep environments and the expectation of ongoing assessment during health and safety visits throughout the life of a case. This training should be provided to all staff. | Completed<br>Level: Local |
| CA should discuss how to provide ongoing training for all CA staff regarding infant safety on a yearly basis. This recommendation is based on the Committee's assessment that there continue to be consistent reviews of infant deaths related to unsafe sleep. | In process<br>Level: Statewide |

| Training<br>*Safety* | |
|---|---|
| The Committee recommends that field staff be given an opportunity to describe what type of trainings they believe they need in order to better assess and respond to children at risk of committing suicide. In addition to what is learned from the field staff, available trainings should include a focus on screening, appropriate intake responses, and case planning for children with suicide indicators and/or mental health issues, regardless of the child's age or program area. | In process<br>Level: Statewide |
| The Committee also recommends that DCYF staff receive training related to safe sleep assessments. The training should be interactive and include presentations showing different sleep environments for different living situations (cars, tents, campers, homes, etc.). The training should also include role-playing and video examples that show how to assess the situation and how to conduct what are often difficult discussions on unsafe sleep practices by caregivers with a child, and other appropriate interventions by the caseworker. The training should also include how an assessment and planning is conducted when there are concerns for substance use by the caregiver. This training should be mandatory. | In process<br>Level: Statewide |
| DCYF employees should attend updated Safety Framework training once they have been promoted to a supervisory position. Likewise, they should also receive updated Safety Framework training if they change disciplines within supervision, such as moving from CPS to CFWS. | In process<br>Level: Statewide |

| Training<br>*Chemical Dependency* | |
|---|---|
| The Committee identified that many families who come into contact with the Department identify using marijuana for recreational use as well as to treat other medical or mental health related ailments. The Committee recommends that DCYF staff should receive training regarding the impacts of marijuana exposure to children (in utero and use post birth by parents), the research supported benefits of marijuana, effects of marijuana on adults, adolescents and children, differing ways to use/ingest marijuana, how does marijuana use impact the body and assessing child safety when a caregiver is using marijuana. The Committee believes this training should be mandatory for all staff. | Completed<br>Level: Statewide |
| The Committee concludes that many families who come into contact with DCYF say they use marijuana recreationally as well as to treat medical or mental health-related ailments. The Committee recommends that DCYF staff receive training related to the following:<br><br>1) The impacts marijuana exposure has on children (in utero and post-birth use by parents);<br>2) The research supported benefits of marijuana; | Completed<br>Level: Statewide |

## Training

***Chemical Dependency***

| | |
|---|---|
| 3) The impact marijuana use has on the body and the effects of marijuana on adults, adolescents, children, and infants;<br>4) The different ways to use or ingest marijuana;<br>5) The assessment of child safety when a caregiver is using marijuana.<br><br>The Committee believes this training should be mandatory for all staff. | |
| The Department should provide training to help staff understand how parental poly substance abuse, as well as marijuana abuse, can impact the risk to children as well as education surrounding co-occurring disorders and how that can escalate risk to children. | In process<br>Level: Statewide |
| DCYF staff should receive training on identifying tremors in newborns and infants that were exposed to substances in utero, the next steps after identifying or hearing reports of tremors, and how to discuss this with parents and/or caregivers. | In process<br>Level: Statewide |
| The Committee recommends that DCYF staff should receive training on identifying tremors in newborns and infants that were exposed to substances in utero, the next steps after identifying or hearing reports of tremors, and how to discuss this with parents and/or caregivers. | In process<br>Level: Statewide |
| DCYF should continue to re-evaluate chemical dependency trainings offered to CA staff to include presenting specific substance abuse/use issues surfacing from child fatality and near fatality reviews. | In process<br>Level: Statewide |
| The Committee also recommends that all DCYF staff should receive mandatory training related to illegal and legal drug use (prescription medications, nicotine/vaping, marijuana, alcohol, kratom, spice, etc.), which should include the following: what various substances look like and how to identify them; the impacts and effects on the person using the substance as well as persons who are present when others use; education about harm prevention and relapse prevention plans and practices by treatment providers; how to assess child safety; and implementation of a safety plan with caregivers that are using substances. | In process<br>Level: Statewide |
| DCYF should consider providing substance abuse training that includes information about typical behavior patterns displayed by users of specific types of drugs (e.g. heroin, methamphetamine, heavy marijuana use, etc.). This training may provide workers with the potential to better assess the caregiver's situation as it relates to child safety. The Committee recommends this training be provided by a subject matter expert from the substance abuse field. | In process<br>Level: Statewide |

## Training

***Domestic Violence***

| | |
|---|---|
| CA should consider developing a training for both Assistant Attorney Generals (AAG's) and field offices regarding legal sufficiency for intervention, identification of safety threats, CA's Domestic Violence Guide and how it directs staff to interact with families when domestic violence is alleged or identified. This training could be a joint endeavor between CA and the Alliance and delivered to all CA and AAG field offices. | Completed[36]<br>Level: Statewide |
| The local unit involved in this case might consider refreshing their domestic violence assessment skills with a Department program manager. | Completed<br>Level: Local |

## Casework Practice

***Policy/Rule Change***

| | |
|---|---|
| CA should include language in the Health and Safety Visits with Children and Monthly Visits with Caregivers and Parents policy 4420 to align with the Infant Safety Education and Intervention policy 1135 stating, "DCFS caseworkers must also review the Infant Safe Sleep Guidelines DSHS 22-1577 at each health and safety visit." The CFWS/FVS Program Manager has started working on this process. | Completed<br>Level: Statewide |
| The CA should remove the term "pack-n-play or bedside co-sleeper" from Infant Safety Education and Intervention policy 1135, procedures 2.b. It should be replaced with "crib, bassinet, or play-yard that meets current federal safety standards. Car seats, swings and sleepers/nappers do not qualify as a safe sleep environment." Also within this policy, the safe sleep guidelines should be listed and not just on the attachment/link. A definition of safe sleep assessment should be included within the policy. This assessment should include observing and assessing all of the places that baby sleeps as well as a discussion regarding how often they sleep in those environments. | Completed<br>Level: Statewide |
| DCYF should consider changing DCYF Policy No. 1135 (Infant Safety Education and Intervention) to require all adults residing in the home receive PPC and safe sleep education. This education requirement should also apply to anyone within the home who is providing care for the child or children that are also involved with DCYF. This would not include situations such as a homeless shelters, residential treatment centers, etc. | Completed<br>Level: Statewide |

[36] DCYF cannot direct the AG's office to participate in trainings but DCYF will pass the recommendation on to the AG's office.

| Casework Practice<br>*Policy/Rule Change* | |
|---|---|
| Current CA policy does not directly state that all parents must be contacted during a CPS investigation or assessment. CA should review the current policy to determine if this is best practice, and if so determined, then the policy should be revised to reflect this. | In process<br>Level: Statewide |
| The Department should review policy 4320 and 4330 and evaluate if changes can be made to make the policies consistent with each other; and to state that staff must first try to utilize certified interpreters in all situations, including cases involving hearing impaired clients. A revised policy should also provide guidance to the worker with regard to what should be done if an ASL certified interpreter is unavailable, or if the hearing impaired client refuses to use a certified ASL interpreter and instead wants a family member or friend to interpret. When this evaluation has been completed the Department should communicate clarifications regarding interactions with ASL speaking clients to all staff to comply with state and federal requirements. | In process<br>Level: Statewide |
| CA should create a policy regarding the use of social media as it pertains to communication between CA staff and clients. | In process<br>Level: Statewide |
| DCYF should consider clarifying CPS safety assessment policy so workers better understand how to utilize all available information about all individuals who have frequent contact with a child(ren) or are who are seeking custody of a child(ren). | In process<br>Level: Statewide |

| Casework Practice<br>*Safety Assessment & Planning* | |
|---|---|
| CA should consider purchasing double locking medication bags to make available to families, specifically for families where the safe storage of medications or medically related items is necessary. This option is favorable to a lock-box when a person needs to access these items while outside of their residence. | In process<br>Level: Statewide |
| The Committee recommends that CA consider changing its response to high risk infants exposed to or affected by substances to include a mandatory plan of safe care. A parent's statements regarding their use should not be taken at face value and should encompass collateral contacts. The CA workers and supervisors should ensure that they have consulted and verified the parent's statements in relation to the toxicology reports. Due to infant's vulnerability, CA should have a thorough understanding of the parent's drug use, the dynamics of the household and functioning within the home, verified protective factors and verified sleeping arrangements for the infant prior to discharge of the infant from the hospital. | In process<br>Level: Statewide |

| Casework Practice<br>*Operations & Administration* | |
|---|---|
| CA needs to address the issue of coverage for supervisors and line staff based on the high turnover rates within the agency. | Completed<br>Level: Statewide |
| CA should add language and a check box to the Placement Agreement form 15-281 to include discussion of policy 1135 including providing the handout Infant Safe Sleep Guidelines 22-1577. The CA Child and Family Welfare Family Voluntary Services (CFWS/FVS) Program Manager has started working on this process. | Completed<br>Level: Statewide |
| CA should remove the link to the Department of Health brochure on safe sleep in Policy 1135. The brochure link is currently not working and the brochure is not utilized by hospitals that are certified as National Safe Sleep hospitals and has been somewhat controversial in the SIDS/Safe Sleep community. | Completed<br>Level: Statewide |
| The Committee believes DCYF is inconsistent across the state with regard to CPS assignment and CPS investigative findings involving unsafe sleep incidents that result in near-fatalities or fatalities. The Committee recommends DCYF discuss this issue with the Attorney General's Office and work to find a consistent directive for field staff. | Completed<br>Level: Statewide |
| The committee recommends that CA consider utilizing a roving unit statewide or in Region 1 to assist in circumstances where staffing levels impact the office and assist with child safety assessments or completing investigations in a thorough manner. | Considered, Not implemented<br>Level: Statewide |
| DCYF management should develop alternatives to current practices to address high workload and staffing vacancies in an effort to reduce overloading employees and improve safety assessment and case planning. The Committee provided one suggestion, which is for the Department to consider using program managers with supervisory and field experience to fill in across the state where staffing levels are low and caseloads are over the recommended levels. | Considered, Not implemented<br>Level: Statewide |
| The Committee identified the need for more trauma informed care of staff who experience a critical incident, such as a fatality or near-fatality. The Committee believes there should be a person or team of people that can be dispatched to the office that is impacted, to provide immediate or within 24-hours, onsite emotional support. This is beyond how the current Peer Support model currently functions. The Committee also believes staff should be treated similar to other first responders; that staff should be relieved of taking new assignments and possibly case responsibilities for a period of time after the incident. The Committee also believes that they should be given paid leave to support their emotional well-being, not as a disciplinary function. | Considered, Not implemented<br>Level: Statewide |

| Casework Practice<br>*Operations & Administration* | |
|---|---|
| The Committee identified the need for more trauma informed care that should be made available to staff that experience a critical incident, such as a fatality or near-fatality. The Committee believes there should be a person or team that can go to the impacted DCYF office in order to provide immediate, or within 24-hours, onsite emotional support. This is beyond how the current Peer Support model currently functions. The Committee also believes that staff should be treated similar to other first responders by relieving them from taking new assignments and possibly case responsibilities for a specified period of time after the incident. The Committee also believes they should be given paid leave to support their emotional well-being. | Considered, Not implemented<br>Level: Statewide |
| The Department should address the inconsistent use of founded findings regarding unsafe sleep related deaths. The Committee acknowledged that each case is unique with differing circumstances. However, the Committee noted that not all unsafe sleep deaths, with prior Department involvement including education to the care providers regarding safe sleep, result in a founded finding for abuse or neglect. | In process<br>Level: Statewide |
| The CFR Committee encourages Washington State and DCYF to advocate for a national central registry for child abuse and neglect information. The CFR Committee also recommended that DCYF consider working with Washington's border states (Oregon and Idaho) on developing agreements for rapid processing of requests for child welfare services history information. | In process<br>Level: Statewide |
| The Department should address the inconsistent use of founded findings regarding unsafe sleep related deaths. The Committee acknowledged that each case is unique with differing circumstances. However, the Committee noted that not all unsafe sleep deaths, with prior Department involvement including education to the care providers regarding safe sleep, result in a founded finding for abuse or neglect. | In process<br>Level: Statewide |
| To improve accountability of contracted providers, CA should pursue different ways to inform CA staff about contractor expectations and the process for reporting concerns about contracted provider service delivery. | In process<br>Level: Statewide |
| CA should include a link to policy 1135 on the Child Information and Placement Referral 15-300. This would allow placements to access the policy and Infant Safe Sleep Guideline form at their convenience. | In process<br>Level: Statewide |
| DCYF should consider developing a Memorandum of Understanding or Formal Protocol between Washington DCYF and Oregon DHS for situations in which coordinating interstate collaboration on CPS investigations involving border counties would clearly benefit child safety. | In process<br>Level: Statewide |

## Casework Practice
***Operations & Administration***

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| The Committee does not agree with the current standard for assessing intakes regarding a family's chronicity and whether the case is a CPS investigation or FAR assessment. The Committee believes DCYF should re-evaluate this and take into consideration the entirety of a family's chronicity as opposed to just considering the last 12 months. | In process<br>Level: Statewide |
| The Committee discussed that DCYF is inconsistent statewide with regard to CPS assignments and investigative findings pertaining to unsafe sleep incidents. The Committee recommends that DCYF discuss this issue with the Attorney General's Office and work to find a consistent directive for field staff regarding this issue. | In process<br>Level: Statewide |
| The Committee discussed that DCYF is inconsistent statewide with regard to CPS assignments and investigative findings pertaining to unsafe sleep incidents. The Committee recommends that DCYF discuss this issue with the Attorney General's Office and work to find a consistent directive for field staff regarding this issue. | In process<br>Level: Statewide |

## Casework Practice
***Multidisciplinary Collaboration***

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| CA should re-initiate the Chemical Dependency Professional (CDP) liaison program. This program previously allowed for CDPs to be located in CA field offices. CDPs were available for substance abuse related consultation and providing information about substance use, client engagement and community resources. The Committee is aware that current state budget constraints may pose a barrier to this recommendation. | Considered, Not implemented<br>Level: Statewide |
| The Department should have chemical dependency professionals (CDP) co-housed in field offices. This affords Department field staff the opportunity to receive education regarding substance use and abuse much easier than if they were not co-housed, it often assisted with a smoother and less time consuming process of getting an evaluation for parents and it in some offices the CDP's were available to respond together with Department staff in the field. | Considered, Not implemented<br>Level: Statewide |
| In an effort to enhance the workers' assessment and analysis of client mental health issues, Department leadership should make a statewide mental health consultant(s) available to staff. The purpose for the statewide mental health consultant(s) would be similar to the purpose of the statewide medical consultants. | In process<br>Level: Statewide |

## Casework Practice

***Multidisciplinary Collaboration***

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| CA should have a Child Abuse Medical Consultation Network (MedCon) discuss mandatory reporting responsibilities with Children's Hospital. This case highlighted a need for more urgency regarding the need for mandatory reporting which can be made to law enforcement or CA. Law enforcement often has the ability to respond immediately as opposed to CA's response time. The Committee also wanted MedCon to discuss that CA cannot place children in protective custody. Placement in protective custody by law enforcement, an order through a dependency case and a hospital hold by a treating physician are the only means to immediately remove a child from the home legally. | In process<br>Level: Statewide |
| Region 5 management should consider meeting with the local Attorney's General Office about the process and protocol for disagreements with legal advice | In process<br>Level: Regional |

## Casework Practice

***Other Casework Practice***

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| DCYF should create a Quick Tip to remind staff about policy 4320 requiring the use of interpreters. | Completed<br>Level: Statewide |
| CA should consider reminding offices that utilizing regional supports such as Safety Administrators, Quality Practice Specialists, program managers or headquarters staff as well as MDTs and CPTs are good resources for shared decision making. | Completed<br>Level: Statewide |

## Partnerships with Community Professionals

***Law Enforcement***

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| The Committee noted the frustration by the CPS staff, as well as law enforcement, when asking law enforcement to place A.F. in protective custody. The relationship between law enforcement and the CA is integral. The King Southwest area administrator should meet with the Chief of the Des Moines Police Department to address the challenges faced by each agency during this case and to better understand each agency's responsibilities and roles in hopes to not repeat this same situation in the future. | Completed<br>Level: Local |