WASHINGTON STATE

OFFICE OF THE FAMILY AND CHILDREN'S OMBUDS

CHILD FATALITIES AND NEAR FATALITIES IN WASHINGTON STATE

AUGUST 2022

Contents

EXECUTIVE SUMMARY 2

SECTION I: OFCO-EXAMINED CRITICAL INCIDENTS 4

CHILD FATALITIES EXAMINED BY OFCO 4

Maltreatment-Related Child Fatalities 6

Manner of Death 6

Child Race and Ethnicity 8

Child Age at Time of Death 8

Infant Deaths Involving Unsafe Sleep 9

Family Contact with the Department of Children, Youth, and Families 10

Fatalities Occurring After Family Reunification 11

Substance Abuse, Domestic Violence, and Mental Health are Risk Factors for Child Fatalities 12

CHILD NEAR FATALITIES EXAMINED BY OFCO 13

Maltreatment-Related Near Fatalities 14

YOUTH SUICIDE 16

Youth Suicide Prevention 17

Suicidality in Foster Youth 18

OFCO Recommendations 18

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

Implementation Status of Recommendations 19

Major Themes of Recommendations 21

APPENDIX: CHILD FATALITY AND NEAR FATALITY REVIEW RECOMMENDATIONS 23

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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 concerns related to children in need of state protection, children residing in state care, and children and families under state supervision due to allegations or findings of child abuse or neglect. As part of its oversight of the state child welfare system, OFCO examines critical incidents, such as child fatalities and near fatalities. OFCO also participates in executive child fatality and near fatality reviews, and reports on the implementation status of recommendations produced from these executive reviews. Through this process, OFCO identifies issues related to these critical incidents and facilitates systemic improvements.

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

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

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

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

Section I of this report describes OFCO's critical incident review activities from January 1, 2019 to December 31, 2021. The critical incidents discussed in this report include child fatalities and child near fatalities.

From January 1, 2019 to December 31, 2021, OFCO conducted 187 administrative examinations of child fatalities involving both child abuse or neglect cases and fatality cases unrelated to child maltreatment, and 110 examinations of child near fatalities. Of these, OFCO considered 89 child fatalities and 67 child

[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).

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

DCYF conducts an **Executive Child Fatality Review** when the death of a child was suspected to be caused by abuse or neglect, and the child or child's family 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.

From January 1, 2019 to December 31, 2021, DCYF conducted 37 Executive Child Fatality Reviews. However, not all child fatalities OFCO identified as related to child maltreatment during this time qualified for an executive review, as they did not meet the statutory requirements.

Section II of this report describes the implementation status of recommendations made in child fatality and near fatality reviews conducted between January 1, 2019 and December 31, 2021. During this period, DCYF conducted 37 child fatality reviews and 40 near fatality reviews. These reviews produced 124 recommendations.

SECTION I: OFCO-EXAMINED CRITICAL INCIDENTS

CHILD FATALITIES EXAMINED BY OFCO

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

OFCO examines these fatalities to:

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

Like OFCO, DCYF conducts a similar administrative review of all critical incidents and convenes an executive child fatality review committee as required by state law.[5] *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*.

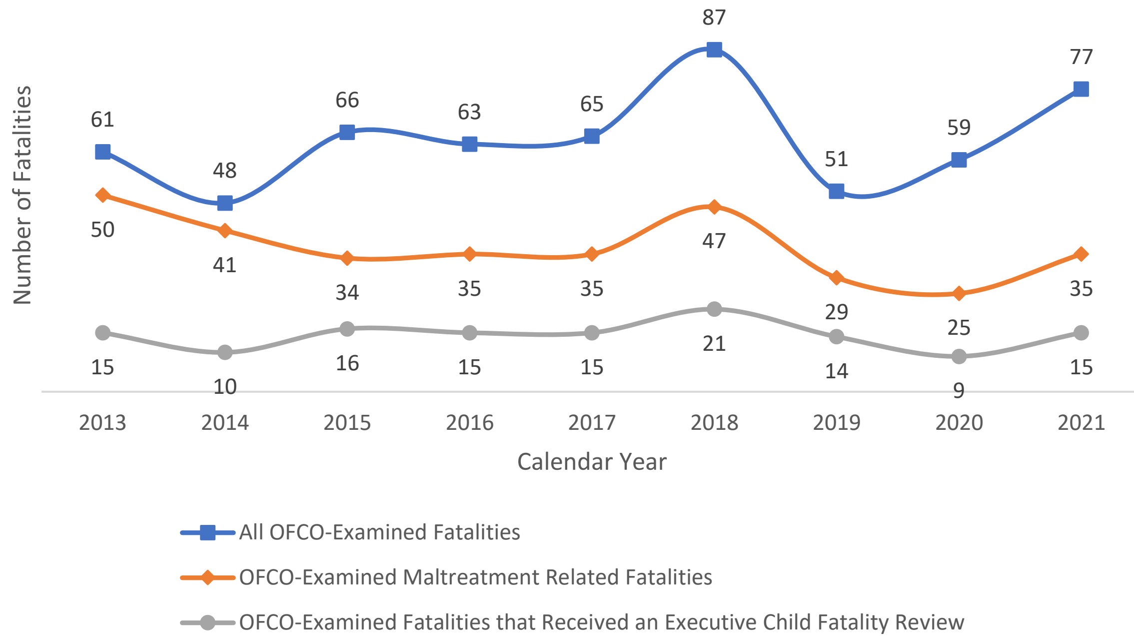
OFCO examined 187 child fatalities between January 1, 2019 and December 31, 2021. Not all fatalities of which OFCO receives notice are related to maltreatment. For example, OFCO may receive notice of an expected medical death of a child whose family has had contact with the Department in the past 12 months.

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

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

Of the 187 child fatalities examined between January 1, 2019 and December 31, 2021, OFCO considered 89 to be related to child maltreatment. The following data describes the profile of these 89 maltreatment-related child fatalities.

[5] 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.



OFCO CHILD MALTREATMENT DEFINITIONS

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

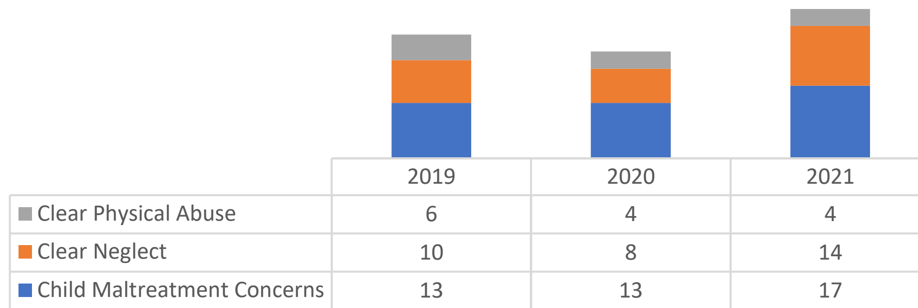
Clear Neglect
A CPS investigation concluded that neglect by a caregiver (e.g. an infant or toddler left unattended) caused the child's death. Law enforcement reports, medical records, and/or an autopsy report may also have concluded that negligent treatment/maltreatment caused the child's death.

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

Maltreatment-Related Child Fatalities

Between January 1, 2019 and December 31, 2021, 14 children passed away from physical abuse and 32 as a direct result of neglect. OFCO found maltreatment concerns in 43 additional cases.

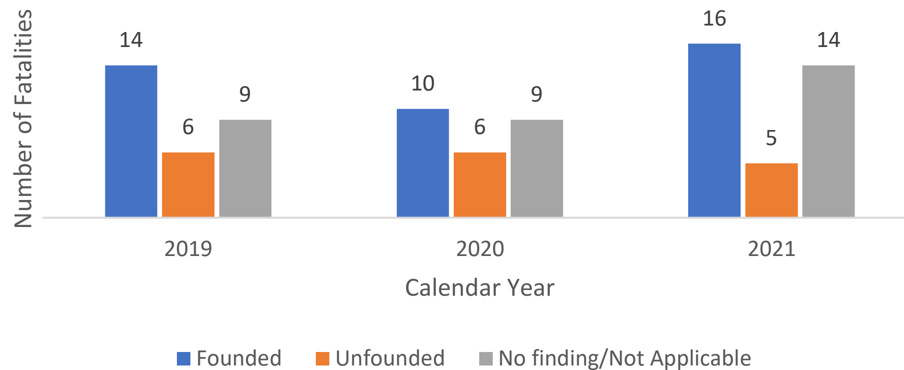
Figure 2: **Type of Maltreatment in Child Fatalities, 2019-2021**



	2019	2020	2021
Clear Physical Abuse	6	4	4
Clear Neglect	10	8	14
Child Maltreatment Concerns	13	13	17

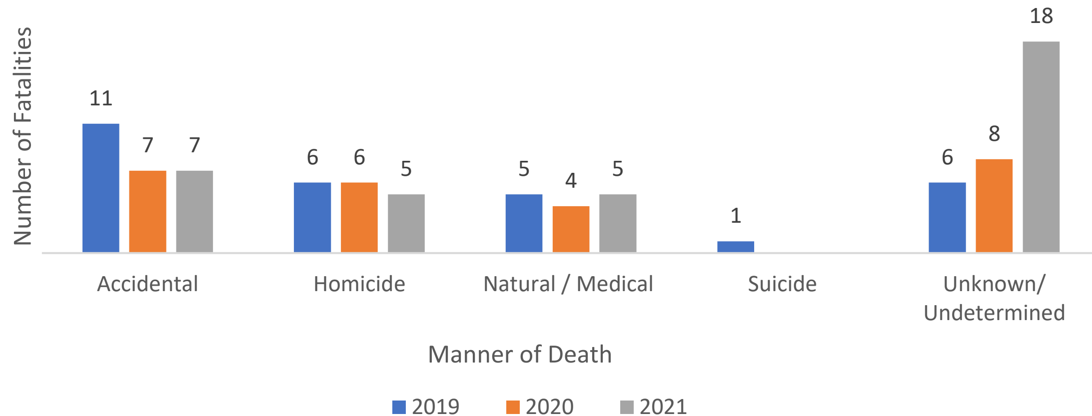
Of the 89 maltreatment-related deaths, 40 resulted in a "founded" finding of neglect and/or physical abuse. Investigations into 17 deaths were "unfounded." No findings were made in the remaining 32 deaths.

Figure 3: **Findings in Maltreatment-Related Fatalities, 2019-2021**



Manner of Death

The manner and cause of death is determined by a medical examiner or coroner. The manner of death describes the context or circumstances of the death and is assigned to one of five categories: natural or medical; accidental; homicide; suicide; or unknown/undetermined. The cause of death details how the death occurred.



Between January 1, 2019 and December 31, 2021, the manner of death for 36% of maltreatment-related fatalities were unknown/undetermined and 28% were determined to be accidental.

EXAMPLES OF CHILD FATALITIES BY MANNER OF DEATH AND CASE SUMMARY

NATURAL/MEDICAL: A baby was born substance exposed and passed away shortly after birth. The family had a CPS risk only investigation closed within the previous 12 months involving the older children who, at the time of the fatality, were no longer in the mother's care. The intake screened out and no investigation was completed.

ACCIDENTAL: The father fell asleep while holding the infant, resulting in the infant's death. At the time of the infant's death, the family had an open CPS case due to concerns related to parental substance abuse. The infant was in shelter care status and was placed in relative care. DCYF approved the father to stay in the home with the relatives and the infant, but he was not to be unsupervised with the infant. The Medical Examiner determined that the infant passed from asphyxia, and the manner of death was ruled as an accident. The investigation resulted in an unfounded finding.

HOMICIDE: The stepfather murdered the family and set the trailer on fire. Three children were found deceased inside the trailer alongside their mother. The family had one screened out intake within the previous 12 months. The investigation resulted in a founded finding of physical abuse by the stepfather.

SUICIDE: A 13-year-old committed suicide with an unsecured firearm while in the care of the parents. The family had recent history with DCYF due to allegations of alcohol and substance abuse, and DCYF had closed a CPS FAR case on the family within the previous 12 months. The investigation resulted in a founded finding of neglect by the parents.

UNKNOWN/UNDETERMINED: A one-year-old was found unresponsive with a bottle cap in his mouth. The autopsy found no signs of injury or suffocation. The Medical Examiner reported that traces of methamphetamine found in the child's blood likely indicated that methamphetamine was used in the presence of the child but was not the cause of death. The manner of death was ruled as undetermined. The children had been removed from the parents the previous year but were returned after the court dismissed the dependency over DCYF's objection. The family also had prior out-of-state CPS history, including a previous infant fatality. The investigation resulted in a founded finding of neglect by the parents.

Child Race and Ethnicity

The percentage of maltreatment-related fatalities of African American/Black children reviewed by OFCO decreased between 2019 and 2021. However, maltreatment-related fatalities of American Indian/Alaska Native and multi-racial children increased.

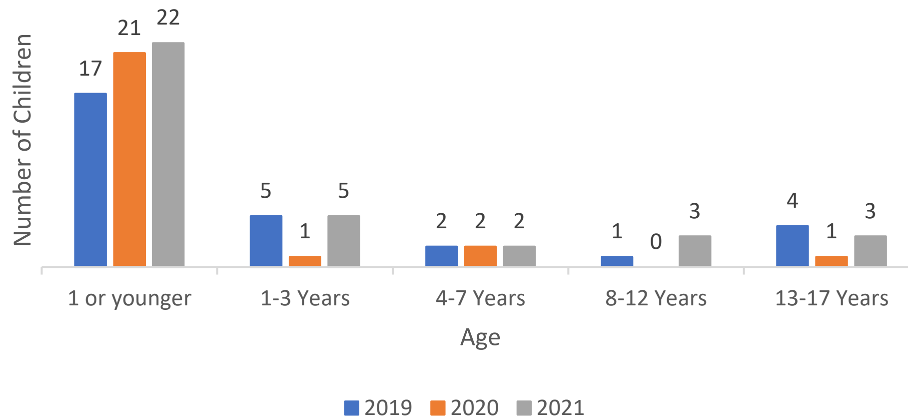
Table 1: **Child Race and Ethnicity of OFCO-Examined Maltreatment Related Child Fatalities, 2019-2021**

	Percentage of OFCO-Examined Maltreatment-Related Child Fatalities			WA Children in Out-of-Home Care[6]	WA State Children[7]
	2019	2020	2021		
African American/Black	17.2%	12.0%	8.6%	9.0%	5.1%
American Indian or Alaska Native	13.8%	8.0%	17.1%	4.5%	2.4%
Asian or Pacific Islander	3.4%	--	5.7%	1.8%	9.9%
Caucasian/White	55.2%	64.0%	45.7%	62.9%	72.2%
Multi-Racial	6.9%	4.0%	17.1%	21.4%	10.4%
Other or Unknown	3.4%	12.0%	5.7%	--	--
Latino / Hispanic	13.8%	12.0%	11.4%	20.6%	21.9%

Child Age at Time of Death

The majority of maltreatment-related fatalities that occurred between January 1, 2019 and December 31, 2021 involved infants (birth to 12 months).

Figure 5: **Child's Age at Time of Death, 2019-2021**



[6] Center for Social Sector Analytics & Technology (2022). [Graph representation of Washington state child welfare data 4/21/2022]. Children in Out-of-Home Care (Count). Retrieved from http://www.vis.pocdata.org/graphs/ooh-counts.
[7] Office of Financial Management. Estimates of April 1 population by age, sex, race and Hispanic origin. 2020. https://ofm.wa.gov/washington-data-research/population-demographics/population-estimates/estimates-april-1-population-age-sex-race-and-hispanic-origin.

Infant Deaths Involving Unsafe Sleep

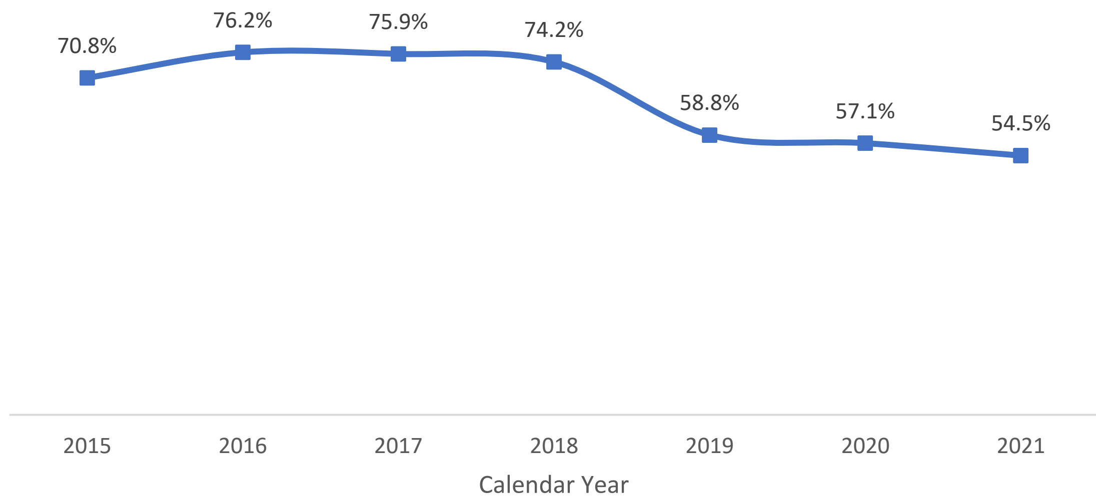
Between January 1, 2019 and December 31, 2021, 34 of the 60 infant fatalities involved unsafe sleep concerns.

Table 2: **Infant's Age at the Time of Sleep-Related Death, 2019-2021**

Infant Age (Months)	2019	2020	2021
0	3	1	2
1	1	4	2
2	1	2	2
3	1	2	1
4			2
5	1		1
6	2	1	2
7	1	1	
8			
9			
10		1	
11			

Between 2016 and 2021, the percentage of OFCO-examined infant fatalities that involved unsafe sleep concerns declined from 76.2% to 54.5%.

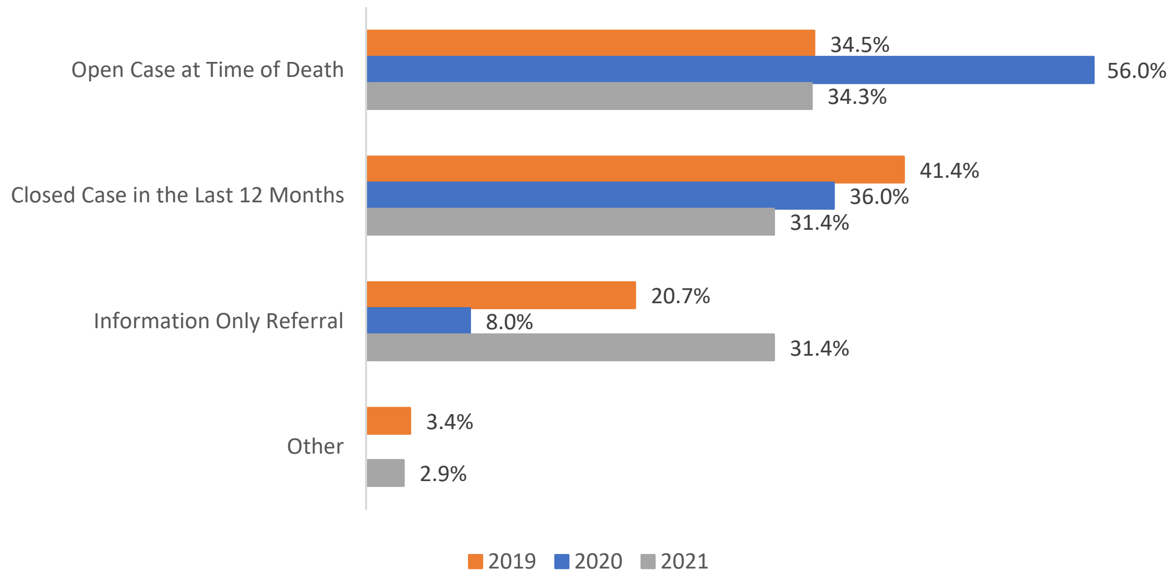
Figure 6: **Percentage of Infant Fatalities Involving Unsafe Sleep Concerns, 2015-2021**



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

Of the 89 maltreatment-related fatalities examined by OFCO between January 1, 2019 and December 31, 2021, 40% of the families involved had an open case with DCYF at the time of death (36 families), and 36% had a closed case within the previous 12 months (32 families).

Figure 7: **DCYF Case Status Within 12 Months of Fatality, 2019-2021**



Of the 36 families with an open case at the time of death, 19 were open for Child Protective Services (CPS) investigation; 8 were receiving Child and Family Welfare Services (CFWS); 4 were open to the Family Assessment Response (FAR) program; and 5 were participating in Family Voluntary Services (FVS).

Table 3: **Program Type and Placement for Open Cases at Time of Death, 2019-2021**

	2019	2020	2021
Child Protective Services (CPS) Investigation Pathway *Investigates screened in reports of child maltreatment*	**2 fatalities** (6.9%) Parental care (1) Relative care (1)	**10 fatalities** (40%) Parental care (7) Relative care (1) Other - Medical care (2)	**7 fatalities** (20%) Parental care (7)
Child and Family Welfare Services (CFWS) *Case management and permanency planning for children and youth in out-of-home placement.*	**4 fatalities** (13.8%) Parental care (2) Relative care (1) Suitable other care (1)	**1 fatality** (4%) Parental care (1)	**3 fatalities** (8.6%) Parental care (3)
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.*	**3 fatalities** (10.3%) Parental care (3)	--	**1 fatality** (2.9%) Parental care (1)
Family Voluntary Services (FVS) *Cases transfer to FVS after a CPS investigation AND the parent refuses services OR the family was determined to be at moderately high or high risk for abuse or neglect. Participation is voluntary.*	**1 fatality** (3.4%) Parental care (1)	**3 fatalities** (12%) Parental care (3)	**1 fatality** (2.9%) Parental care (1)

Fatalities Occurring After Family Reunification

The safe reunification of families is the primary goal of a dependency proceeding and the Department is required to offer or provide services to address concerns that led to a child's removal from the home.[8] Sixty percent of children exiting DCYF care are reunited with their family. In 2019 through 2021, 10,618 children returned to their parents' care.[9]

OFCO reviewed the 37 child fatalities that received executive reviews between 2019 and 2021 and found that in 4 cases, involving 5 children, the fatality occurred after the child was returned to the parents' care in a dependency proceeding. Four of the 5 children were between two and three years of age, and all died of physical abuse. The other child was 15 years old and died of a drug overdose. Three of the fatalities occurred between one and five months after the child was returned home. The other two fatalities occurred 13 and 14 months after reunification, respectively.

[8] RCW 13.34.
[9] Reunification. https://www.dcyf.wa.gov/node/3275.

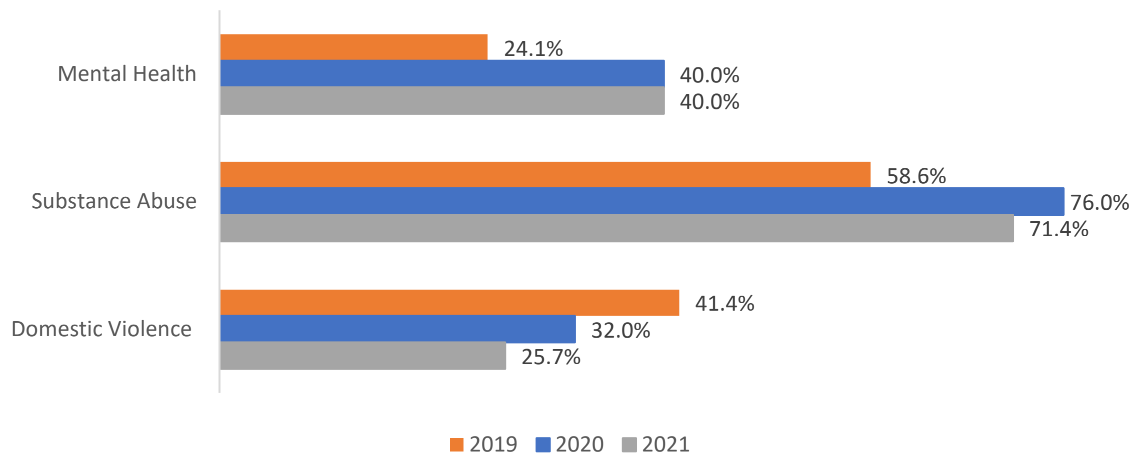
Substance Abuse, Domestic Violence, and Mental Health are Risk Factors for Child Fatalities

Parental substance abuse is a major risk factor for child fatalities, maltreatment, and involvement with the child welfare system. Over 68% of the children who died between January 1, 2019 and December 31, 2021 came from families with a history of drug or alcohol abuse (61 families). Of the families with known substance abuse history, 49% (30 families) had a documented history of prenatal drug use; 48% (29 families) of opiate use; 54% (33 families) of methamphetamine use; and over 60% (37 families) of other substances, 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 risk factors were present in 82% of the fatalities examined by OFCO between January 1, 2019 and December 31, 2021.

Figure 8: **Family Risk Factors in Child-Maltreatment Fatalities, 2019-2021**



CHILD NEAR FATALITIES EXAMINED BY OFCO

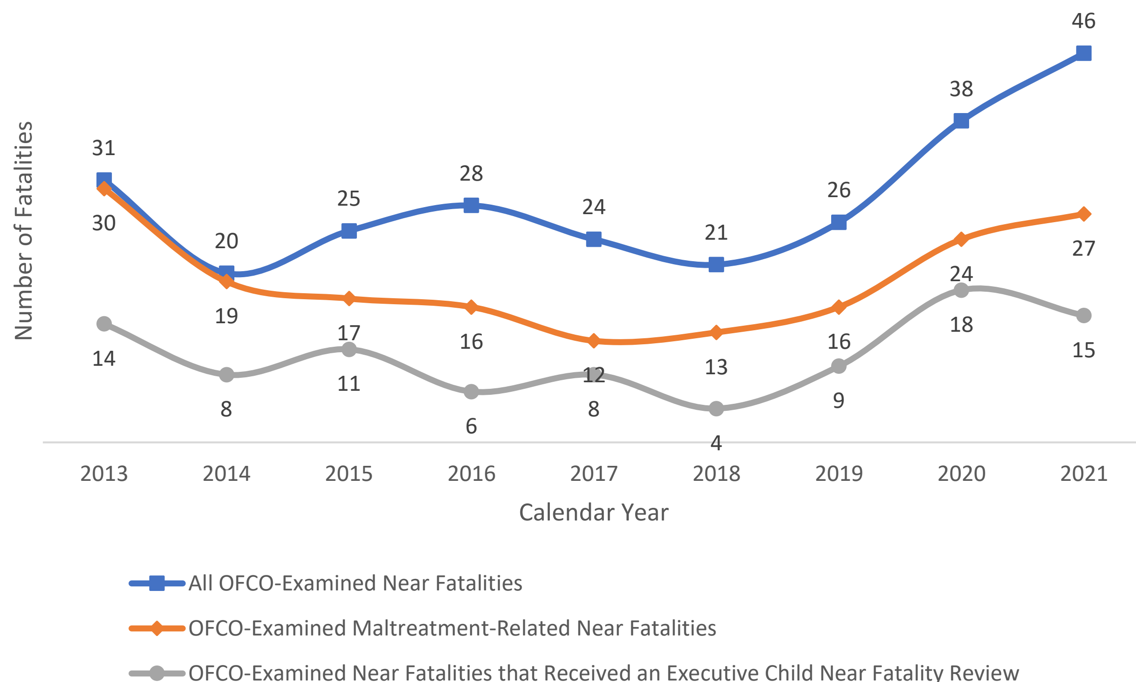
State law requires DCYF to notify OFCO of the near fatality[10] of any child who has been in the Department's custody, or receiving services, within the last 12 months.[11] OFCO conducts a preliminary review of all near fatalities involving alleged child abuse or neglect when the family had an open case 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 110 near fatalities between January 1, 2019 and December 31, 2021. OFCO considered 67 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 Child Near Fatalities by Year**

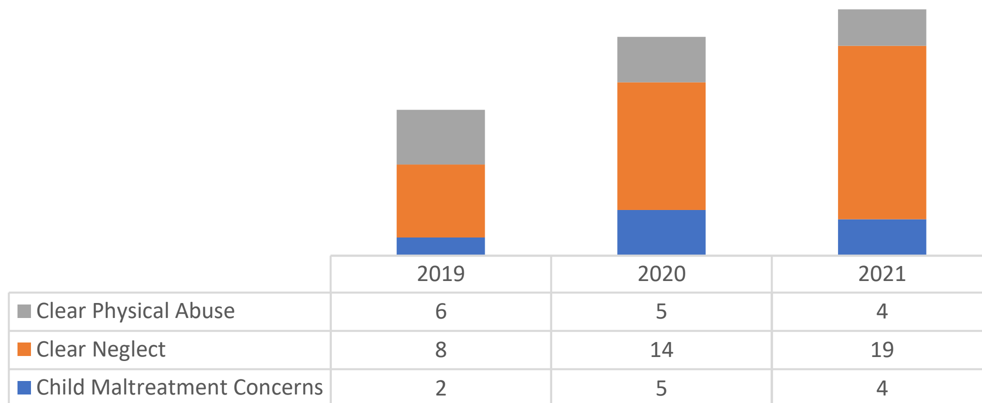


[10] RCW 74.13.500 defines "near fatality" as "an act that, as certified by a physician, places the child in serious or critical condition."
[11] RCW 74.13.640(2).

Maltreatment-Related Near Fatalities

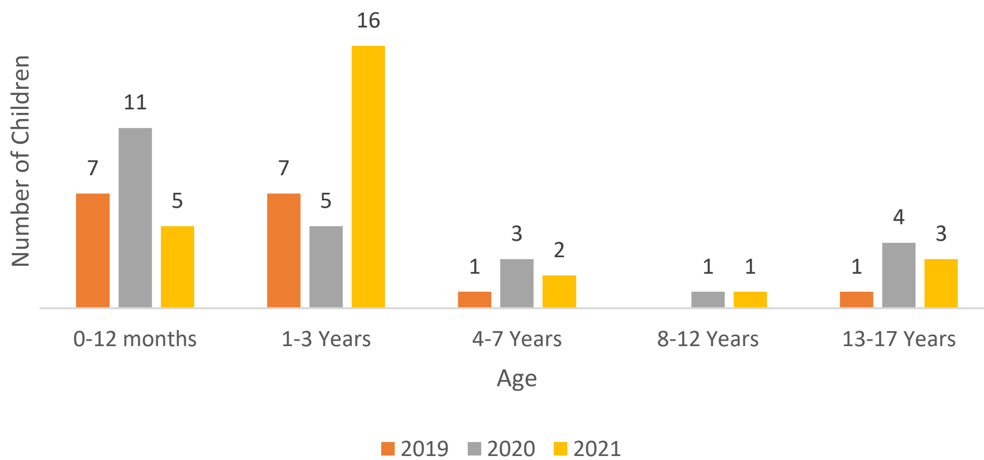
OFCO identifies child near fatalities reported to CPS that were directly caused by child abuse or neglect, as well as those in which abuse or neglect concerns may have contributed to the incident, and the family had DCYF history in the preceding 12 months. Of the 110 near fatalities examined by OFCO between January 1, 2019 and December 31, 2021, 67 were determined to either be caused by abuse or neglect, or abuse or neglect concerns were present. The vast majority of maltreatment-related near fatalities during this period involved children ages three years and under.

Figure 10: **Maltreatment-Related Child Near Fatalities, 2019-2021**



	2019	2020	2021
Clear Physical Abuse	6	5	4
Clear Neglect	8	14	19
Child Maltreatment Concerns	2	5	4

Figure 11: **Child Age at Time of Near Fatality, 2019-2021**



EXAMPLES OF MALTREATMENT-RELATED NEAR FATALITIES

UNSAFE SLEEP AND NEGLECT: A mother left her children home alone. Upon returning, the mother discovered the children had fallen asleep and her six-month-old infant was unconscious underneath the other children. The infant was taken to the hospital for care and recovered. The investigation resulted in a founded finding of neglect by the mother due to the mother leaving the infant child unsupervised in the home.

CHILD INJURED IN A CAR ACCIDENT: A two-year-old child was injured in a car accident. The vehicle, driven by the mother, flipped over and rolled into a body of water. The child was fully submerged under water for several minutes. The mother was cited for vehicular assault and driving under the influence. The investigation resulted in a founded finding of neglect by the mother.

INFANT EXPOSED TO AND/OR INGESTED METHAMPHETAMINE: A three-month-old child was brought to the hospital after experiencing seizure-like symptoms. The child arrived at the emergency room in critical condition with abnormal body movements. The child later tested positive for methamphetamine. Additionally, medical providers found burns on the child's body that were consistent with an induced burn from a meth pipe. The child was treated for methamphetamine ingestion and exposure. The parents were arrested the following day for child endangerment with a controlled substance. The investigation resulted in founded findings of physical abuse and neglect by the parents.

YOUTH SUICIDE

In the United States, suicide is the second-leading cause of death among youth ages 15 to 24.[12] Between 2011 and 2020, suicide rates increased for this age group.[13] Further, the Center for Disease Control and Prevention (CDC) estimated that one in four youth under the age of 18 have struggled with suicidal ideation since the beginning of the COVID-19 pandemic.[14] In Washington state, suicide is the leading cause of death for youth ages 10 to 17, and the second leading cause of death for young adults ages 18 to 24.[15]

Of the 297 critical incidents examined by OFCO between January 1, 2019 and December 31, 2021, twenty were deaths by suicide, and 8 were suicide attempts. OFCO considered only one of these 28 critical incidents to be related to child maltreatment. Of the 28 youth, 46% (13 youth) were noted to have a history of self-harm and/or suicidal ideation, and 25% (7 youth) had at least one prior documented suicide attempt. The average age of youth involved was 15.5 years. Over 70% of the youth were Caucasian. Seventeen of the youth were male, 9 were female, one identified as transgender male, and one identified as transgender female. Three of the youth were noted to be victims of sexual abuse.

Table 4: **Race and Ethnicities in Youth Suicides (Fatalities and Near Fatalities), 2019-2021**

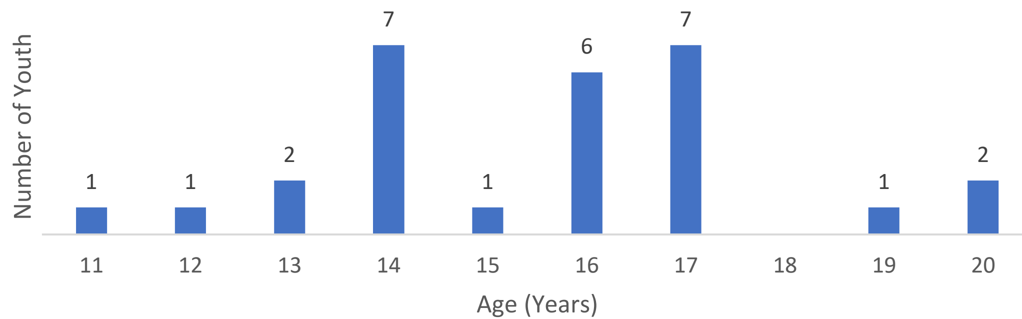
African American/Black	5	17.9%
Caucasian/White	20	71.4%
Multi-Racial *Caucasian/White, African American/Black, and American Indian or Alaska Native (1)* *Caucasian/White and American Indian (1)* *Caucasian/White and Asian (1)*	3	10.7%
Hispanic	7	25.0%

[12] National Alliance on Mental Illness, https://www.nami.org/Your-Journey/Kids-Teens-and-Young-Adults/What-You-Need-to-Know-About-Youth-Suicide.

[13] https://sprc.org/scope/age.

[14] "Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020". Centers for Disease Control and Prevention. https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm.

[15] "Washington State Violent Death Reporting System Sharing Data to Prevent Youth Suicide | 2015-2018". Washington State Department of Health. https://doh.wa.gov/sites/default/files/legacy/Documents/Pubs//140-244-WAVDRSyouthsuicide.pdf?uid=62b7cb1c8ce63.
"Washington State Violent Death Reporting System Sharing Data to Prevent Young Adult Suicide | 2015-2018". Washington State Department of Health. https://doh.wa.gov/sites/default/files/legacy/Documents/Pubs//140-245-WAVDRSyoungadultsuicide.pdf?uid=62b7cb1c8ca83.



Youth Suicide Prevention

Youth suicide is preventable, and efforts to reduce and eliminate it can and should be aimed at all levels of social influence. The United Health Foundation reports that youth suicide can be reduced by:

- Knowing the signs. Four out of five suicide deaths are preceded by warning signs such as suicidal threats, previous suicide attempts, a preoccupation or obsession with death, depression, and making final arrangements.
- Making it more difficult to die in an act of deliberate self-harm. Interventions include removing guns from homes with at-risk youth, lethal means counseling, and reducing or removing available medications.
- Improving access to mental health resources. Examples include medical interventions and support groups, available and effective clinical care for mental health disorders, and family and community support.[16]

There are a variety of efforts employed to combat youth suicide at the federal and state level. The Federal Communications Commission (FCC) adopted the National Suicide Hotline Designation Act in 2020, designating 988 as the nationwide number for individuals in crisis to connect with suicide prevention services and mental health counselors. House Bill 1477[17] (also known as the Crisis Call Center Hubs and Crisis Services Act) was passed by the Washington State Legislature and signed into law on May 13, 2021, to support the implementation of 988 and expand suicide prevention services and behavioral health crisis responses for Washington residents. As of July 16, 2022, 988 is available nationally through call, text, or chat functions.

The Washington State Office of Superintendent of Public Instruction provides resources and supports for suicide prevention relating to Washington youth. Second Substitute House Bill 1216 funded Behavioral Health Coordinator/Navigator positions in all nine of Washington’s Educational Service Districts to help school districts develop and implement suicide prevention and behavioral health supports for

[16] https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/teen_suicide/state/WA.
[17] https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bill%20Reports/House/1477-S2.E%20HBR%20FBR%2021.pdf?q=20220607144523.

students.[18] Through this provision, schools will continue to engage in much of the front-line suicide prevention work in Washington state.

Suicidality in Foster Youth

Foster youth are uniquely vulnerable to suicidality as they have often been exposed to trauma, removed from their homes and families, and are frequently separated from their school and community. Suicide rates among youth in foster care are among the highest in the United States, and they are significantly more likely to die by suicide than youth not in foster care.[19] As children are primarily removed from their homes due to concerns relating to maltreatment, abuse, and neglect, and suicide risk is also correlated with histories of maltreatment, neglect, lack of social support, and abuse, it is easy to see how these groups relate and overlap.[20]

Youth suicide is preventable, when risk is identified, and interventions are made. Given that foster youth are often disconnected from their birth families, move frequently, change schools, or do not attend school, and may not see a physician for regular medical care, many of the social structures usually tasked with identifying suicide risk and referring youth for proper care are not available to them. Assessment tools, however, can be used by those working in child welfare and related fields, both by clinicians and lay people alike. Free and brief universal suicide screening measures are available, and brief suicide prevention programs, such as crisis response planning, are frequently accessible.[21]

OFCO Recommendations

For these reasons, OFCO recommends that:

- DCYF train all caseworkers on universal suicide screening tools. All caseworkers conduct these screening tools at the time of removing youth from the home, and at regular intervals throughout DCYF involvement. All caseworkers make appropriate referrals to address concerns that arise during the screening. DCYF conduct additional and more frequent screenings when youth have previously displayed suicidality or made suicide attempts.
- DCYF provide training to foster parents and kinship caregivers on suicide prevention. Topics should include understanding risk factors of suicide among foster youth, recognizing warning signs, how to support a foster child's mental health and build protective factors, and how to obtain professional help.

[18] https://www.k12.wa.us/student-success/health-safety/mental-social-behavioral-health/youth-suicide-prevention-intervention-postvention.
[19] Brown, Lily A. "Suicide in Foster Care: A High Priority Safety Concern." Association for Psychological Science.
[20] Suicide Looms Large in Minds of Many Foster Youth (imprintnews.org).
[21] Brown, Lily A. "Suicide in Foster Care: A High Priority Safety Concern." Association for Psychological Science.

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

Implementation Status of Recommendations

The Department of Children, Youth, and Families (DCYF) conducts a child fatality review when the death of a child was suspected to be caused by abuse or neglect, and the child was in the care of or receiving services from DCYF at the time of death, or in the preceding 12 months.[22] 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[23] who was in the care of or receiving services from the Department at the time of the incident, or in the preceding 12 months.[24] 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.[25]

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.[26] 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.[27]

DCYF must issue a report on child fatality review results within 180 days following the fatality, unless granted an extension by the Governor.[28] These reports are subject to public disclosure and must be posted on the Department's public website. The Department is required to redact confidential

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

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

[24] 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.

[25] 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.

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

[27] RCW 74.13.640(3).

[28] Id.

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).[29]

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

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

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

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

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

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

To promote accountability and the consistent implementation of recommendations from fatality reviews, OFCO is required to issue an annual report to the Legislature on the implementation of recommendations issued by fatality review committees.[30] This report also includes recommendations from near fatality reviews.

This section of the report describes the implementation status of recommendations made in child fatality and near fatality reviews conducted by DCYF between January 1, 2019 and December 31, 2021. During this period, DCYF conducted 37 fatality reviews and 40 near fatality reviews. These reviews produced 124 recommendations**.** OFCO reviewed information provided by DCYF and found that 47 recommendations (37.9%) were implemented and 18 were pending, in progress, or on hold (14.5%). Thirty-eight recommendations (30.6%) were considered and not implemented, and 18 recommendations (16.9%) were not implemented as they reflected current law or policy. Most of the recommendations addressed statewide issues (75.8%).

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

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

Table 5: **Child Fatality and Near Fatality Review Recommendations by Implementation Status and Targeted Organizational Level, 2019-2021**

	Number of Recommendations	Percent	Statewide (#)	Region (#)	Office (#)
Partial, Modified, or Full Implementation	47	37.9%	27	9	11
Pending, In Progress, On Hold	18	14.5%	13	1	4
Considered, Not Implemented	38	30.6%	36	2	0
Not Implemented, Already in Policy/Practice	21	16.9%	18	1	2

Major Themes of Recommendations

Table 6: **Child Fatality and Near Fatality Review Recommendations by Topic, 2019-2021**

Topic		Number of Recommendations	Percent of Recommendations
Training		37	29.8%
	Casework Practice & Staff Support	(8)	
	Chemical Dependency	(3)	
	Domestic Violence	(6)	
	Medical Care	(4)	
	Safety & Risk Assessment	(12)	
	Other training	(4)	
Casework Practice		72	58.1%
	Multidisciplinary Collaboration	(8)	
	Operations and Administration	(19)	
	Policy and Procedure	(16)	
	Practice Consultation	(8)	
	Safety Assessment & Planning	(9)	
	Staff Support	(9)	
	Other Casework Practice	(3)	
Partnerships with Community Professionals		15	12.1%

Table 7: **Status of Child Fatality and Near Fatality Review Recommendations by Topic, 2019-2021**

Topic	Implemented	Pending, In Progress, On Hold	Considered, Not Implemented	Already Exists in Policy/Practice
Training	43.2%	24.3%	16.2%	16.2%
Casework Practice	31.9%	6.9%	43.1%	18.1%
Partnerships with Community Professionals	53.3%	26.7%	6.7%	13.3%

APPENDIX: CHILD FATALITY AND NEAR FATALITY REVIEW RECOMMENDATIONS

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

Listed below by topic are the 124 recommendations made in child fatality and near fatality reviews conducted from January 1, 2019 through December 31, 2021 and DCYF's implementation status for each recommendation. To preserve their intent and meaning, the following recommendations are quoted directly from the executive reports.

TRAINING **CASEWORK PRACTICE & STAFF SUPPORT**	
DCYF should create an onboarding system for new staff and newly promoted staff that allows for more hands-on mentoring and support while the staff learn about the requirements and nuances pertaining to their new positions. This onboarding is in addition to the Regional Core Training and Supervisor Core Training provided to new staff and staff that have been promoted.	**Status: Considered, Not Implemented**
The Committee suggested that DCYF message out agency-wide in a clear and concise fashion regarding expectations about training requirements and timelines. The Committee felt domestic violence training and refresher trainings should be prioritized due to the complexities of this type of assessment. To ensure training is not overlooked, local office administrators and supervisors are encouraged to communicate training expectations and opportunities with staff in addition to the statewide messaging.	**Status: Not Implemented, Already in Policy/Practice** *There are mandatory trainings in place which include domestic violence. Training opportunities are widely made available to staff on an ongoing basis. Training is available through The Learning* Center*, which includes information about which training the worker must complete. The training guide was updated and distributed to staff after this committee recommendation was made.*
The Committee recommended updated training related to the FAR investigative pathway as compared to the CPS investigative pathway and to reinforce to all case carrying staff the similarities and differences between the two pathways.	**Status: Not Implemented, Already in Policy/Practice**

TRAINING **CASEWORK PRACTICE & STAFF SUPPORT**	
The Committee believes it is critical that DCYF address staff retention and develop a plan that requires staff training through Regional Core Training (RCT) and other required in-service training within staff's first year of service and that prohibits the assignment of cases before staff is ready. The following recommendation should be overseen by local office leadership, such as an area administrator, through ongoing supervision and consultation. The Department should utilize the onboarding plan that is recommended for new employees through the UW Alliance RCT training model, which supports the gradual assignment of cases after a worker has completed various training activities.	**Status: Implemented, Statewide** *Already in statute (RCW 74.14b.010) and to be discussed with leadership.*
The Committee recognizes that because of time limitations, the staff may not always know about relevant training opportunities. This is the case; despite the fact the Department has access to a wide variety of UW Alliance classroom and online trainings. With this in mind, the Committee recommends the local office leadership, including the area administrator and supervisors, disseminate upcoming training opportunities to staff at all-staff meetings and unit meetings.	**Status: Modified/Partial Implementation, Local Office** *Training is distributed monthly by UW Alliance and discussed in DCYF Digest. Local leadership reinforces this.*
The Committee learned that as a result of various training and policy improvements, the agency is addressing clinical supervision, assessment supervision, safety assessment, and efficacy statewide. The Committee recommends the area administrator determine what available trainings, if any, would benefit the caseworker and supervisor to attend for practice improvement and improving critical thinking skills.	**Status: Implemented, Region**
The Committee recommended that Region 6 review their onboarding expectations for supervisors regarding line staff. Specifically, in this case, the caseworker for the intake was new to DCYF. The caseworker shared with the Committee that they were not given direction by their then supervisor on how to approach the case, questions to ask, or what to look for. The supervisor discussed with the Committee that their supervisory methods were to allow caseworkers to learn from their peers and answer questions that were asked by staff. The Committee believed more guidance should have been provided by the supervisor to the caseworker.	**Status: Implemented, Region** *PIP Strategy regarding learner-centered coaching is in process. This includes participation by supervisors and improving their ability to provide clinical supervision. Monthly supervision policy is also being revised. Training is occurring across the state and available to all supervisors and staff. Learner-centered coaching is now a part of new supervisor training.*

TRAINING CASEWORK PRACTICE & STAFF SUPPORT	
For purposes of caseworker retention, the Committee recommends DCYF offer a training for workers, the court, and other legal parties regarding roles, respect and civility with the local office and the court system.	**Status: On Hold**

TRAINING CHEMICAL DEPENDENCY & DOMESTIC VIOLENCE	
The Committee recommends that DCYF provide statewide mandatory training to all field staff statewide regarding substance use/abuse. This training must be provided by a qualified person within the substance abuse field who has current subject-matter knowledge. The training should focus on the following: 1. Training about substances most commonly known to the community that are being abused; 2. Training about the interactions of the abused substances with other substances; and 3. Training about the factors DCYF field staff should consider when deciding whether it is appropriate to ask that a subject matter expert (for example, a Substance Use Disorder Professional) work with a client or provide consultation services about an issue specific to a particular client. The Committee does not believe there are any current training opportunities specific to this recommendation. If there is a current training consistent with this recommendation, the Committee recommends DCYF inform all field staff about the specific training.	**Status: Modified/Partial Implementation, Statewide** *The DCYF Recommendations Review Committee made a recommendation to management to consider mandatory in-service refresher training for staff every two years.*
The Committee recommends the promotion of statewide education for caseworkers and DCYF staff regarding Narcan. This should include training that is offered by county health departments or through online health department resources so that caseworkers can be better informed when speaking with families about the risk of overdose. This would also enhance workers' ability to direct families to community-based resources for education, supports, and supplies as needed.	**Status: Not Implemented, Already in Policy/Practice** *Substance abuse training is currently available, and the Department of Health and local health care authorities are providing community education about the availability of Narcan. The responsibility for this community education lies with health care authorities.*

TRAINING CHEMICAL DEPENDENCY & DOMESTIC VIOLENCE	
DCYF should identify evidence-based literature about marijuana use and the impacts on parenting. Once identified, the literature should be made widely available and shared with field offices so that DCYF caseworkers can disseminate this information to the families and clients served by DCYF.	**Status: Considered, Not Implemented** *The social worker should be having conversations with parents regarding the impact of use versus abuse and how either use or abuse could impact their ability to parent.*
The Department should explore the feasibility of requiring mandatory domestic violence training every one or two years for all child welfare workers. This could be in-service training or on-going electronic training. The training should include subject matter pertaining to lethality assessments as a part of child safety assessments.	**Status: In Progress** *The UW Alliance offers ongoing webinar courses for child welfare workers on domestic violence.*
The Committee recommended annual domestic violence and substance use disorder refresher training for all staff. This will address case workers staying current with trends and treatment modalities in these respective fields.	**Status: Not Implemented, Already in Policy/Practice** *Committee makes a recommendation to management to consider mandatory in-service refresher training for staff every two years.*
The Committee suggests an adaptation to the current domestic violence training be considered to include an opportunity for caseworkers to roleplay a specialized domestic violence assessment. The Committee believes the opportunity for roleplay may enhance learning how to conduct this type of assessment.	**Status: Implemented, Statewide**
The Committee recommends that all DCYF field staff attend or should have taken the Domestic Violence in Child Welfare training within the last two years. The Alliance offers this training. All Kelso field staff need to retake the Domestic Violence in Child Welfare, regardless of when they last took the training.	**Status: Modified Implemented, Statewide** *The Child Welfare Leadership team (CWLT) decided on a just in time e-learning for domestic violence cases. The Alliance has been brought on board to begin the work.*

TRAINING CHEMICAL DEPENDENCY & DOMESTIC VIOLENCE	
The Committee recommends the staff involved in the case complete the 16-hour DCYF Domestic Violence in Child Welfare webinar provided by the Alliance (the contracted provider for DCYF trainings). Tacoma staff who have not taken the training since March 2020 should also take the course. DCYF should consider requesting all field staff complete the training if they have not done so since March 2020. Due to the need for webinar-based trainings, this training was modified and updated in March 2020.	**Status: Modified Implemented, Local Office** *The Child Welfare Leadership team (CWLT) decided on a just in time e-learning for domestic violence cases. The Alliance has been brought on board to begin the work.*

TRAINING MEDICAL	
An eLearning course about diabetic care needs should be developed in collaboration with The Alliance for Child Welfare Excellence through the University of Washington. This training should not be mandatory but should be available to caseworkers who may benefit from the training.	**Status: In Progress** *Information sheets and training for diabetes is available in the Alliance catalog.*
An eLearning course about diabetic care needs should be developed in collaboration with The Alliance for Child Welfare Excellence through the University of Washington. This training should not be mandatory but should be available to caseworkers who may benefit from the training.	**Status: Not Implemented, Already in Policy/Practice** *Information sheets and training for diabetes is available in the Alliance catalog.*
DCYF should create a diabetes 101 e-learning. The hospital social worker and two Committee members who work specifically in that field, all stated that Type 1 diabetes diagnoses are on the rise. These are challenging cases that require a deep understanding of the consequences of poorly managed diabetic care and how food and exercise impact the body’s need for insulin. The Committee believes all staff should receive this training and that DCYF headquarters staff should consider whether a short, yearly refresher course should occur. The Committee identified that a stronger understanding of Type 1 diabetes and more reliance on the hospital endocrinology social worker’s and physician’s medical opinions, may have resulted in earlier intervention and possibly less injury to child’s body.	**Status: Modified Implementation, Statewide** *Information sheets are available. There is a diabetes training available in the Alliance catalog.*

TRAINING MEDICAL	
The Committee recommended that DCYF create a field guide for staff regarding malnutrition. While this topic is discussed at DCYF Safety Boot Camp trainings, the Committee discussed that infrequent occurrences of these cases can lead to a loss of learned information and that staff would benefit from a guide that could be accessed online, and therefore be available to all staff regardless of the time of day or whether they are working in the field. The guide should be somewhat short and discuss what to look for (i.e., observe the chest or spine area, look at nails, hair, etc.), questions to ask (i.e., food restrictions, details of all food and drink consumed within the last 24 hours, etc.), and briefly discuss intersectionality with disabilities, food deprivation as discipline, as well as next steps (immediate medical assessment, law enforcement, etc.).	**Status: On Hold**

TRAINING SAFETY & RISK ASSESSMENT	
DCYF should continue messaging the importance of assessing infant safe sleep and provide updates regarding Consumer Product Safety Commission, American Academy of Pediatrics, and Centers for Disease Control and Prevention guidelines and infant care products. Consideration should be given to requiring a brief annual refresher training on infant safe sleep (online or classroom), especially for child welfare workers who have infants on their caseloads.	**Status: Implemented, Statewide** *Policy 1135 was updated and implemented. This policy was revised to update the safe sleep requirements as a result of recommendations from a Fatality Review Team.*
DCYF should consider reinstituting specific training for child welfare workers on recognizing indicators of parental ambivalence for risk and safety assessment.	**Status: Considered, Not Implemented**
The Committee requests a safety planning training for both CPS and CFWS sections to be hosted by the Quality Practice Specialist (QPS) team for the specific office. The focus should ensure that the staff understands when a safety plan is required and the elements that should be addressed to ensure appropriate monitoring by individuals who can safely monitor and reliably report back to the caseworker.	**Status: Implemented, Local Office** *The local office held several trainings and are offering it regionwide. Safety assessments and safety planning are discussed in detail, including when it applies to supervision level at Family Time versus when returning home for placement. Supervisors and staff can also request 1:1 with the QPS.*

TRAINING SAFETY & RISK ASSESSMENT	
The Committee recommends a targeted training on global assessments and assessing safety throughout the life of the case be offered to CFWS caseworkers in this office and should be considered statewide as well.	**Status: On Hold**
The Committee recommends the office connect with the UW Alliance to review available training opportunities to address the subject matters. One example of available training is the Child Protection Medical Consultation (MedCon) that provides training on child abuse injuries and the role of medical consultants.	**Status: On Hold**
The Committee further recommends a training to the particular office to increase caseworkers' understanding and application of Sirita's Law. The content should include assessing safety, risk, and the needs of the family to include both the biological parent and the non-parental caregiver. The training should also focus on service delivery and engagement with the entire family unit. Available resources for this training may include the CFWS Program Manager (Statewide), Quality Practice Specialist and UW Alliance.	**Status: On Hold**
The Committee recommends that all staff (excluding administrative staff) in the Lakewood office receive Safety Framework training and complete a follow-up coaching session by the Alliance coaches. The coaching session allows for a deeper-rooted assessment with regard to whether the information from the training has been fully understood and engrained in fieldwork and supervision.	**Status: Implemented, Local Office** *Safety Framework training occurred by providing additional sessions and the QPS provided follow-up coaching.*
The Committee heard from agency program staff that the agency is addressing clinical supervision, supervision of assessments, and improvement in the accuracy and efficacy of assessments through training, procedure, and policy improvements. The Committee believes supervisors statewide, especially the supervisors located in the local office, might benefit from supervisor-specific training to enhance accuracy and critical thinking in Structured Decision Making Risk Assessment (SDMRA) and domestic violence and safety assessments.	**Status: In Progress** *The supervisors of the local office have taken the SDMRA training and policy updates have occurred.*
The Committee recommended on-going training opportunities that pertain to assessing children in homes where there is domestic violence, substance abuse, and other trauma related impacts should be made available to all case carrying staff.	**Status: Not Implemented, Already in Policy/Practice**

TRAINING SAFETY & RISK ASSESSMENT	
All social services specialists and area administrators in all field offices, including after-hours staff, should be required to attend and successfully complete Safety Boot Camp training. This training includes but is not limited to training about sentinel injuries, assessment of safe sleep environments, and investigation protocols.	**Status: Considered, Not Implemented** *After-hours workers are required to completed Regional Core Training. Many topics covered in Regional Core Training are also covered in Safety Boot Camp.*
The Committee recommends that all staff receive at an all-staff meeting an overview of "Assessing Child Safety in the Context of DV". The Committee also recommends that staff who have not attended the "Assessing Child Safety in the Context of DV" training must attend the training within 12 months unless they have attended the "DV in Child Welfare" training within the last year.	**Status: Modified/Partial Implementation, Statewide** *The DCYF Recommendations Review Committee made a recommendation to management to consider mandatory in-service refresher training for staff every 2 years.*
The Committee recommended that training related to DCYF Policy 4420 (Health and Safety visits with Children and Youth and Monthly Visits with Parents and Caregivers) and RCW 74.13.031.16 be included in the Supervisory Core Training.	**Status: Implemented, Statewide**
DCYF should provide training for case carrying staff and supervisors about the use of history when assessing child safety.	**Status: Considered, Not Implemented**

TRAINING OTHER TRAINING	
The Committee recommends that DCYF obtain training and/or education for staff regarding the Marshall Islands and this population's culture. This training should be available statewide for staff and could be provided by an expert or offered in an e-learning format.	**Status: Considered, Not Implemented**
The Committee recommends the Kelso office receive a refresher training regarding policy requirements related to the ICWA, including when and how to contact Tribes and engagement with Tribes.	**Status: Modified Implemented, Local Office** *The area administrator determined which staff needed this training.*

TRAINING OTHER TRAINING	
The Committee recommends DCYF provide to all field staff mandatory suicide awareness training. This training should include what questions to ask, provide information on risk factors, provide suicide resources within the family's community including prevention, intervention, support, and provide instruction about what next steps should be if suicidal ideation or attempts are identified. The Committee understands it is difficult to schedule trainings due to the high turnover experienced by DCYF. With that in mind, the intent for this recommendation is for an approximately 90-minute training for groups no larger than 30 individuals. This training should occur within the next 12 months for all current DCYF staff and be required ongoing training for all new staff.	**Status: Implemented, Statewide** *Suicide Awareness training was included as an annual training for all DCYF staff.*
DCYF should consider using the specific case for a statewide Child Fatality Lessons Learned training. This is not due to any definite critical errors but instead due to the number of issues the case would facilitate for case discussions.	**Status: In Progress** *The case is being added to the Lessons Learned curriculum.*

CASEWORK PRACTICE MULTI-DISCIPLINARY COLLABORATION	
The Committee believes collaboration between Region 5 and the Mary Bridge Endocrinology clinic would benefit staff and the families they both serve. This collaboration may include DCYF asking Mary Bridge Endocrinology staff to attend all-staff meetings to discuss Type 1 diabetes and care needs. It may also include providing basic information about the disease and include working on pamphlets for staff to have and/or distribute to families impacted by this disease. The Committee also believes the hospital social worker and nurse diabetic care educators could provide support and education to staff when requested, and if available, a more formalized process may also benefit DCYF's clients.	**Status: Implemented, Region** *Mary Bridge provided Diabetes 101 training to the region.*

CASEWORK PRACTICE MULTI-DISCIPLINARY COLLABORATION	
The Committee recommends that DCYF reconsider using the Early Intervention Program (EIP) through the Tacoma-Pierce County Health Department. One of the Committee members previously held the public health nurse position that worked those types of referrals from DSHS. The Committee believes the direct referral process worked very well in Pierce County and, if reinstated, may assist families with more support sooner and possibly prevent some cases from rising to the level of a CPS intervention. This would possibly decrease the impacts of ongoing, mismanaged diabetic care that may possibly result in permanent damage. This case demonstrates how a regular referral to a public health nurse for children with special medical needs did not work well. The current program only works if the parent accepts the offer of support. Under the EIP referral program, a parent does not have the ability to refuse the referral without notification to DCYF. The EIP program met weekly, sometimes biweekly, in the family's home to teach a variety of skills to children and parents, complete development assessments, and referrals to appropriate agencies or programs.	**Status: Considered, Not Implemented**
The Committee recommends that the DCYF Region 5 management, including the area administrator and/or including the Deputy Regional Administrator or Regional Administrator, attempt another meeting with Kitsap Mental Health (KMH). The information shared during the review was that KMH refuses to release information pursuant to records requests made by DCYF, even when clients and DCYF utilize the form provided by KMH. The Committee understands the Kitsap County Area Administrator has attempted numerous times to engage KMH during her 10 years in her current role. However, one Committee member shared that there has been a change in staff and management, and they may be more open to collaboration.	**Status: Pending**
The Committee recommends DCYF leadership in Region 5 meet with hospital staff to discuss documentation. This case highlighted a situation where the hospital documented that DCYF staff approved a child's discharge from the hospital. DCYF staff does not make medical decisions and therefore cannot approve or deny anyone's discharge. This was discussed by the Committee and during DCYF staff interviews, and it is an ongoing struggle. It has been resolved in another part of the state by DCYF staff meeting with hospital staff to discuss the issue.	**Status: Implemented, Local Office**

CASEWORK PRACTICE MULTI-DISCIPLINARY COLLABORATION	
In addition to utilizing internal DCYF consultation and collaboration, the Committee recommended DCYF have closer on-going collaboration with medical professionals involved in a child's life.	**Status: Implemented, Statewide**
DCYF should consider providing a resource to caregivers and relatives who live in the same home or provide substantial care to children involved in DCYF when there are allegations regarding substance use/abuse. This education should include information about typical behavior patterns displayed by people who are using specific types of drugs. For example, heroin, methamphetamine or heavy marijuana use. The training should be designed to provide the caregivers with a better understanding of drug related behaviors or actions that may impact child safety. The Committee recommends a subject matter expert from the substance abuse field provide this training.	**Status: Considered, Not Implemented**
The Committee suggests DCYF explore ways to develop a more formal integrated team case approach. This should encourage information sharing with professionals who are working with family members (e.g., medical providers, educators, mental health providers and those providing assessments). The information-sharing should reduce the likelihood the worker accumulates information without the benefit of multiple professional perspectives having the opportunity to discuss the family's issues.	**Status: Considered, Not Implemented**
The Committee recommends DCYF work with substance use disorder and mental health agencies to co-locate staff within each DCYF office. Ideally, a co-occurring provider could provide for both identified areas of need.	**Status: Considered, Not Implemented**

CASEWORK PRACTICE OPERATIONS AND ADMINISTRATION	
The Committee recommends DCYF create a document that is uploaded into FamLink at the conclusion of an adoption selection committee meeting. The form should describe who was present, who facilitated the meeting, and who participated in the process. The form should also include a section that describes what information was shared and how a decision was made. DCYF should also create a statewide training regarding when and how to utilize this process.	**Status: Considered, Not Implemented**
For purposes of databases used for child safety assessments, the Committee recommends DCYF review the scope of who within DCYF has access to such databases and more specifically for field staff. Database examples include, but are not limited to, Support Enforcement Management System (SEMS), Automatic Client Eligibility Systems for DSHS (ACES), and Barcode. These databases are state agency databases that often times contain needed contact information. Access to these types of databases should be given to DCYF staff so DCYF may more effectively do its job.	**Status: Not Implemented, Already in Policy/Practice** *DCYF staff have Barcode and ACES available upon request.*
Despite the fact that many staff are unaware of Form No. 02-607 (Reasonable Efforts to Locate form), the Committee believes the form is a useful tool for CPS staff. Accordingly, the Committee recommends that the headquarters CPS Program Manager should evaluate the best method to ensure all field staff are aware of the form. The Committee also recommends that an active hyperlink to Form No. 02-607 be inserted in the resources section of DCYF Practices and Procedures 2310 CPS Initial Face-to-Face Response policy or within the body of the policy itself.	**Status: Considered, Not Implemented**
The Committee received information regarding concerns about staff to supervisor ratios. The staff member who provided this information included detailed duties for a supervisor of case carrying staff and how that correlated to necessary hours to complete the stated tasks. The Committee believes a workload study should be conducted to review the current supervisor to case carrying staff ratio.	**Status: Considered, Not Implemented**
The Committee recommends that FAR case be given access to the Code C through the NCIC checks. The Committee believes this tool could have aided the CPS worker by allowing them to confirm the mother's and stepfather's drug-related criminal charges and hopefully aided in a further assessment of possible current substance abuse.	**Status: Considered, Not Implemented**

CASEWORK PRACTICE OPERATIONS AND ADMINISTRATION	
The Committee also recommends DCYF continue to increase its communication with families and the inclusion of subsequent documentation that confirms the conversations occurred. The documented discussions may include conversations about child safety, including car seat safety, and medication storage discussions for families who may be involved in medically assisted treatment programs.	**Status: Not Implemented, Already in Policy/Practice**
To ensure DCYF Form 13-904 is appropriate and addresses the needs of a diabetic individual, DCYF should collaborate with a diabetic care clinic to review, and if necessary, revise the form. After the form has been reviewed, revised, and approved, DCYF headquarters should ensure the field offices (all programs) are made aware of the form and provide guidance pertaining to when and how the form should be used.	**Status: Not Implemented, Other** *The source of the form is unknown. The form should be retired as staff should follow practice for medical issues.*
DCYF should ensure that when working with families to develop clear, concrete expectations that will demonstrate behavioral change, that DCYF seeks to ensure the safety of the children. This should be utilized when discussing a trial return home to a parent(s), but also with relative or fictive kin caregivers. This information should be shared with the parties and court.	**Status: Not Implemented, Already in Policy/Practice**
For purposes of program fidelity, DCYF should assess contract oversight processes and consider program fidelity audit solutions. DCYF should consider providing DCYF staff with a tip sheet or training that provides staff with an awareness of in-home contracted provider requirements.	**Status: Implemented, Statewide**
DCYF should provide a process for staff to submit concerns to address model fidelity issues.	**Status: Implemented, Statewide**
The Committee recommends that the local office cease use of any unofficial or unauthorized forms while screening and assessing for domestic violence.	**Status: Implemented, Local Office**

CASEWORK PRACTICE OPERATIONS AND ADMINISTRATION	
The Agency might consider adding an initial line next to the 42 CFR Part 2 citation on the Agency release of information form.	**Status: Not Implemented, Other** *The line requested for initials on the consent form is regarding the recipient receiving the consent form. There is already a specific box above the signature line which specifies that the consent is regarding a request for chemical dependency information.*
The Committee recommends that DCYF remove the functionality within FamLink which allows caseworkers to approve their own Safety Assessment in the Comprehensive Family Evaluation. The Committee believes the approval of the Safety Assessment should be the responsibility of the supervisor.	**Status: Considered, Not Implemented**
The Committee identified gaps within an investigation. Those gaps included documentation of forensic interviews, obtaining law enforcement reports, and collaboration with law enforcement and the prosecutor's office. These types of interactions, information sharing, and investigative steps are often outlined in a Child Abuse Center (CAC) protocol. It does not appear the Skagit County protocol has been updated and signed since 2014. The Committee believes it would benefit DCYF staff, and ultimately the community as a whole, for DCYF and the other multi-disciplinary team (MDT) members to revisit this protocol. As part of this meeting, there needs to be a clear understanding for DCYF staff regarding roles and requirements, specifically addressing who can request a forensic interview and how those are conducted. The local DCYF office involved should then receive a refresher training about the protocol.	**Status: Implemented, Region** *The Skagit County protocol was reviewed and is being updated.*
For purposes of making timely and accurate screening decisions, the Department should explore options for increased access to a child and youth's medical history.	**Status: Considered, Not Implemented**
The Committee recommends that Region 4 assess how to gain access to electronic court records. This case highlights the fact that the office did not have access to such information which could have been beneficial.	**Status: Considered, Not Implemented** *Records are available through the AAG.*

<table>
<tr><th colspan="2">CASEWORK PRACTICE
POLICIES AND PROCEDURES</th></tr>
<tr><td>The Committee recommends DCYF Intake Area Administrators, the Intake Program Manager, and CPS program Manager review screened out intakes received from medical providers. The review is to specifically evaluate cases that pertain to medical providers who call to report an injury involving a child that is less than four years of age in which the medical provider concludes the injury is consistent with the explanation given.

The Committee also recommends the above identified DCYF staff review Practices and Procedures Policy No. 2200 (Intake Process and Response). In particular, the Committee recommends the identified staff consider whether section 1.c.ii.A.I.iv. ("Abuse or neglect reported by a physician, or a medical professional on a physician’s behalf, regarding a child under age five") should be revised.</td><td>Status: Considered, Not Implemented</td></tr>
<tr><td>The Committee recommends DCYF develop policies and procedures to address adequate precautions for interacting with parents who are known to be actively using methamphetamine. The Committee suggests DCYF consider consultation with the Department of Health. If possible, the Committee believes DCYF might consider the use of substance residue kits and/or swab testing. The Committee believes any new related policy and/or procedures should include the following considerations and situations:
• Parent-child visitation in the home, at the DCYF office and/or contracted facility.
• Contracted providers who work in the homes where persons are using or suspected of using methamphetamine.
• DCYF meetings with parents that occur either in the home or DCYF offices.</td><td>Status: Not Implemented, Already in Policy/Practice
Current policy identifies safety precautions for staff if manufacturing meth is suspected (Practices and Procedures 8212) Also, visitation guide establishes considerations for appropriate site of visitation. Cost of residue kits is prohibitive, and legal authority to swab clients is a question.</td></tr>
<tr><td>The local office should work with the regional program managers to review policies that pertain to initial contact and engagement with the tribe, courtesy supervision, health and safety, and FVS time frames.</td><td>Status: Implemented, Local Office</td></tr>
</table>

CASEWORK PRACTICE POLICIES AND PROCEDURES	
It is recommended that DCYF policy specifically address virtual home visits with families to ensure the agency is able to assess safety to the best of its ability. The policy should include language specifically allowing DCYF to request that parents be able to show their home environment, including a safe sleep environment. A picture of the home/safe sleep environment is less preferable but also acceptable. The policy should include language about the agency's response, including allowing for an in-person visit if a parent refuses to allow a virtual visit or refuses to send pictures of the home environment. Under this in-person visit option, the caseworker must wear personal protective equipment (PPE). If a virtual visit is impossible because the parent does not have the necessary technology, the agency should work to provide technological access to facilitate the visit.	**Status: Considered, Not Implemented** *Making a specific policy based on an emergency pandemic situation is difficult. The workers are still able to conduct home visits.*
To establish a strong continuity of care when a CFWS case is transferred from one worker to another, the Committee recommends the receiving CFWS worker incorporate into his or her practice a review of any previous Child Health and Education Tracking (CHET) Screening reviews. If the new CFWS worker conducts this review, the new case CFWS worker should have a better understanding of prior recommendations designed to address the child's health needs, mental health needs and education needs. For referrals previously recommended by the CHET Screening that have not been made, the new CFWS worker should be able to make such referrals after assuming responsibility for the case. This recommendation was developed specifically for the local office due to frequent case transfers within CFWS but should be considered a statewide best practice.	**Status: Modified/Partial Implementation, Statewide** *This recommendation was already in policy (Practices and Procedures, 4240). Practices and Procedures, 4122 regarding Case Transfer was updated.*
Department CFWS workers assigned as the primary caseworker, in addition to having a courtesy supervision caseworker for monthly health and safety visits, should adhere to the expectations in the courtesy supervision policy. The primary assignment CFWS worker has responsibility for service referrals, decision making, and payment authorization.	**Status: Implemented, Statewide**
The Wraparound Intensive Services (WISe) screenings should be implemented in cases involving a child or youth who is experiencing placement instability, or emotional, behavioral, or academic challenges. WISe access is based on Medicaid eligibility for mental health services and can provide intensive supports to children and youth statewide.	**Status: Not Implemented, Already in Policy/Practice** *Policy already requires WISe screening in certain cases and allows it in others.*

CASEWORK PRACTICE POLICIES AND PROCEDURES	
All intakes, statewide, should include the household composition at the beginning of the narrative.	**Status: Not Implemented, Already in Policy/Practice** *Many intake units already include the household composition at the beginning of an intake, but this practice is not uniform around the state.*
It is recommended that the local office evaluate their practice for case transfers from CPS to FVS through the regional Quality Practice Specialists observing the current case transfer process. The Quality Practice Specialists can evaluate the effectiveness of the case transfer process, and make suggestions to enhance collaboration, critical thinking, and on-going case assessment.	**Status: Implemented, Local**
The local DCYF office should continue to work toward enhanced collaboration for all case transfers to ensure that all relevant information is shared and to ensure continuity of care when a case transitions to a new caseworker. The DCYF office should ensure that detailed information related to family history, patterns of behaviors, ongoing concerns, and outstanding needs is provided.	**Status: Modified/Partial Implementation, Local Office** *A policy revision was rolled out to staff in a policy roll out training offered by the UW Alliance.*
The Committee recommended DCYF Policy 4420 (Health and Safety visits with Children and Youth and Monthly Visits with Parents and Caregivers) clearly articulate DCYF's responsibility to assess the safety of all children in the home to better align with RCW 74.13.031.16.	**Status: Modified/Partial Implementation, Statewide**
The Committee recommended that all intakes called in reporting the use of life-saving measures, such as CPR or Narcan, should be coded as near fatality, even if the referrer does not use the term near fatality. If a physician later determines the incident was not a near fatality, then the case would no longer be considered a near fatality or treated as such.	**Status: In Progress**

CASEWORK PRACTICE POLICIES AND PROCEDURES	
The Committee recommends DCYF consider adopting a statewide practice requiring monthly case collaboration between caseworkers and supervisors for cases that may be handled by multiple DCYF offices. The purpose of this communication goal is to provide additional opportunities for shared decision-making and enhance the continuity of care provided to the child(ren) and family. It is recommended the case collaboration be documented in a case note, regardless of whether it occurs by virtual meeting, in-person, telephone, or email.	**Status: In Progress**
The Agency might consider adopting a policy that requires a shared planning meeting with providers and parents if there are multiple failed attempts to communicate with substance use providers.	**Status: Not Implemented, Already in Practice and/or Addressed** *An FTDM should occur if there is a placement decision being made.*
In recognition of the Region 2 positive communication efforts between primary DCYF staff and licensing staff, the Committee encourages DCYF to consider amending policy requirements so that statewide communications mirror the communications occurring in Region 2. DCYF may also want to consider whether it should implement a 30-day document submission policy. If DCYF decides to do this, the Committee recommends the required completion date be 30 days from the placement date and to include allowance for background checks on persons who frequent the home or who have supervised and unsupervised contact with the children.	**Status: Considered, Not Implemented**

CASEWORK PRACTICE PRACTICE CONSULTATION	
In cases of professional disagreement, the Committee encourages DCYF to consider an avenue for line staff to seek consultation from upper management outside of their direct supervisor. The Committee believes the ideal process should be normalized so that consultation may occur quickly and without retaliation or stigma.	**Status: Considered, Not Implemented**

CASEWORK PRACTICE PRACTICE CONSULTATION	
For CFWS cases of complex nature involving challenges related to complex medical needs, placement disruptions or concerns, and other wellbeing challenges, the local office should utilize triage staffing hosted by the local Quality Practice Specialist team to facilitate a conversation about safety, permanency, wellbeing, and to hear from other skilled professionals about ideas they may have for addressing concerns and meeting the needs of a family.	**Status: Implemented, Local Office**
Region 4, King County, has Domestic Violence Best Practice staffings. Those teams include DCYF staff and community subject matter experts. The staffings are for DCYF to staff difficult cases and to obtain current information regarding domestic violence. The Committee believes all regions should have this type of team and they should not be tied to or connected to triage staffings. The staffings should include community subject matter experts who work in the domestic violence field.	**Status: Modified Implemented, Statewide** *The Child Welfare Leadership team (CWLT) decided on a just in time e-learning for domestic violence cases. The Alliance has been brought on board to begin the work.*
DCYF should implement Substance Use Best Practice Staffings in all regions.	**Status: Modified Implemented, Statewide** *The Child Welfare Leadership team (CWLT) decided on a just in time e-learning for domestic violence cases. The Alliance has been brought on board to begin the work.*

<table>
<tr><th colspan="2">CASEWORK PRACTICE
PRACTICE CONSULTATION</th></tr>
<tr><td>The Committee’s recommendation is for DCYF to create resource availability for case workers to consult with substance use disorder (SUD) professionals who have an understanding of and experience in supporting individuals with co-occurring disorders and domestic violence history. The scope of the consultation may include, but is not limited to, the following: case worker education regarding substance use and misuse, current trends and risks factors related to specific substances, interpretation of SUD records, and how to identify service and safety needs to be met. The Committee would like to see the following made available:
• DCYF to contract with community-based SUD professionals who could provide case consultation upon request. This service could be utilized statewide by case workers through a network of professionals that can provide written, virtual, or telephonic case consultation.
• DCYF to develop a memorandum of understanding for resource sharing with DSHS partners who have access to SUD consultation services.
• DCYF child welfare to collaborate with Juvenile Rehabilitation (JR) regarding SUD resources utilized by JR and determine if resource sharing could occur within the agency.
• DCYF to promote the availability of the statewide SUD program manager so that all local offices are aware this position is available to field questions related to SUD specific services and navigation of the SUD system.</td><td>Status: Modified Implemented, Statewide
These recommendations were shared with the newly hired SUD program manager.</td></tr>
<tr><td>In an effort to improve practice and address case-specific deficiencies identified in the findings, the Committee recommends that in addition to potential attendance at available trainings, the caseworker and supervisor may benefit from a one-on-one consultation with the regional program manager or deputy regional administrator. The Committee understands the regional administration has taken steps to address and implement this recommendation.</td><td>Status: Implemented, Region</td></tr>
</table>

CASEWORK PRACTICE PRACTICE CONSULTATION	
The Committee recommends DCYF consult with the Risk Management Administrator about triage staffing documentation. In particular, the consultation should address whether there is liability to DCYF if the triage staffing case notes contain a statement that DCYF should file a dependency petition if certain conditions within the case are not appropriately addressed. The consultation should also include a discussion about what liability, if any, attaches to the agency if the agency does not file a petition and a critical incident then occurs. Any guidance provided by Risk Management should then be shared and discussed at the statewide Leads Meetings. Attendees at the lead meetings include headquarters staff and representatives from all regions. Topics discussed at these meetings focus on the agency's work; and information from the meetings is then disseminated to the various regions.	**Status: Considered, Not Implemented**
The Committee identified that this case was an example of possible misuse of substances and not an addiction issue. This is a nuance that is often difficult for staff to discern. More collaboration with substance use professionals may have been helpful in this case. DCYF used to have substance use treatment professionals housed in field offices. These providers were available to help educate staff or discuss challenging cases. They also went into the field with staff. The Committee recommends that DCYF work toward either a collaborative relationship as previously described or create a system for field offices to build that relationship and/or a possible hotline-like system for staff to access professionals in this field to aid in cases where substance use has been identified.	**Status: Modified Implementation, Statewide** *After this recommendation, DCYF created and hired a Substance Use Disorder Program Manager position. This position will provide expertise in the area of substance use for staff.*

CASEWORK PRACTICE SAFETY ASSESSMENT & PLANNING	
In an attempt to address inconsistencies pertaining to the accurate use of the safety framework, the Committee encourages DCYF to continue to consider alternative methods of implementing practice standards, perhaps through the state and regional Program Improvement Plans.	**Status: Considered, Not Implemented**

CASEWORK PRACTICE SAFETY ASSESSMENT & PLANNING	
The Committee acknowledged the challenges caseworkers may face in gathering all pertinent information to complete a thorough assessment. With that in mind, the Committee suggested that DCYF focus on individualized skill building for caseworkers to help them learn how to effectively gather pertinent information and evaluate the information gathered to assess child safety. The Committee suggested providing this technical support and guidance through individualized clinical supervision and coaching.	**Status: Not Implemented, Already in Policy/Practice** *Safety-related resources were already in place and available at the time the incident occurred.*
DCYF headquarters staff need to assess the definition of Structured Decision Making (SDM) question numbers 5 and 7. With regard to number 5, the Committee discussed that each time a diabetic ketoacidosis event occurs, there is more than likely damage to the child's body. With regard to number 7, Type 1 diabetes should be considered medically fragile. According to the subject matter experts involved with this review, the medical field considers a child who has been diagnosed with Type 1 diabetes to be medically fragile. Had those two items indicated "Yes", the result may have better assisted the staff in understanding the high risk associated with the case. After the headquarters definition assessment is completed, any necessary additions or changes should be distributed statewide to the DCYF offices for notification of the changes and updated training.	**Status: Considered, Not Implemented**
It is recommended that the region develop a formalized protocol on how to handle cases when the court returns a child home over the Department's objection and there is an active safety threat. Below are suggestions that may be included in this formalized process: • DCYF will complete a triage staffing utilizing DCYF child safety experts to evaluate the safety and risk and ensure accuracy in the completed assessments as well as provide suggestions for how to mitigate the safety and risk, address barriers, and develop an appropriate case plan. • The local office area administrator should have a conversation with the AAG section lead to discuss the court ruling and strategize on how DCYF should proceed with the legal case. • DCYF may also work with the AAG to develop a protocol on how DCYF will respond in court when the court orders a child home over DCYF's objection and DCYF continues to have significant concerns about child safety.	**Status: Not Implemented, Already in Policy/Practice**

CASEWORK PRACTICE SAFETY ASSESSMENT & PLANNING	
The Committee recommended DCYF apply the principles of the harm-reduction model when developing safety plans and service provisions for parents who have substance abuse concerns. It was further recommended that the content of these conversations be documented through case notes, shared planning meeting notes, etc. This could include, but is not limited to, providing resources to access medically assisted treatment programs (MAT), identifying who will care for the child if a relapse occurs, and medication storage and safety.	**Status: In Progress**
DCYF program staff should assess ways to achieve accuracy in staff completion of the SDM's and the supervisor reviews. This includes how to utilize critical thinking during the assessment process. Once an assessment has been completed, DCYF should implement necessary changes to improve staff completion of the SDM; and enhance the critical thinking necessary to appropriately utilize the tool to assess the risk to children.	**Status: Pending**
The Committee recommends the DCYF Substance Use Disorder Program Manager consider development of a SUD Protocol to aide caseworkers in uniformly assessing child safety impacts that are related to parent/caregiver substance use.	**Status: Implemented, Statewide**
The Committee believes mailed or faxed police reports can cause a delay in assignment and assessment of child safety. The Committee believes DCYF should work with law enforcement agencies statewide to either call in reports or email them and eliminate faxing and mailing.	**Status: Considered, Not Implemented**
DCYF should add a question to the gathering questions, specifically identifying suicide as a topic. The question should be asked of children 10 years of age or older and ask the following: has the child considered and/or attempted suicide or considered and/or attempted to kill himself or herself. If a child answers "Yes", then there should be documented follow-up regarding what next steps the worker took to address the issue. Next steps may include, but not be limited to, provide a crisis help number, contact a crisis mental health professional, discussion of weapons or access to other means related to their suicidal ideation or plan, and engaging the child's parent or caregiver.	**Status: Considered, Not Implemented**

CASEWORK PRACTICE STAFF SUPPORT	
The Committee believes DCYF should submit a request to the legislature to fund a critical incident protocol. The Committee recognizes the emotional toll that it takes on DCYF staff when a critical incident occurs. This is especially the case if the Department does not have a staff support protocol. The Committee discussed that a protocol similar to the law enforcement protocols would be appropriate. The Committee believes a funded protocol should be created that supports a triage response from a group specifically trained to respond. The protocol should include directives that relieve the assigned staff from new responsibilities. This triage team would provide protected time for the worker and supervisor to address their secondary trauma needs. This would not take the place of any Peer Support or other emotional support programs.	**Status: Considered, Not Implemented** *Legislation (HB1631) was introduced during the 2020 legislative session that addressed many of these recommendations, including development of a unit of staff that would take over caseloads for staff experiencing a critical incident. That bill passed and was eventually signed into law. However, the provision in the bill allocating additional staff to temporarily cover caseloads following a critical incident was removed from the bill before its final passage. DCYF funded and posted a position for a designated Peer Support administrator to administer the DCYF's Peer Support program.*

CASEWORK PRACTICE STAFF SUPPORT	
Recognizing the emotional toll on DCYF staff when a child fatality or near-fatality occurs, the Committee recommends that DCYF submit a request to the legislature to fund a critical incident protocol. The Committee believes a protocol similar to those used by many law enforcement agencies would be appropriate. Key components of a DCYF critical incident protocol should include directives that relieve the involved staff from new responsibilities and a triage team to provide protected time for the worker(s) and supervisor(s) to address their secondary trauma needs. The critical incident protocol would be in addition to any Peer Support or other emotional support programs available to DCYF staff. .	**Status: Considered, Not Implemented** *Legislation (HB1631) was introduced during the 2020 legislative session that addressed many of these recommendations, including development of a unit of staff that would take over caseloads for staff experiencing a critical incident. That bill passed and was eventually signed into law. However, the provision in the bill allocating additional staff to temporarily cover caseloads following a critical incident was removed from the bill before its final passage. DCYF funded and posted a position for a designated Peer Support administrator to administer DCYF's Peer Support program. The department has a critical incident protocol established several years prior to this recommendation. The protocol does not include the use of secondary teams to respond to critical incidents in the field.*

CASEWORK PRACTICE STAFF SUPPORT	
Recognizing the emotional toll on DCYF staff when a child fatality or near-fatality occurs, the Committee recommends that DCYF submit a request to the legislature to fund a critical incident protocol. The Committee believes a funded protocol similar to those used by many law enforcement agencies would be appropriate. Key components of a DCYF critical incident protocol should include directives that relieve the involved staff from new responsibilities and a triage team to provide protected time for the worker(s) and supervisor(s) to address their secondary trauma needs. The critical incident protocol would be in addition to any Peer Support or other emotional support programs available to DCYF staff.	**Status: Considered, Not Implemented** *Legislation (HB1631) was introduced during the 2020 legislative session that addressed many of these recommendations, including development of a unit of staff that would take over caseloads for staff experiencing a critical incident. That bill passed and was eventually signed into law. However, the provision in the bill allocating additional staff to temporarily cover caseloads following a critical incident was removed from the bill before its final passage. DCYF funded and posted a position for a designated Peer Support administrator to administer the DCYF's Peer Support program.*
The Committee recognized the importance of casework staff receiving supports to address the trauma impacts that may occur due to working in child welfare. The Committee wanted to ensure that staff who exit state service and no longer have access to DCYF Peer Support and EAP are made aware of alternative resources. The Committee suggested that during staff exit interviews, individuals are provided with a list of community-based therapeutic resources.	**Status: Considered, Not Implemented** *Out of scope.*
DCYF should develop a response system for addressing critical incidents. The goal of this response system would be to de-brief, address secondary trauma impacts on staff, and create a cultural change within the agency on how support is provided to case workers in the field. This system of response would be mandatory for those in an office/unit that have experienced a critical incident and be provided by a specialized, professional team. This would be in addition to the Peer Support program that is already available to DCYF employees.	**Status: Modified/Partial Implementation, Statewide** *An FTE for a full-time Peer Support Administrator was approved and the position was filled.*

CASEWORK PRACTICE STAFF SUPPORT	
Instead of focusing on task-oriented notations, clinical supervision should be provided in such a manner that oversight and documentation demonstrates the use of critical thinking and the information gathered is used to assess and address safety and risk.	**Status: Implemented, Statewide**
The Committee believes it is critical that DCYF address staff retention and develop a plan that requires staff training through Regional Core Training and other required in-service training within staff's first year of service and that prohibits the assignment of cases before staff is ready. The following recommendation should be overseen by local office leadership, such as an area administrator, through ongoing supervision and consultation. The Committee recommends that leadership ensure a plan for a daytime staff transition to after-hours so that staff is relieved when there are unresolved matters from the daytime.	**Status: Considered, Not Implemented** *These decisions are case-specific and may depend upon capacity of after-hours to take on additional work, as well as having budget considerations.*
The Committee believes it is critical that DCYF address staff retention and develop a plan that requires staff training through Regional Core Training and other required in-service training within staff's first year of service and that prohibits the assignment of cases before staff is ready. The following recommendation should be overseen by local office leadership, such as an area administrator, through ongoing supervision and consultation. Leadership needs to address the matter of staff safety so that if a worker feels unsafe when meeting with a family individually, a plan is developed to support them in performing their work safely.	**Status: Not Implemented, Already in Policy/Practice**
The Committee believes it is critical that DCYF address staff retention and develop a plan that requires staff training through Regional Core Training and other required in-service training within staff's first year of service and that prohibits the assignment of cases before staff is ready. The following recommendation should be overseen by local office leadership, such as an area administrator, through ongoing supervision and consultation. The Committee identified the importance of additional support for offices struggling with turnover and retention, such as utilizing resources offered through Quality Practice Specialists (QPS) and UW Alliance for training.	**Status: Not Implemented, Already in Policy/Practice**

CASEWORK PRACTICE STAFF SUPPORT	
The Committee recommends that for DCYF programs experiencing significant turnover, the area administrator should develop a plan with the unit supervisor to address the turnover and a plan to improve retention. For the staff to do their jobs effectively, these plans should ensure the staff have the necessary training and support from their area administrator, immediate supervisor, and DCYF management. This plan should include utilizing the training and coaching supports that are available through the UW Alliance, Regional Quality Practice Specialists, and Program Managers.	**Status: Not Implemented, Already in Policy/Practice** *The Department is already implementing strategies for staff retention and availability of coaching.*
The Committee recognizes the important need for the Peer Support program coordinator to continue to reach out and offer support to caseworkers who have experienced work-related traumatic events and critical incidents. To encourage regional leaders to offer direct support to caseworkers following a critical incident and to encourage the offerings provided by Peer Support, the Committee recommends the Peer Support program coordinator connect with statewide regional leadership.	**Status: Modified/Partial Implementation, Statewide**
The Committee discussed a lack of consistent support to new or struggling field staff. To offer support, shadowing, mentoring, and other services to new staff, the Committee recommends that DCYF hire sufficient staff into the Social Service Specialist 4 positions. The Committee was told during the staff interviews that a lack of support and training has been a consistent theme in staff exit interviews, especially during COVID. While the Alliance has coaches that can go into the field and help staff, there are not enough coaches to fill this need. This issue has also been raised during many previous reviews by caseworkers, supervisors, and area administrators.	**Status: Considered, Not Implemented**

CASEWORK PRACTICE OTHER CASEWORK PRACTICE	
The DCYF MedCon should contact the two pediatricians from the intake to discuss this case. The discussion should include information about sentinel injuries and the physicians' responses to them. The MedCon should also share that Child Abuse Intervention Department (CAID) is a resource to the pediatricians for any future injuries or concerns that the pediatricians may have about their patients.	**Status: Considered, Not Implemented**

CASEWORK PRACTICE OTHER CASEWORK PRACTICE	
The local office reported that they developed a schedule to support and supervise the children who are spending time at the office awaiting a new placement. The Committee requested the office expand this plan to address whether the children's medical, dental, academic and therapeutic needs are being met when the children do not have an identified placement that is assisting in the oversight of these well-being needs.	**Status: Not Implemented, Already in Policy/Practice** *There is already an expectation that any child in the Department's care be assessed to have their needs met, regardless of placement setting. In addition, Field Operations has established new protocol regarding office stays since the fatality review team met. The new protocol requires staffing with the Regional Administrator when a child is in a hotel stay for five nights, and another staffing with the Assistant Secretary or the Director of Field Operations when a child is in a hotel for ten consecutive nights, and then every fourteen days thereafter.*
The Committee also recommends the adoption selection committee members should be diverse and include representation from the child(ren) and family's ethnicity and culture.	**Status: Considered, Not Implemented**

PARTNERSHIPS WITH COMMUNITY PROFESSIONALS	
The Committee recommended that DCYF request an addition to the memo of understanding with the Confederated Tribes of the Colville Reservation to include that the tribe will provide history to DCYF when they request DCYF to conduct an investigation or assessment for a family.	**Status: In Progress**
The Committee recommended that DCYF review the local law enforcement protocol to see if Colville Tribal law enforcement is included. If they are not included, the Committee recommends that this topic be brought up and request their inclusion.	**Status: In Progress**

PARTNERSHIPS WITH COMMUNITY PROFESSIONALS	
The Committee recommended the local DCYF office identify a point of contact at the family court to enhance future collaboration on cases shared between DCYF and family court.	**Status: Not Implemented, Already in Policy/Practice** *The local office already had a family court contact person who they could reach out to for information.*
The recommendation below was developed from the Committee's discussion about the transfer, for continued monitoring, of a case to the tribe. Although to some degree there was communication and information sharing, the Committee would like the local office to continue to work with the tribe to ensure the communication is more streamlined. The purpose of a more streamlined approach is to encourage continuity of care for the family. This may include a case staffing and more comprehensive written documentation in either the FAR family assessment, investigative assessment, or a closing summary to identify the roles and responsibilities, next steps, and any necessary follow-up.	**Status: Implemented, Local Office**
The Committee identified the untimely receipt of the law enforcement report as a system issue that more than likely impacted this case. The Committee, not knowing the relationship in Pierce County between DCYF and the law enforcement agencies, recommended that DCYF discuss how the lack of timely reports negatively impacts our ability to conduct comprehensive assessments and investigations and attempt to work on a solution with the law enforcement agencies to obtain reports in a timely manner. The Committee also discussed that sometimes it may be helpful to speak with certain officers or deputies directly to gather history until reports are received.	**Status: Modified/Partial Implementation, Region**
The Committee recommends court improvement and teamwork with the juvenile court system in the county. The Committee specifically recommends that DCYF regional leadership, including area administrators, take steps to develop an ongoing dialogue to address systemic challenges between the court, DCYF, and other legal parties.	**Status: Implemented, Region**
To foster positive stakeholder working relationships, address barriers as they may arise, and improve the outcomes in the court process for children and their families, the Committee recommends the continuation of DCYF leadership participation in the county's Tables of Ten work group between the court, legal parties, and DCYF.	**Status: On Hold**

PARTNERSHIPS WITH COMMUNITY PROFESSIONALS	
The Committee recommends that DCYF work with DCYF's legal team and neighboring states (Oregon and Idaho) to discuss how cases that move between state lines can have a more fluid and comprehensive assessment. The Committee believes if there was a reciprocal memorandum of understanding, or something similar, DCYF cases would be more comprehensive, completed in a more timely manner, and closure may occur more quickly.	**Status: Considered, Not Implemented**
Cultural connections should be developed within the county to help bridge the gap between the agency and the cultural community for Asian Pacific Islanders (API). DCYF should familiarize themselves with local resources that are available to families within their communities that may be culturally relevant and help them to more effectively engage. DCYF should collaborate with the Asian Pacific Islander community to share information about DCYF's role and responsibilities so that the API community can support its members should they have DCYF involvement.	**Status: Implemented, Region**
The Committee recommends DCYF consider partnering (possibly with the DEI Council and the United Indians of All Tribes) with culturally relevant groups to develop a resource for all DCYF staff to access when there is a need for cultural understanding and insight, or a need for resources and community services for a member of a culturally relevant group who is also a DCYF client. The Committee would like to see a rapid response to DCYF staff when the staff person makes a request for assistance to the identified team or representative.	**Status: Implemented, Statewide**
The Committee recommends DCYF create opportunities for increased collaboration with the court, legal parties, Assistant Attorney General, and relevant community partners by providing training related to child safety including indicators for physical abuse and negligent treatment.	**Status: Not Implemented, Already in Policy/Practice**
In an effort to build DCYF's collaboration with community partners and service providers in this region, the Committee recommends: (1) that DCYF's roles and responsibilities be clarified with the various stakeholders; (2) DCYF emphasize to the stakeholders the importance and urgency of information sharing; and (3) DCYF describe to the stakeholders the impacts on child safety when information is not timely shared.	**Status: Implemented, Statewide**

PARTNERSHIPS WITH COMMUNITY PROFESSIONALS	
The Committee recommends the region develop a formal plan that describes how to respond when a community provider refuses to release records to DCYF. Recommendations for this plan include a description for when it is appropriate to notify DCYF's chain of command about the refusal. It was also suggested that regional leadership (area administrators) work with community-based providers and partners to educate the providers and partners about DCYF's roles and responsibilities, and how DCYF uses the records to assess child safety.	**Status: Modified/Partial Implementation, Region**
The Committee recommends that the local Area Administrator contact the director of the Oregon clinic to identify communication issues and attempt to develop rapport. At the writing of this report, the local Area Administration and regional administration had taken notice of the recommendation and informed the writer that the recommendation will be implemented.	**Status: Implemented, Local Office**
It was suggested that the local DCYF office work with the Assistant Attorney General, Guardian ad Litem/CASA program, and the court to develop a memorandum of understanding to ensure appropriate and timely notification from DCYF to the GAL/CASA program for shared cases.	**Status: On Hold**