WASHINGTON STATE

OFFICE OF THE FAMILY AND CHILDREN'S OMBUDS

CHILD FATALITIES AND NEAR FATALITIES IN WASHINGTON STATE

SEPTEMBER 2023

Table of Contents

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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 12 months preceding 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 are any unaddressed safety issues, and, if so, may conduct a more thorough review.

Section I of this report describes OFCO's critical incident review activities from January 1, 2022, to December 31, 2022. The critical incidents discussed in this report include child fatalities and child near fatalities. It is important to note that OFCO is not notified of all child fatalities or near fatalities, only those that are recorded in the DCYF reporting system.

[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).

From January 1, 2022, to December 31, 2022, OFCO conducted 85 administrative examinations of child fatalities involving both child abuse or neglect cases and fatality cases unrelated to child maltreatment, and 62 examinations of child near fatalities. Of these, OFCO considered 39 child fatalities and 35 child near fatalities to be related to child maltreatment. Through this process, OFCO identified common factors and systemic issues regarding these critical incidents.

One such systemic issue discussed in this report is the increase in child fatalities and near fatalities occurring following the accidental ingestion of drugs. Over the past five years, there has been a significant increase in these events. In 2018, OFCO reviewed only five such cases. In 2022, however, OFCO reviewed 52 critical incidents resulting from a child accidentally ingesting drugs.[5] Infants and toddlers are at the greatest risk, as 23 of these children were four years old and younger. The majority of these incidents (19) involved fentanyl. This problem is not unique to Washington State; one national study found a 52% increase in fentanyl and other opioid poisoning related child fatalities from 2015 to 2018.

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.[6] 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 officials, chemical dependency treatment providers, domestic violence treatment providers, mental health treatment providers, child health- providers, or social work practice specialists. 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.

During this reporting period, DCYF implemented changes in its approach to facilitating critical incident reviews. Responding to a critical incident by blaming an individual for problems in casework that are, in reality, rooted in systemic issues can be harmful and counterproductive. A safety science response to a critical incident instead balances individual responsibility with system accountability.[7] DCYF is now utilizing a "systems focused" critical incident review process designed to support a culture of safety that leads to improvements for families as well as the professionals who engage with them.[8] System-focused critical incident reviews incorporate the sciences of safety, improvement, and implementation, and are grounded in a core set of values: family centered, workforce informed, and systems focused. Child fatality and near fatality reviews now start with a broad understanding of the family's needs as well as the incident itself. The family's unmet needs and barriers to services are captured as improvement opportunities. This review process recognizes the complex and highly pressured work child welfare professionals engage in and the need to build smarter systems of support. The goal of a systems focused review is to identify systemic barriers and challenges and find high impact ways to improve outcomes for families. Additionally, in 2021, DCYF joined the National Partnership for Child Safety (NPCS), a

[5] See Figure 14, page 16 of report.
[6] RCW 74.13.640.
[7] How are Child Welfare Leaders Applying Safety Science to Critical Incident Reviews? Casey Family Programs, June 29, 2021. https://www.casey.org/critical-incident-reviews/.
[8] See, Systems-Focused Critical Incident Review, University of Kentucky, Center for Innovation in Population Health.

collaboration of state, county, and tribal child welfare agencies aimed to improve child safety, prevent child maltreatment and fatalities, and strengthen families. Members of this partnership employ a standardized platform for critical incident reviews, share data, and develop strategies to prevent child abuse and fatalities.[9]

Section II of this report describes the implementation status of recommendations made in child fatality and near fatality reviews conducted between January 1, 2022, and December 31, 2022. During this period, DCYF conducted 15 child fatality reviews and 22 near fatality reviews. These reviews produced 75 recommendations. Recommendations specifically addressing child fatalities and near fatalities related to accidental drug ingestion and overdose include:

- Education and training for families and child welfare workforce on the dangers of fentanyl; parent engagement; warning signs and risk factors; assessing child safety, and prevention planning.
- Provide fentanyl testing strips to parents and professionals to detect the presence of fentanyl.
- Expansion of substance use disorder assessment and treatment resources.
- Increase access to drug lockboxes and Naloxone for families.

[9] Currently, there are 33 jurisdictions who are members of the NPCS. https://nationalpartnershipchildsafety.org/.

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.[10] *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 85 child fatalities between January 1, 2022, and December 31, 2022. 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.

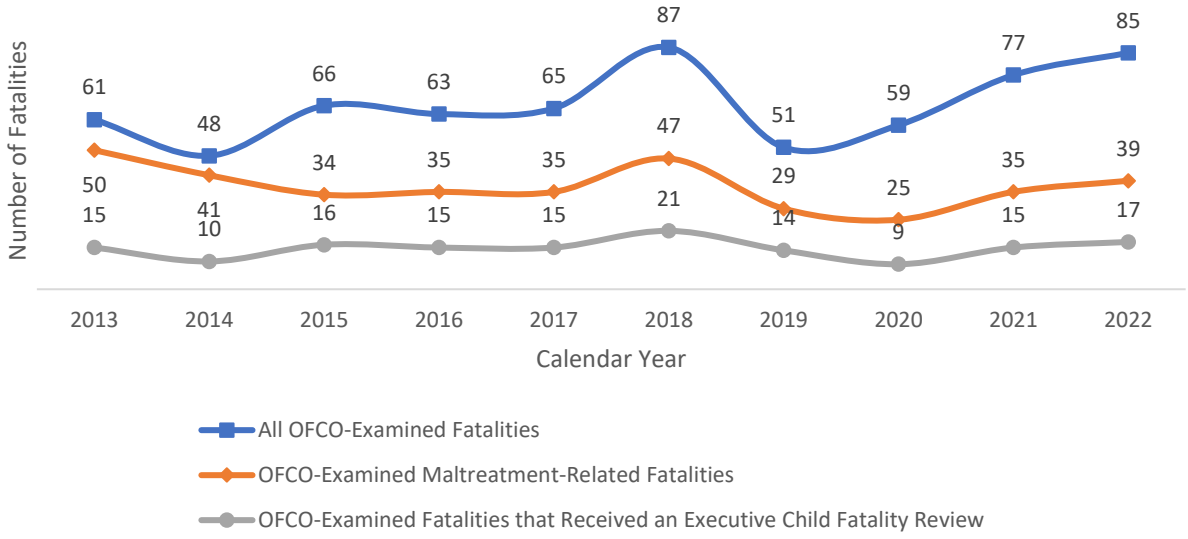
OFCO defines **maltreatment-related fatalities** to be those in which:

- 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 85 child fatalities examined between January 1, 2022, and December 31, 2022, OFCO considered 39 to be related to child maltreatment. The following data describes the profile of these 39 maltreatment-related child fatalities.

[10] 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.

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



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.

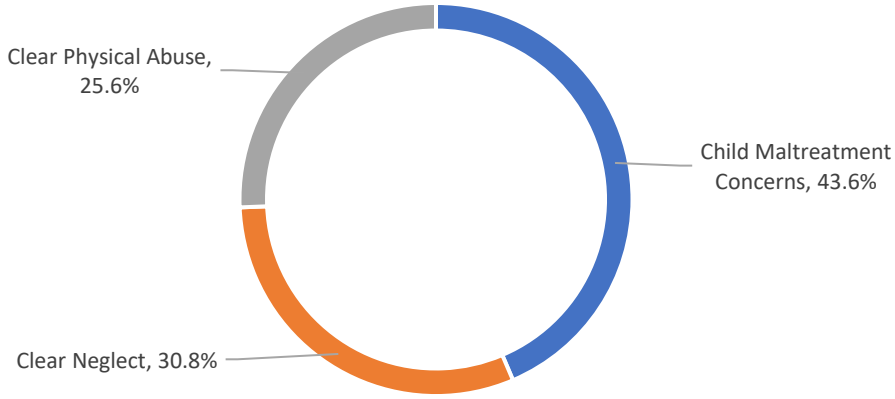
Clear Neglect
A CPS investigation concluded that neglect by a caregiver (e.g. an infant or toddler left unattended) caused the child's death. Law enforcement reports, medical records, and/or an autopsy report may also have concluded that negligent treatment/maltreatment caused the child's death.

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

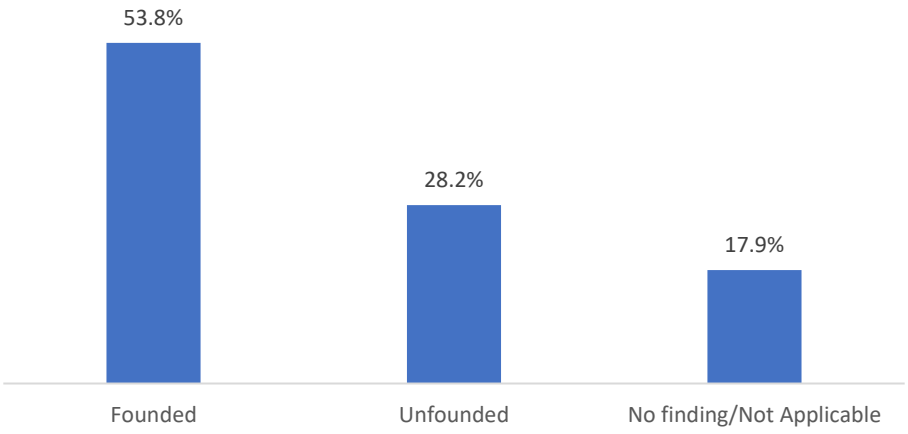
Of the 39 child fatalities related to child maltreatment, ten children passed away from physical abuse and 12 as a direct result of neglect. OFCO found maltreatment concerns in 17 additional cases.

Figure 2: **Type of Maltreatment in Child Fatalities, 2022**



Investigations into 21 of the 39 fatalities resulted in a "founded" finding of neglect and/or physical abuse. Investigations into 11 deaths were "unfounded." No findings were made in seven deaths.[11]

Figure 3: **Findings in Maltreatment-Related Fatalities, 2022**



[11] Findings may not have been made for many reasons, including no intake being made regarding the death, the intake screened in for a risk only investigation, or the intake screened out.

MANNER OF DEATH

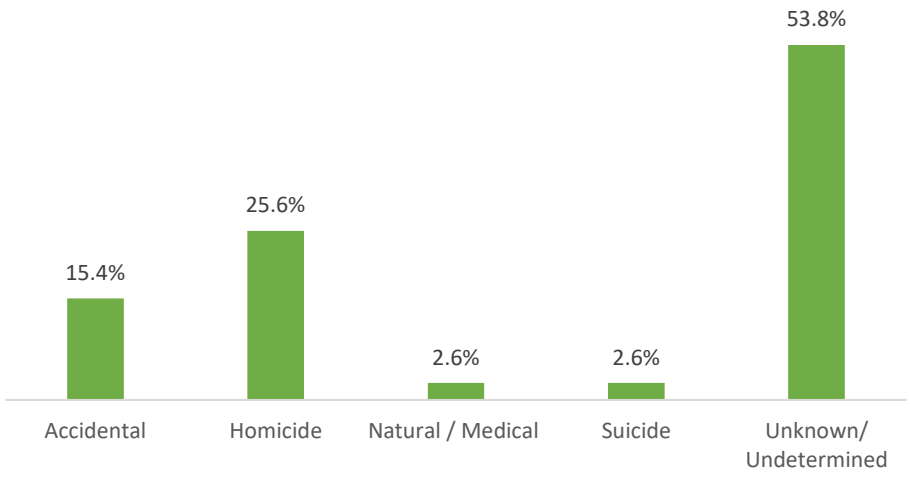
The manner and cause of death is determined by a medical examiner or coroner. The manner of death describes the context or circumstances of the death and is assigned to one of five categories:

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

The cause of death details how the death occurred. For example, the manner of death is determined as natural or medical when the cause of death is pneumonia, or the manner of death is determined as accidental when the cause of death is a motor vehicle accident. SIDS is generally considered a subset of natural or medical death, however, if significant risk factors were present during the scene investigation, such as an unsafe sleep environment or inappropriate bedding, the manner of death may be classified as unknown or undetermined. The manner of death may also be classified as unknown or undetermined for drug overdoses as there may not be enough information to establish whether the overdose was accidental or intentional.

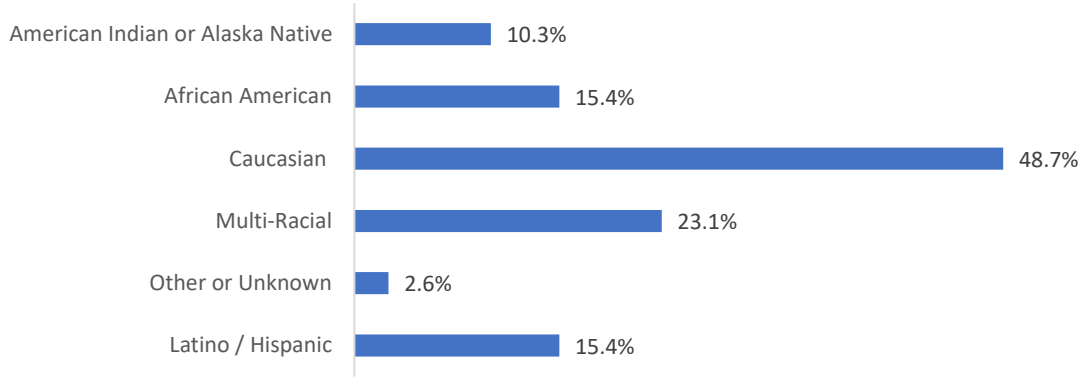
Of the 39 maltreatment-related child fatalities, the manner of death for 21 fatalities were unknown or undetermined, ten were homicide, and six were accidental.

Figure 4: **Manner of Death, 2022**



CHILD RACE AND ETHNICITY

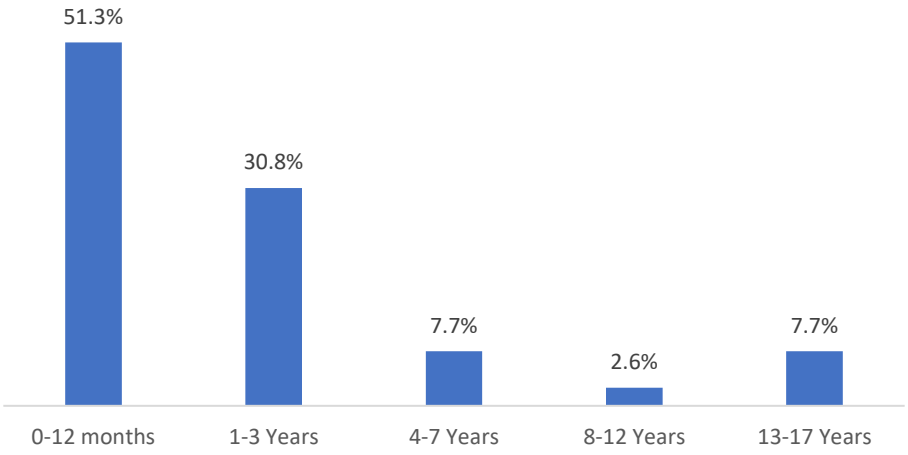
Figure 5: **Child Race and Ethnicity, 2022**



CHILD AGE AT TIME OF DEATH

Over 82% of the maltreatment-related child fatalities involved children ages three and younger (32 fatalities). Infants (birth to 12 months) accounted for over half of the fatalities (20 fatalities).

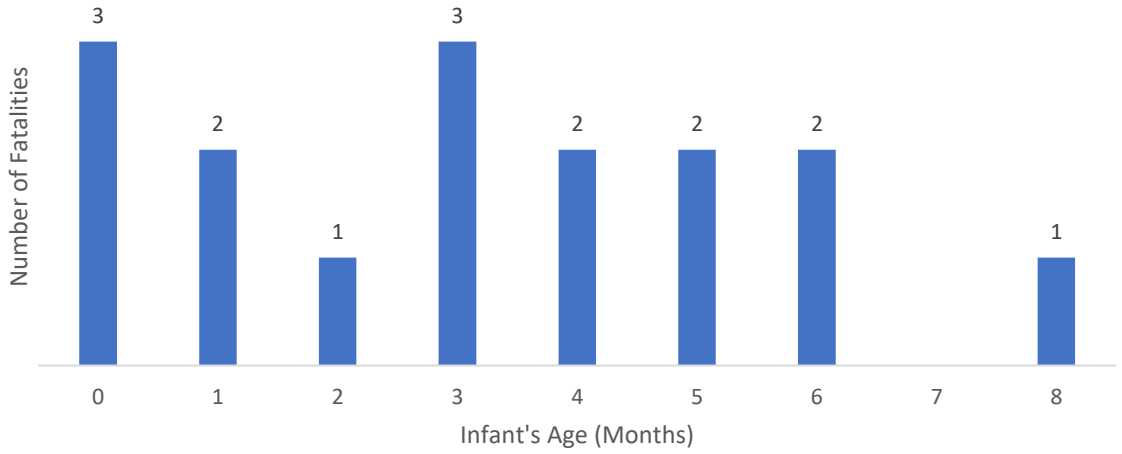
Figure 6: **Child's Age at Time of Death, 2022**



INFANT DEATHS INVOLVING UNSAFE SLEEP

Sixteen of the 20 infant fatalities (80%) involved unsafe sleep concerns. The majority of these infants were 6 months and younger.

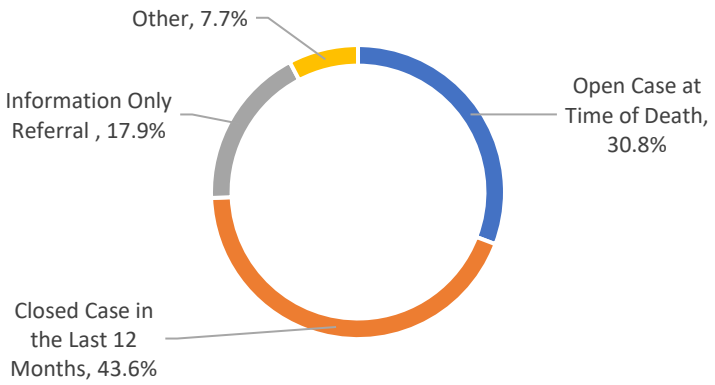
Figure 7: **Infant's Age at the Time of Unsafe Sleep-Related Fatality, 2022**



FAMILY CONTACT WITH THE DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES

Of the 39 maltreatment-related fatalities examined by OFCO between January 1, 2022, and December 31, 2022, 12 families (30.8%) had an open case with DCYF, and all 12 children were in the parents' care at the time of death. Two fatalities occurred in a licensed foster home, and one fatality had an open case in tribal court. Seventeen families (43.6%) had a case closed within the previous 12 months.

Figure 8: **DCYF Case Status Within 12 Months of Fatality, 2022**



Of the 12 families with an open case at the time of death, six were open for Child Protective Services (CPS) investigation, two were receiving Child and Family Welfare Services (CFWS), three were open to the Family Assessment Response (FAR) program, and one was participating in Family Voluntary Services (FVS).

Table 1: **Program Type for DCYF Open Cases at Time of Death, 2022**

Program Type	Number of Fatalities
Child Protective Services (CPS) Investigation Pathway *Investigates screened in reports of child maltreatment.*	6 fatalities
Child and Family Welfare Services (CFWS) *Case management and permanency planning for children and youth in out-of-home placement.*	2 fatalities
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
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

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.[12]

Of the 39 maltreatment-related fatalities, three fatalities occurred after family reunification. One child died of physical abuse during an open dependency within three months of returning to the parents on a trial return home. Two fatalities occurred after the dependency was dismissed and the child was returned to the parents' care: one child died as a result of neglect 10 months after reunification, and the other died of fentanyl intoxication three years after reunification. All three children were three years of age or younger.

Four families had previous dependencies that did not involve the child that passed.

[12] RCW 13.34.

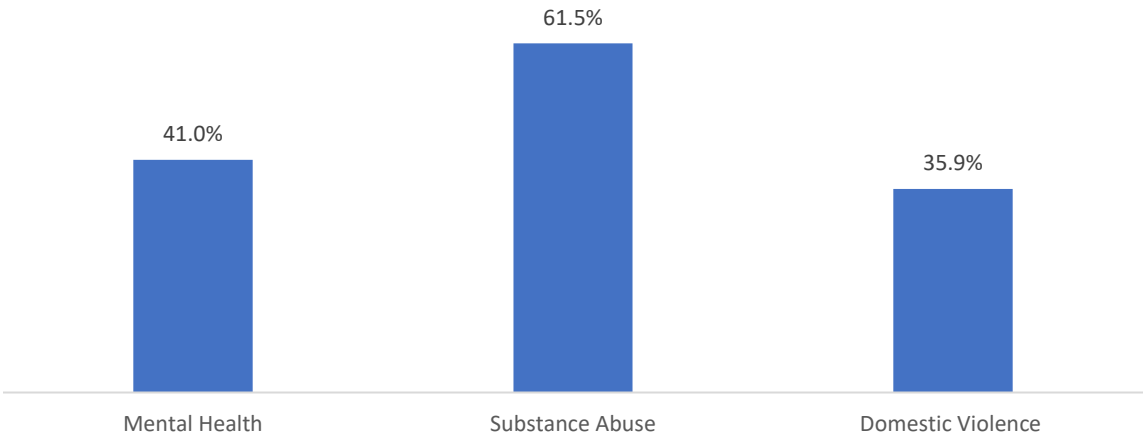
SUBSTANCE ABUSE, DOMESTIC VIOLENCE, AND MENTAL HEALTH - RISK FACTORS FOR CHILD FATALITIES

Parental substance abuse is a major risk factor for child fatalities, maltreatment, and involvement with the child welfare system. Of the 39 maltreatment-related fatalities, over 61% of the children came from families with a history of substance abuse (24 families). Of the 24 families with known substance abuse history, 58.3% (14 families) had documented history of prenatal drug use; 62.5% (15 families) of opiate use; 54.2% (13 families) of methamphetamine use; and 62.5% (15 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 three risk factors was present in 87.2% of the maltreatment-related fatalities.

Figure 9: **Family Risk Factors in Child Maltreatment-Related Fatalities, 2022**



CHILD NEAR FATALITIES EXAMINED BY OFCO

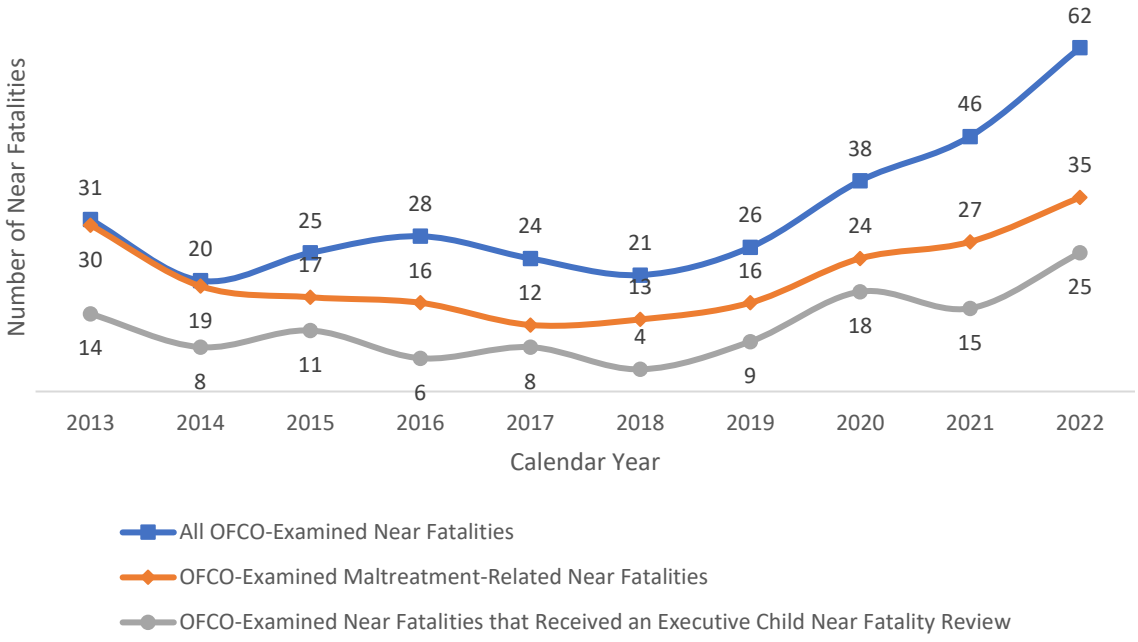
State law requires DCYF to notify OFCO of the near fatality[13] of any child who has been in the Department's custody, or receiving services, within the last 12 months.[14] OFCO conducts a preliminary review of all near fatalities involving alleged child abuse or neglect when the family had an open case 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 62 near fatalities between January 1, 2022, and December 31, 2022. OFCO considered 35 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 10: **OFCO-Examined Child Near Fatalities by Year**



[13] RCW 74.13.500 defines "near fatality" as "an act that, as certified by a physician, places the child in serious or critical condition."
[14] 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 62 near fatalities examined by OFCO between January 1, 2022, and December 31, 2022, 35 were determined to be caused by abuse or neglect, or abuse or neglect concerns were present. Over 65% of the maltreatment-related near fatalities were caused by neglect, and the majority involved children ages three years and under.

Figure 11: **Maltreatment-Related Near Fatalities, 2022**

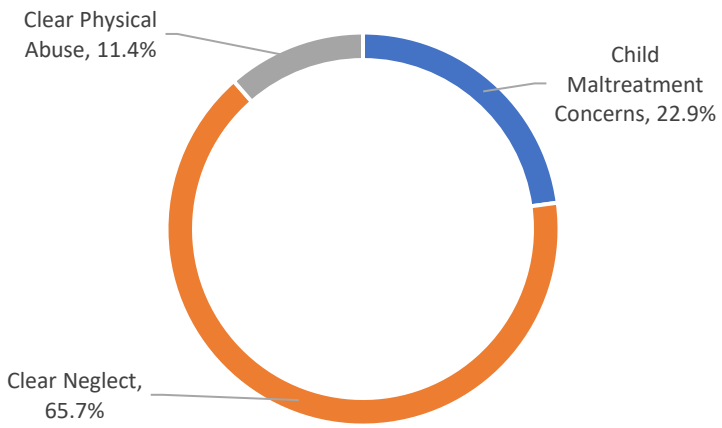
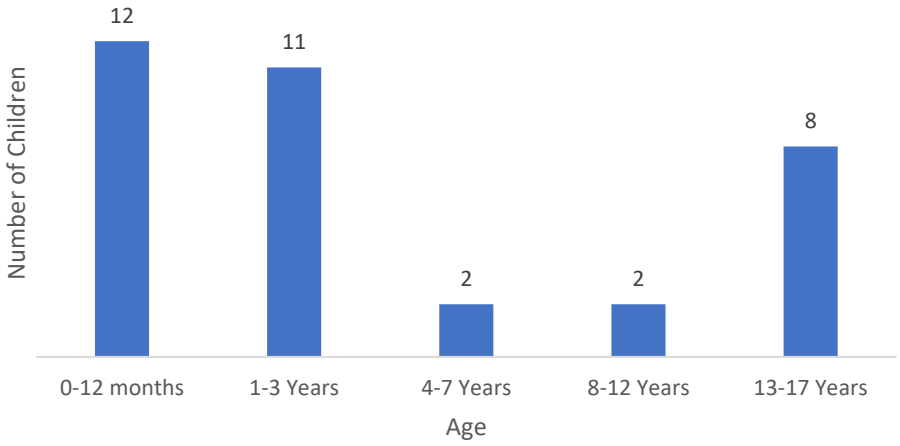


Figure 12: **Child Age at Time of Near Fatality, 2022**

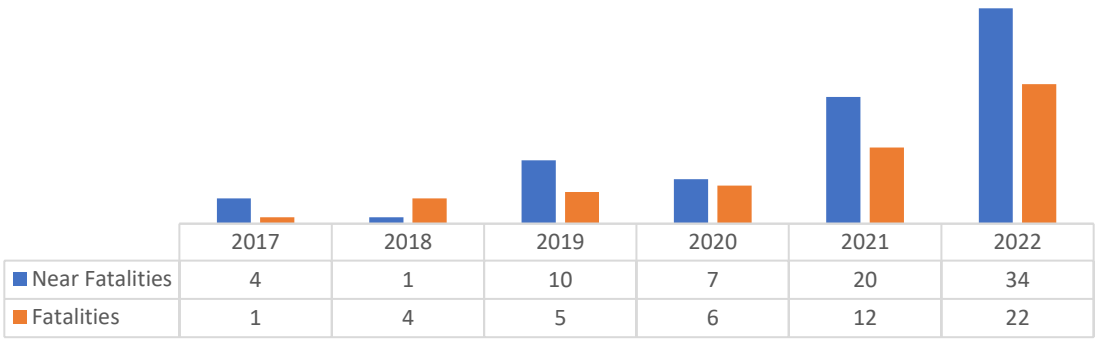


ACCIDENTAL INGESTION OF DRUGS AND OVERDOSES

In the last four years, OFCO has seen a significant increase of critical incidents involving a child's accidental ingestion of drugs and overdose. Between January 1, 2022, and December 31, 2022, OFCO examined 85 child fatalities and 62 child near fatalities. Of these incidents, over a quarter of the child fatalities (22 fatalities) and more than half of the child near fatalities (34 near fatalities) involved accidental ingestions and overdoses. Over 67% of these accidental ingestions and overdoses involved fentanyl. In comparison, in 2018, OFCO examined four child fatalities -one involving fentanyl, and one near fatality related to a child accidentally ingesting drugs.

The dramatic increase in critical incidents involving a child ingesting fentanyl or other opiates is a national problem and not unique to Washington State. A 2023 study reviewing child death review reports in forty states from 2015-2018 found that opioids are the most common substance contributing to fatal poisonings among young children. The study noted that in recent years, children have been exposed to new opioid sources, such as heroin, fentanyl, and opioids used in medication-assisted treatment, and that opioid poisoning related child fatalities increased from 24% in 2015 to 52% in 2018. Younger children are at the greatest risk, as children aged 5 years and younger have the highest rate of emergency department visits for unintentional drug-related poisonings.[15] In 2021, 40 infants and 93 children ages one to four years died from accidental fentanyl poisoning in the United States, a sixfold increase among children younger than 5 years since 2018.[16] Adolescent drug overdose deaths have also increased since 2021 and 77% of these deaths involved fentanyl.[17]

Figure 13: **Critical Incidents Involving Accidental Ingestion and Overdoses, 2017-2022**



	2017	2018	2019	2020	2021	2022
Near Fatalities	4	1	10	7	20	34
Fatalities	1	4	5	6	12	22

[15] Gaw CE, Curry AE, Osterhoudt KC, et al. *Characteristics of Fatal Poisonings Among Infants and Young Children in the United States*. Pediatrics. 2023;151(4): e2022059016.
[16] Gaither JR. National Trends in Pediatric Deaths From Fentanyl, 1999-2021. JAMA Pediatr. 2023;177(7):733–735.
[17] Id.

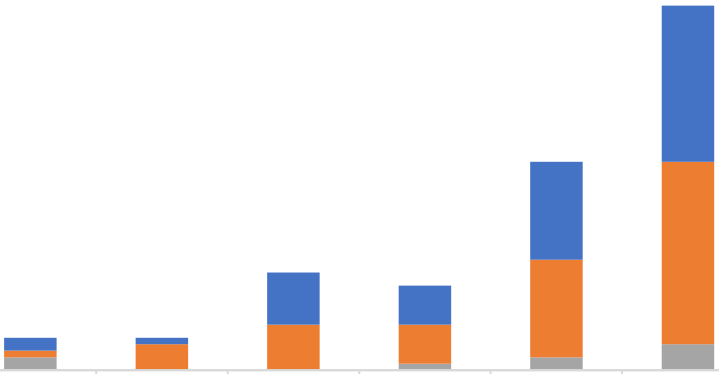
Of the 56 incidents involving accidental ingestions and overdoses by children in Washington in 2022, 24 involved accidental ingestion by children 11 years of age or younger, 28 involved accidental overdoses by youth 11 to 20 years of age while using substances, and 4 involved intentional overdoses by youth ages 13 to 17.

Fentanyl was the most common drug involved in these incidents. Over 67% (38 incidents) of the accidental ingestions and overdoses examined by OFCO between January 1, 2022, and December 31, 2022, involved fentanyl; 19 of the 24 accidental ingestions by children 11 years of age and younger and 19 of the 28 accidental overdoses by youth 11 to 20 years of age while using substances involved fentanyl.

Recommendations arising from critical incident reviews specifically addressing child fatalities and near fatalities related to accidental drug ingestion and overdose include:

- Education and training for families and the child welfare workforce on the dangers of fentanyl; parent engagement; warning signs and risk factors; assessing child safety; and prevention planning.
- Provide fentanyl testing strips to parents and professionals to detect the presence of fentanyl.
- Expansion of substance use disorder assessment and treatment resources.
- Increase access to drug lockboxes and Naloxone for families.

Figure 14: **Accidental Ingestion and Overdoses, 2017-2022**



	2017	2018	2019	2020	2021	2022
Accidental Ingestion, Ages 0 to 11	2	1	8	6	15	24
Accidental Overdose, Ages 11 to 22	1	4	7	6	15	28
Intentional Overdose, Ages 12 to 20	2	0	0	1	2	4

Figure 15: **Age of Children Involved in Accidental Ingestion and Overdoses, 2022**

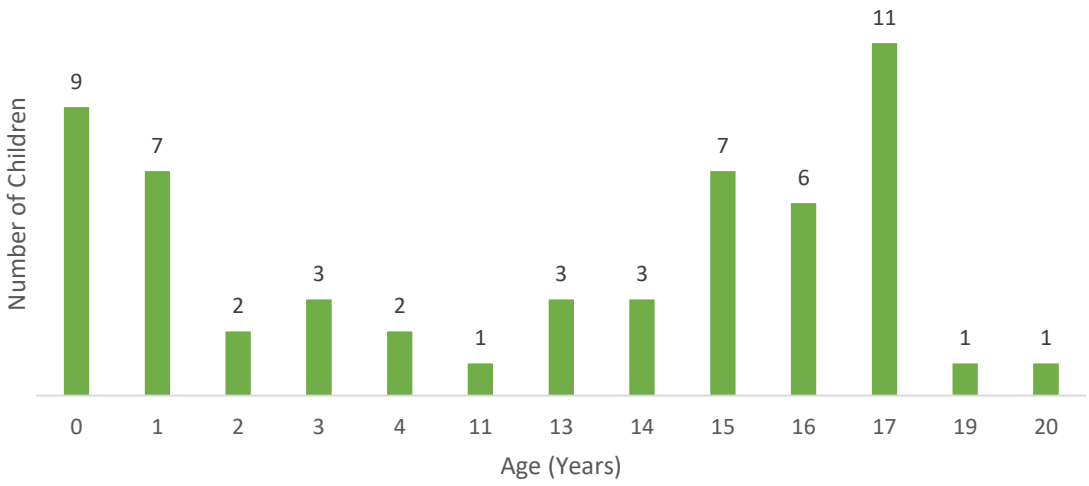


Figure 16: **Race and Ethnicity of Children Involved in Accidental Ingestion and Overdoses, 2022**

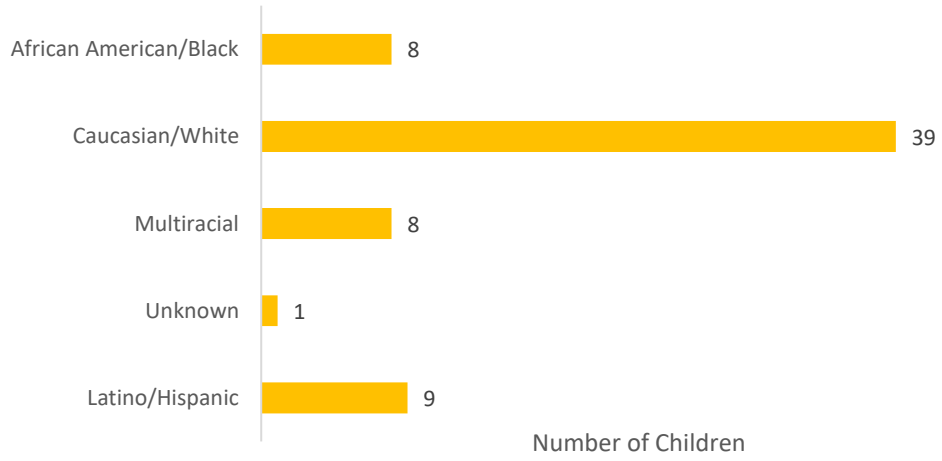
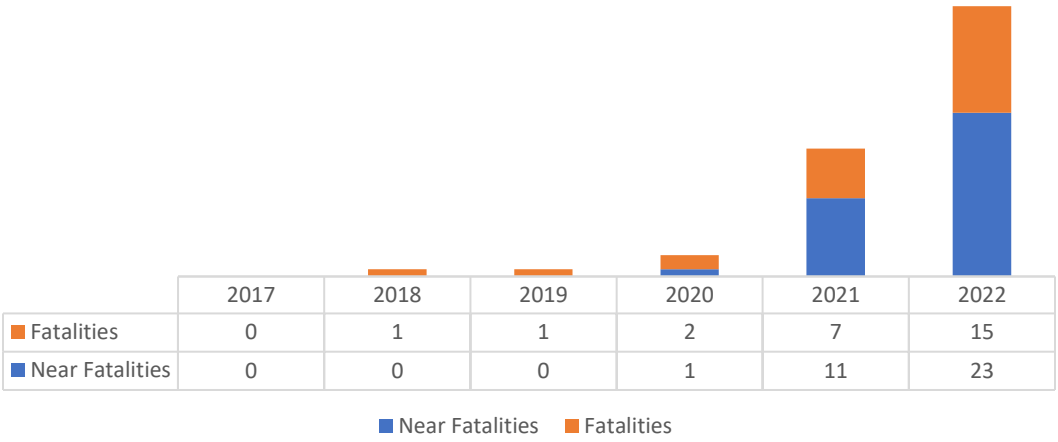
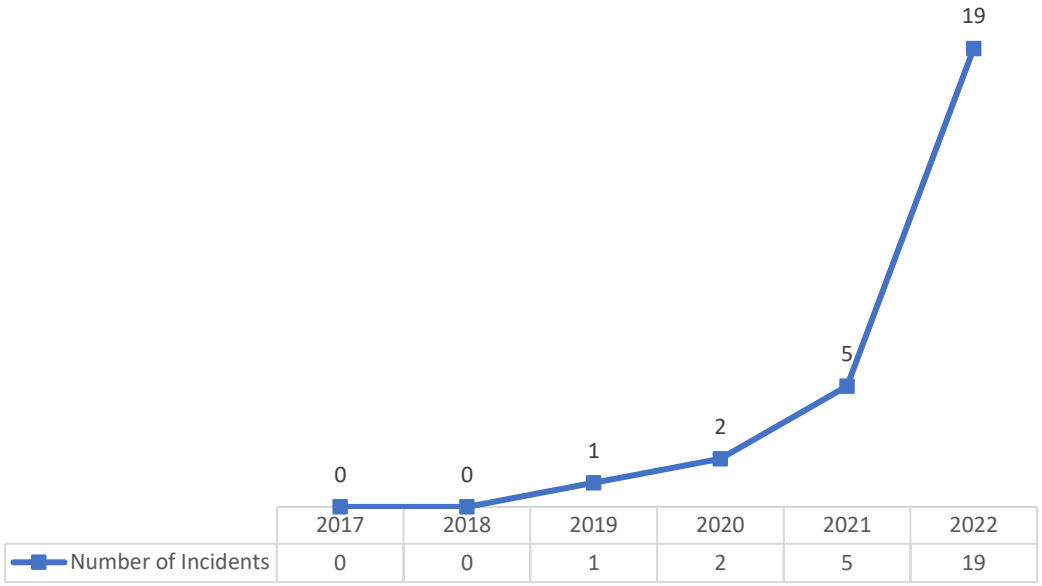


Figure 17: **Critical Incidents Involving Fentanyl**
All Children and Youth, 2017-2022



	2017	2018	2019	2020	2021	2022
Fatalities	0	1	1	2	7	15
Near Fatalities	0	0	0	1	11	23

Figure 18: **Critical Incidents Involving Accidental Ingestion of Fentanyl**
by Children Ages 0-11, 2017-2022



	2017	2018	2019	2020	2021	2022
Number of Incidents	0	0	1	2	5	19

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.[18] 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[19] who was in the care of or receiving services from the Department at the time of the incident, or in the preceding 12 months.[20] 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.[21]

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.[22] These reviews 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.[23]

DCYF must issue a report on child fatality review results within 180 days following the fatality, unless granted an extension by the Governor.[24] These reports are subject to public disclosure and must be posted on the Department's public website. The Department is required to redact confidential information contained in these reports to protect the child's privacy, as well as the privacy of siblings, and any other information protected by law (e.g., HIPPA protected information).[25]

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[18] 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.

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

[20] RCW 74.13.640(2). 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.

[21] 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.

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

[23] RCW 74.13.640(3).

[24] Id.

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

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.[26] 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, 2022, and December 31, 2022.

During this period, DCYF conducted 15 fatality reviews and 22 near fatality reviews. These reviews produced 75 recommendations; DCYF has provided the status of 72 of these recommendations. OFCO reviewed the information provided by DCYF and found that 45 recommendations (60%) were implemented or are in the process of being implemented. Nine recommendations (12%) were considered but not implemented, and an additional 16 recommendations (21.3%) were not implemented because they reflected current policy or practice (although policy or practice may not have been adhered to in the individual circumstances). Two recommendations are on hold.[27] Majority of the recommendations addressed statewide issues.

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

[27] "On Hold" status means that the Department has not yet determined whether or not to implement a recommendation.

Table 2: **Child Fatality and Near Fatality Review Recommendations by Implementation Status and Targeted Organizational Level, 2022**

Status	Number of Recommendations	Percent	Statewide (#)	Region (#)	Local Office (#)
Partial, Modified, Full Implementation	45	60.0%	39	1	5
On Hold	2	2.7%	2	0	0
Considered, Not Implemented	9	12.0%	8	0	1
Already Exists in Policy/Practice	16	21.3%	15	0	1

MAJOR THEMES OF RECOMMENDATIONS

Table 3: **Child Fatality and Near Fatality Review Recommendations by Topic, 2022**

Topic	Number of Recommendations	Percent
Training	**17**	**22.7%**
Chemical Dependency and/or Domestic Violence	*10*	
Safety & Risk Assessment	*2*	
Casework Practice and/or Staff Support	*5*	
Casework Practice	**56**	**74.7%**
Operations and Administration	*8*	
Policy and Procedure	*10*	
Safety Assessment & Planning	*21*	
Practice Consultation	*7*	
Staff Support	*7*	
Other casework practice	*3*	
Partnerships with Community Professionals	**2**	**2.7%**

Table 4: **Status of Child Fatality and Near Fatality Review Recommendations by Topic, 2022**

Topic	Partial, Modified, Full Implementation	On Hold	Considered, Not Implemented	Already Exists in Policy/Practice
Training	76.5%	--	11.8%	--
Casework Practice	57.1%	3.6%	10.7%	26.8%
Partnership with Community Professionals	--	--	50%	--

Recommendations Addressing Substance Use and Child Safety

As previously discussed, Washington state experienced a dramatic increase in child fatalities and near fatalities related to the accidental ingestion of drugs and overdoses. Twenty recommendations made in fatality and near fatality reviews targeted prevention of drug related critical incidents. Six recommendations involved caseworker training, and fourteen recommendations related to changes in practice. Some recommendations were identified in more than one review. These recommendations and their implementation statuses are summarized below:

Recommendations Made in Fatality and Near Fatality Reviews in 2022 Targeting Prevention of Drug-Related Critical Incidents
Implementation Completed
• Provide families with a pamphlet regarding the risks of fentanyl as well as with Naloxone when they receive a lockbox. • Research fentanyl testing strips and determine if it would be appropriate for DCYF to create access and availability to testing strips.
Implementation In Progress
• Develop training curriculum on accidental ingestion of drugs. The training should include information about the risk of ingestion for both prescription and illicit substances; engaging parents about the risk of ingestion; and prevention planning for families with children of all ages. • Educate staff about the warning signs and risk factors when assessing child safety in an environment where substance use may be present. • Provide education and training to staff on fentanyl and its impact on child safety. • Develop a tip sheet for caseworkers on how to create prevention plans with parents to reduce the risk of accidental ingestion by a child. • DCYF should provide funding for substance use disorder assessment and treatment if a parent is uninsured or unable to access treatment because of cost. • Caseworkers must provide collateral information for a substance use disorder assessment to ensure the assessment is based on all relevant available information and not solely on the client's self-report. • DCYF should develop ways to support caseworkers in creating harm reduction plans for parents who continue to use substances while caring for their children.
Already Exists in Policy/Practice
• Educate staff on how to help clients locate and access Naloxone in their communities. • Provide caseworkers with access to lockboxes to distribute to families and discuss safe medication/substance storage as a preventative measure. • Contract with a licensed mental health and substance use professional to provide case consultation to caseworkers.
Considered, Not Implemented
• Develop a protocol requiring caseworkers to address safety planning for harmful and illicit substances with all families served. Protocol should include: educate families about signs of an overdose and how to respond; safety planning for children in the home and relapse prevention; and provide lockboxes to families. • Caseworkers should be provided with and use oral swabs as the primary tool for substance use testing.

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 recommendations made in child fatality and near fatality reviews conducted from January 1, 2022, through December 31, 2022, 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	
The Committee recommends that DCYF assess the current bias and critical thinking trainings provided by the Alliance, specifically reviewing content related to living and working in small communities and how to handle that in a professional and unbiased manner.	Status: Modified Implementation, Completed
The Committee recommends that the two offices involved in this case should complete Advanced Guidelines for Difficult Conversations training.	Status: Modified Implementation, Completed
Region 5 case carrying staff and supervisors should complete the three-part training series, Quality Matters. If staff previously completed the series, the Committee recommended staff complete the series a second time.	Status: Considered, Not Implemented
The Area Administrator should work with the local office on their case transfer process.	Status: Implement, In Progress
The Kelso office should receive either a training or discuss the TRH policy 43051A and specifically discussing the pieces relating to persons who may act as a caregiver but isn't a legal party to a case (i.e. boyfriend/girlfriend, husband/wife but not a legal parent).	Status: Unknown

TRAINING Chemical Dependency and/or Domestic Violence	
DCYF should collaborate with the Alliance to incorporate more "wheels" at Regional Core Training, place laminated Power and Control and Post-Separation wheels in DCYF offices, and work on communicating the different "wheels" to the fields. Possible ways to do that include discussing the "wheels" at all-staff meetings or leads meetings and placing them in the Digest email (DCYF's internal weekly communication email).	Status: Considered, Not Implemented
DCYF should work with the Alliance to create a Facilitated Cohort Learning Session to Support DV practices.	Status: Implement, In Progress
The University of Washington Alliance should consider accidental ingestion curriculum development. The training should include, but not be limited to: information about the risk of ingestion for both prescription and illicit substances; how to begin conversations with parents about the risk of ingestion; and prevention planning for families with children of all ages.	Status: Implement, In Progress
DCYF should create a system that requires staff to take DV and substance use training every two years. This is necessary due to changes in language, treatments, ideology, current understanding, and other factors. The Committee discussed that this is a requirement for many other social service and professional services providers and is a positive process for maintaining current standards of practice as it relates to the work conducted by DCYF.	Status: Modified Implementation, In Progress
DCYF should provide staff education about the correlation between early childhood sexual abuse and the victim's inability to provide a urine sample during observed urinalysis testing. This knowledge will allow DCYF staff to have a more trauma-informed approach to interactions with parents who suffered childhood sexual abuse and are also experiencing substance use issues.	Status: Implement, In Progress
DCYF should provide staff education about the warning signs and risk factors when assessing child safety in an environment where substance use may be present.	Status: Implement, In Progress
Field staff should be educated on how to help clients locate and access Naloxone in their communities.	Status: Already Exists
Collaborate with UW Alliance to request that they include information sharing in Regional Core Training about DCYF's Fentanyl training (DCYF Child Welfare Fentanyl – What Case Workers Need to Know).	Status: Implement, Completed

TRAINING Chemical Dependency and/or Domestic Violence	
DCYF staff should receive education/training regarding fentanyl and the impacts it can have on child safety. This should include, but not be limited to, training for new staff at the Regional Core Training provided by University of Washington Alliance.	Status: Implement, In Progress
DCYF should create yearly refresher trainings regarding substance use, domestic violence, and engaging persons involved in DCYF cases. Program Managers for these specific areas should be involved in making sure the refreshers are up to date with information specific to those topics.	Status: Modified Implementation, In Progress

TRAINING Safety & Risk Assessment	
CPS and CFWS staff who were assigned to this case in 2020 and 2021 should: • Review the SDM appendix definitions and apply them to practice. • Work with the program managers or coaches to go over safety assessment policy in detail and have a training or consultation on protective factors vs. capacity, as well as compliance vs. behavioral progress. • Work with the program managers or Alliance coaches to go over Safety Assessment policy. Coaching should include: (1) documenting threshold; (2) understanding conditions for return home and how to document the conditions in assessments; (3) protective factors vs. capacity; and (4) compliance vs. behavioral progress.	Status: Implement, In Progress
The Area Administrator should consider working with the 2021 primary investigator and CPS supervisor on the following: • The lack of response and assessment to allegations of child drug exposure. • Reviewing health and safety policy requirements. • Improving comprehensive gathering of information and analysis skills for safety and investigative assessments. • Identifying cases that should be elevated for internal case consultation and/or FTDM or shared planning meetings.	Status: Implement, In Progress

CASEWORK PRACTICE Operations and Administration	
DCYF HQ staff should review form 10-042, CPS Casework Checklist, for case closure to discuss ways to remind staff about the form and communicate how useful it can be. DCYF HQ staff should also remind supervisors that the checklist may be a helpful roadmap when closing a case.	Status: Implement, In Progress
DCYF's human resources department (HR) should evaluate the minimum qualifications for hiring social service specialists and determine whether any modifications should be made that may expand and diversify DCYF's current hiring practices.	Status: Implement, Completed
Because of high employee vacancy rates, a DCYF statewide response system should be considered to address the current staffing crisis for the Region 4 King County offices. The Committee also understands that other offices may also need assistance.	Status: Implement, Completed
The Committee suggested DCYF take advantage of support from other neighboring DCYF offices to assist with the current staffing shortages.	Status: Already Exists in Policy/Practice
The Committee recommends that DCYF create adolescent specific caseworkers within all areas of casework (CPS, FVS, FVS, CFWS, and adoptions). The Committee discussed that adolescents present unique aspects within child welfare and that having a caseworker who has received trainings specific to adolescents and/or is familiar with local resources is vital.	Status: Considered, Not Implemented
DCYF should create a Domestic Violence Program Manager position. That position should be filled by a subject matter expert who will work on updating policy, training, and language used within the context of discussing and describing all aspects of domestic violence including interpersonal and intimate partner violence.	Status: Modified Implementation, In Progress
The Committee respectfully recommends that DCYF convene a workgroup between the Licensing Division and Adoptions to develop a communication process to notify the LD when an adoption is finalized in a licensed foster home.	Status: Modified Implementation, In Progress
DCYF should create a DV Best Practices group for each of the six regions. This is based on the group that is established in Region 4.	Status: Modified Implementation, In Progress

CASEWORK PRACTICE Policy & Procedure	
The Committee identified that the Critical Incident Review team is made aware of challenges or issues experienced by staff in the field during the review process. There is currently no process or procedure for how the information is to get back to program managers or groups to share the information learned during reviews. Specifically related to this case, the Committee recommends that when challenges or issues related to service providers (such as a significant lack of providers) is identified, the Critical Incident Review team will connect with the service array team that is being created.	Status: Implement, Completed
The Committee recommends that DCYF's headquarters program managers should review the current policy and guidance surrounding non-CPS intakes, discuss the legal issues related to the different types of intakes and cases, and provide updated non-CPS intake guidance to the regions.	Status: Modified Implementation, In Progress
It is recommended that DCYF consider modifying Policy 4122 Case Transfer to include language that both the sending and receiving supervisor will participate with case transfers, along with the sending and receiving caseworkers.	Status: Considered, Not Implemented *Policy already requires "sending supervisors must discuss cases transferring with receiving supervisors within three calendar days of the request to transfer."*
It is recommended that DCYF develop a policy requiring an internal, collaborative staffing for ongoing CFWS cases when a new intake leads to a CPS investigation. This policy should include cases where the CFWS and CPS cases are housed in the same office and also when there may be a case assignment to multiple offices.	Status: Already Exists in Policy/Practice
DCYF should consider a policy change for Policy No. 1135 (Infant Safety Education and Intervention) by including language that the Plan of Safe Care should follow a child and be updated when the child's placement is changed.	Status: Already Exists in Policy/Practice
DCYF should create an alternate pathway for intakes that do not screen in that are related to emotional abuse of children and for allegations of domestic violence. DCYF should work with community partners to create avenues for those screened out reports to go to that can provide resources and or services to families experiencing these events. The Committee believed this was also a way to allow for earlier intervention and possibly prevent a family from needing DCYF intervention.	Status: Modified Implementation, In Progress

CASEWORK PRACTICE Policy & Procedure	
The Committee believes the regional administration should be made aware of the Committee's discussion about intakes and law enforcement notification.	Status: Implement, Completed
Specific to the LGBTQ+ youth community, there are higher rates of suicide, self-harm, mental health challenges, substance use, etc. The Committee would like DCYF to explore an alternative option for intakes that do not meet the legal threshold for DCYF contact. These options would be local responses that could come from a multitude of resources within each community. These resources may also help prevent future involvement by child welfare or even future placement in out-of-home care for youth. A similar pathway and partnership were created for substance exposed infants when no other safety concerns are present. The Committee is recommending that DCYF explore a way to create such a process for adolescents.	Status: Modified Implementation, In Progress
The Committee believed that, in addition to following the case transfer policy, the local office should consider implementing a case transfer staffing process that includes immediate FamLink documentation of all safety and/or risk issues, along with a detailed service plan.	Status: Already Exists in Policy/Practice
The Committee recommended that there should be a link in the Trial Return Home policy to the FTDM policy since there is a requirement within the FTDM policy prior to a trial return home occurring.	Status: Unknown

CASEWORK PRACTICE Safety Assessment & Planning	
DCYF headquarters should consider adding DV term and guidance to the Safety Framework gathering questions guide and worksheet (Question 6)	Status: Already Exists in Policy/Practice
DCYF should consider the development of a tip sheet for caseworkers that describes how to create prevention plans with parents to reduce the risk of ingestion events.	Status: Modified Implementation, In Progress
Caseworkers should have access to lockboxes and provide those to all families served. Caseworkers should also discuss safe medication/substance storage as a preventative measure.	Status: Already Exists in Policy/Practice

CASEWORK PRACTICE Safety Assessment & Planning	
The Committee recommends that DCYF create a procedure for staff to have access to lockboxes/lock bags/lock pouches, to give to families when appropriate. Families can use these to store medications as well as for a harm reduction (reducing or minimizing negative consequences) method for substance use. DCYF would discuss identified items to be stored in the locked container so an appropriate size is given to the family.	Status: Already Exists in Policy/Practice
The Committee recommended that DCYF consider developing a protocol requiring field staff to address safety planning for harmful and illicit substances with all families served. The Committee suggested the voice of individuals with lived SUD experience and expertise should be included in the protocol development. The Committee suggested the following be included in the protocol development: • DCYF field staff should have knowledge of Naloxone (Narcan) and have access to carry it should they choose to. • Field staff are able to educate families about signs of an overdose and how to respond and where and how they can access Naloxone. • Family centered planning to include safety planning to keep children safe from harmful substances in the home and discuss relapse prevention plans to include those who may care for the children should a parent relapse or engage in substance use. • Provide lockboxes and/or lock bags to families with instructions to utilize for harmful or illicit substances.	Status: Considered, Not Implemented *DCYF reported that while a procedure doesn't need to be developed here, the sub-bullets are already occurring as part of the SUD program.*
The Committee recommends that DCYF provide lockboxes to all families with an open DCYF case, prioritizing those families who have a reported opioid/opiate addiction. Additionally, it is recommended that DCYF have lockboxes available in all state vehicles for ease of access and delivery to families during home visits and other points of contact.	Status: Partial Implementation, In Progress *DCYF will provide lockboxes as needed and as currently available in concrete goods.*
DCYF field offices should keep a regular allotment of lockboxes or other locked devices for staff to easily access. That way staff can take one from the office on their way to meet with a client as opposed to having to order them after the fact.	Status: Implement, Completed
DCYF should endorse a pamphlet regarding the risks of Fentanyl. The pamphlet along with Naloxone (Narcan) should be provided to families when they receive a lockbox. Naloxone is a medication that can reverse an opioid overdose.	Status: Implement, Completed

CASEWORK PRACTICE Safety Assessment & Planning	
DCYF staff have multiple tools to assess child safety and alleged parental substance use. One tool that was recently added is oral swabs for substance use testing. The Committee recommends that DCYF use oral swabs as the primary parental substance use testing source. The advantages of oral swabs over the use of urinalysis testing include: oral swabs do not require a person to travel to a testing site, are less invasive, are easier to administer, and are less costly. Oral swabs are also more difficult to tamper with during the sample collection process because the collection takes place under direct supervision.	Status: Considered, Not Implemented
The cost of a substance use assessment should not be a barrier for an uninsured parent to complete an assessment. DCYF should provide the necessary funding if the parent is uninsured or insurance does not cover the cost of an assessment. Additionally, a substance use assessment must be based on more than just self-reported information. The assessment must also be based on collateral information collected by the agency. The DCYF substance use program manager should discuss this issue with all six regional leads.	Status: Implement, In Progress
DCYF should work with the Substance Use Program Manager to discuss a way to help support staff in creating plans for families experiencing substance use. This is not a safety plan but rather a harm reduction plan for parents who are continuing to use while caring for their children.	Status: Modified Implementation, In Progress
DCYF staff working to create the Family Practice Model should include practice standards and expectations for staff to include: • assessing a child's needs should include discussing children's schedules and nutritional needs, • full body observation of infants (diaper change observation) and identifying how frequently that should occur (such as at each contact, health and safety visits, etc.), • specifically addressing timely follow through when families ask for concrete goods (diapers, car seats, safety gates, etc.)	Status: Modified Implementation, In Progress

CASEWORK PRACTICE Safety Assessment & Planning	
For purposes of practice and assessment improvement, the Committee believes DCYF should consider adding the following to DCYF's existing policies: • During the assessment of outdoor areas, require Licensing staff, CPS caseworkers, CFWS caseworkers, and courtesy supervision caseworkers to assess travel trailers and recreational vehicles. • Require workers in all programs to discuss with caregivers the planned sleeping arrangements for areas outside the primary sleep environment and document the caregiver's plan for safe sleep while traveling or napping outside the primary residence. • Require an immediate internal staffing with assigned licensing staff, supervisors, and regional and headquarters program staff if a licensor or SAM worker receives information concerning the caregiver's suitability during the initial or ongoing assessments. The Committee believes this staffing will allow DCYF to better analyze, collaborate, and document DCYF's actions and assess health or safety concerns.	Status: Already Exists in Policy/Practice
DCYF headquarters should consider adding an alert in FamLink to notify AAs and program staff when a safety plan override is selected so that they are able to better follow the safety plan policy.	Status: Implement, Completed
DCYF should alter the Present Danger Assessment tool to include the term 'torso' in the "Injuries to Face/Head" line under the Maltreatment heading. Torso is included further in the document in the Face/Head section.	Status: Implement, In Progress
Within the definitions in the Present Danger Assessment tool, DCYF HQ program managers should review the definition of "serious bodily injury" to include the term 'sentinel injury.' While the injury itself may not appear to be serious, the seriousness of a sentinel injury is often related to fatal or near-fatal events to come.	Status: Implement, In Progress
It is respectfully recommended that DCYF explore providing field staff with tools and resources to share with families related to the risks of fentanyl. This may include the following, but is not limited to these suggestions: • Create access to Naloxone (Narcan) so that field staff readily have this available should they wish to carry it in the field.	Status: Already Exists in Policy/Practice

CASEWORK PRACTICE Safety Assessment & Planning	
It is respectfully recommended that DCYF explore providing field staff with tools and resources to share with families related to the risks of fentanyl. This may include the following, but is not limited to these suggestions: • Research fentanyl testing strips and determine if it would be appropriate for DCYF to create access and availability to testing strips. • Create a DCYF endorsed pamphlet on the risks of fentanyl that can be provided to families.	Status: Implement, Completed

CASEWORK PRACTICE Practice Consultation	
The Committee recommended the DCYF SUD program manager position require licensure as a certified substance use disorder professional so that DCYF caseworkers can access professional consultation.	Status: Modified Implementation, Completed *Program manager has been hired. Part of the position description was a preference for SUD professional, but not required. The program manager will be improving system wide access to SUD professionals.*
The Committee respectfully recommended that DCYF develop a contract with subject matter experts in the field of developmental disabilities and mental health to provide consultation to DCYF field staff. This consultation could be utilized, but not limited to, helping field workers understand diagnoses, receive suggestions about beneficial accommodations, and create tailored care plans for individuals with developmental disabilities, mental health diagnoses, and/or co-occurring disorders.	Status: Implement, Completed

CASEWORK PRACTICE Practice Consultation	
It is recommended that DCYF hire an internal DV expert that can provide direct support and consultation to field caseworkers. This would include, but is not limited to, the following supports: • Assist field workers in learning how to formulate questions related to DV and how to begin difficult conversations with parents. • Provide consultation on the development of safety plans where behavioral expectations are outlined for the family to follow. • Model engagement and interviewing with the offending parent. • Accompany field workers to assist with assessment with assessment and engagement during their interactions with families.	Status: Already Exists in Policy/Practice
The Committee speculates that a helpful approach would be for DCYF to remind field supervisors of the option, and need, to take advantage of regional Child Protection Medical Consultants for complex medical cases. The Committee believes Type 1 diabetes falls under this category. This resource can help to educate staff, answer questions about the disease, review medical records, and provide other necessary assistance.	Status: Implement, In Progress
DCYF should consider contracting with a licensed mental health and substance use professional to provide case consultation to caseworkers.	Status: Already Exists in Policy/Practice

CASEWORK PRACTICE Practice Consultation	
The Committee respectfully recommends that DCYF create a Health Lead position, with designation of one lead per region to provide consultation and guidance to field staff regarding access to medical care for children and families. This may include, but would not be limited to: • Receive notification of incoming cases with allegations of medical neglect or children with medically complex care needs. This notification could be provided by local field staff assigning CPS intakes, but ideally would be notified automatically through Famlink. • Provide education and consultation to field staff about the Managed Care Organizations, the Washington State Health Care Authority, and Fostering Well-Being. • Assist field staff in collaborating with the Managed Care Organizations, Washington State Health Care Authority, and Fostering Well-Being to address medical and well-being needs for children served by DCYF, such as requesting nursing services. • Creating access to DCYF resources such as Regional Medical Consultation and Fostering Well-Being through education and hands-on support of field staff. • Act as a liaison between DCYF and local hospitals and medical professionals. • Update relevant health care resources on DCYF's intranet and sharing with field staff.	Status: Modified Implementation, In Progress
The Committee believes DCYF should advocate for consistent medical care for children with special health care needs that are receiving DCYF services. The Committee believes that cases with prior court involvement and unresolved child/ren's medical issues should be elevated for response and advocacy for continuity of medical care. With this in mind, the Committee recommended that DCYF hold a meeting with the regional medical consultant and child's medical providers in all cases involving children with ongoing and unexplained bruising, poor physical development, and/or poor weight gain over a period of time.	Status: Already Exists in Policy/Practice

CASEWORK PRACTICE Staff Support	
DCYF should consider hiring a licensed therapist that can provide therapeutic support to DCYF staff who may be experiencing secondary trauma.	Status: Implement, In Progress

CASEWORK PRACTICE Staff Support	
The Committee respectfully recommends DCYF continue to expand the array of services and supports offered to field staff through the Peer Support program. This may include, but would not be limited to: • A DCYF staff psychologist. • Contracted, licensed mental health professionals to provide therapeutic services to DCYF staff.	Status: Implement, In Progress
The Committee recommends that DCYF create clinical supervision for field supervisors. This process is expected of supervisors when conducting their monthly case review staffings with caseworkers. However, there is not a process in place for supervisors to receive that support. There was discussion that the area administrators, who supervise the office supervisors, do not have the capacity to provide this.	Status: Modified Implementation, In Progress
DCYF should consider completing an independent workload study of DCYF's CPS program in order to adequately resources staff so they may complete comprehensive assessments with an emphasis on parent engagement.	Status: Already Exists in Policy/Practice
The Committee respectfully recommends that DCYF discontinue the practice of supervisors being assigned to case-carrying activities. This recommendation is made with the goal of supervisors having sufficient time to provide support and clinical supervision to their staff teams properly.	Status: On Hold
The Committee recommends that DCYF develop a statewide supervisor mentorship program. The purpose of the mentorship program would be to create access for new supervisors and allow them greater opportunities to communicate, collaborate, and receive support from experienced supervisors from all programs.	Status: On Hold
The Committee recommended DCYF complete a needs assessment of the FVS program to ensure it is appropriately resourced and to offer additional guidance and support to the field offices. The Committee suggested the following be considered: • Provide additional training for FVS caseworkers due to the high-risk nature of the cases. • Weight FVS cases higher due to the level of monitoring and oversight required. • Identify neutral facilitators to assist with case transfer staffings to FVS. • Designate FVS case-carrying only caseloads that do not include additional case assignment duties.	Status: Considered, Not Implemented *Workload study is underway and will help determine what an appropriate caseload is. This will also inform decision packages in the future. There is an escalation process in policy.*

CASEWORK PRACTICE Other casework practice	
DCYF should consider sending foster and kinship caregivers bi-annual information and updates for infant care and sleeping practices. The information should include product recalls, product warnings, and for educational purposes, information about cases involving fatalities and near fatalities.	Status: Implement, In Progress
Region 5 should be reminded to utilize form number 02-607 Guidelines for Reasonable Efforts to Locate Children and/or Parent.	Status: Modified Implementation, In Progress
The Committee recommended that DCYF create a small online reference or resource guide for staff regarding malnutrition, bonding and attachment, and child development. The resource should be somewhat short and provide information on what to look for in relation to child size and development, nutrition, and bonding or attachment.	Status: Considered, Not Implemented *There is a bill in process and these topics are covered in training as well as linked on the website.*

PARTNERSHIPS WITH COMMUNITY PROFESSIONALS	
It is recommended that DCYF identify field staff in each region to develop a list of community-based resources within the Asian, Pacific Islander, and Native Hawaiian (APINH) communities that could be shared regionally with all field staff. The Committee also recommended DCYF staff build collaborative connections within the APINH communities to help educate about DCYF's role and function and build culturally relevant connections for the families served by DCYF.	Status: Considered, Not Implemented *Lists are out of date as soon as they are published. This information is available online for staff.*
The Committee understands that trainings and policy currently exists that require DCYF to consider the family and individual's cultural needs. These needs should be integrated into the services provided by DCYF. The Committee believes a stronger approach should be taken. Like Indian Child Welfare cases, the Committee recommends DCYF provide similar emphasis on engagement and collaboration with cultural experts or representatives within agencies and communities. This may be accomplished by encouraging the cultural experts and representatives to attend staffings such as FTDMs/shared planning staffings and other meetings. This may also be accomplished by encouraging the cultural experts and representatives to collaborate on trainings for staff to learn about other cultures. DCYF should also work to identify appropriate local agencies that may collaborate with staff and support DCYF clients.	Status: Unknown