

Office of the Family and Children's Ombuds

Child Fatalities and Near Fatalities in Washington State

A report on data and reviews

August 2017



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EXECUTIVE SUMMARY

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

OFCO CRITICAL INCIDENT REVIEWS

Section I of this report provides an account of OFCO’s critical incident review activities from January 1, 2016 through December 31, 2016. The critical incidents discussed in this report include:

- **Child Fatalities:** When there is an open case on the family at the time of the fatality or any Children’s Administration (CA) history with the family within twelve months of the fatality, including “information only” referrals; or when the fatality occurred in a CA or Department of Early Learning (DEL) licensed, certified, or state operated facility.
- **Child Near Fatalities:** When the near fatality is a result of alleged child abuse and/or neglect and there is an open case or a case with CA history within twelve months, including “information only” referrals; or the near fatality occurred in a CA or DEL 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.
- **Recurrent Maltreatment:** When children in the same family experience recurrent maltreatment— defined as three founded reports of alleged abuse or neglect within the last twelve months.

OFCO conducts its own administrative examinations of all child fatalities and near fatalities both involving child abuse or neglect and cases unrelated to child maltreatment, of children, whose family had Children’s Administration history within one year prior to the incident. As described in this report, OFCO examined a total of **63 child fatality cases** and **28 near fatality cases** in 2016. Through its review process OFCO identifies common factors and systemic issues regarding these critical incidents.

Key points discussed in this report include:

- The vast majority of child fatalities and near fatalities related to maltreatment involved children under the age of three years. Unsafe sleep practices continue to be a leading factor associated with infant deaths.
- Fatalities of Native American and African American children are disproportionately high relative to their representation in the state population.

- Major risk factors in these child fatalities include: **substance abuse** by and/or **mental health** problems of a caregiver; and/or a history of **domestic violence** in the family. Opioid use specifically has been increasing both nationally and across Washington in recent years. From 2013 to 2016, OFCO identified 33 maltreatment related deaths of children 0-3 years of age where a caregiver's opiate use was a known risk factor.

OFCO also reviewed **89 cases of recurrent maltreatment in 2016**. As noted in previous reports, child neglect continues to constitute the largest number of the founded reports in recurrent maltreatment cases and is more likely to recur than physical or sexual abuse.

IMPLEMENTATION OF CHILD FATALITY AND NEAR FATALITY REVIEW RECOMMENDATIONS

State law requires CA to conduct a child fatality or near fatality review when the death or near-death of a child was suspected to be caused by child abuse or neglect, and the child was in the care of or receiving services from DSHS/CA at the time of death, or in the year prior. The purpose of reviewing these incidents 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.

Section II of this report describes the implementation status of recommendations made in child fatality and near fatality reviews conducted by CA between August 1, 2015 and June 29, 2016. During this time period, CA conducted reviews in 13 child fatalities and 8 near-fatal incidents.

The 13 fatality reviews resulted in **28 recommendations**, while the 8 near fatality reviews resulted in **13 recommendations**. Based on information provided by CA, OFCO found that **78 percent of the recommendations were either completely implemented or in the process of implementation**, and 14.6 percent were considered, but not implemented. The vast majority of recommendations addressed either statewide issues (63.4 percent) or local office concerns (34.1 percent), while a much lower number were tailored to remedy regional concerns (2.4 percent).

Recommendations made in child fatality and near fatality reviews have led to significant changes in state law, Department policy, and child welfare practices at the local, regional, and state levels.

TERMS AND ACRONYMS

AIRS	Administrative Incident Reporting System
Alliance for Child Welfare Excellence	Partnership/entity providing child welfare training for CA staff, foster parents and other professionals
CA	Children’s Administration
CASA	Court Appointed Special Advocate
CPS	Child Protective Services
CFWS or CWS	Child and Family Welfare Services or Child Welfare Services
DCFS	Division of Child and Family Services
DDA	Developmental Disabilities Administration
DEL	Department of Early Learning
Dependent Child	A child for whom the state is acting as the legal parent
DOH	Department of Health
DLR	Division of Licensed Resources
DSHS	Department of Social and Health Services
ECFR	Executive Child Fatality Review
ECNFR	Executive Child Near Fatality Review
FamLink	Statewide Automated Child Welfare Information System (CA’s electronic record-keeping system)
FAR	Family Assessment Response
FRS	Family Reconciliation Services
FVS	Family Voluntary Services
FTDM	Family Team Decision Meeting
GAL	Guardian ad Litem
ICPC	Interstate Compact for the Placement of Children
ICWA	Indian Child Welfare Act
Med-Con	Child Protection Medical Consultants, statewide physician consultation service available to CA for child abuse cases
MODIS	DSHS Management and Operations Document Imaging System. CA uses it to electronically scan and store case and provider file records.
NAS	Neonatal Abstinence Syndrome
NICU	Neonatal Intensive Care Unit
NFP	Nurse-Family Partnership®
OFCO	Office of the Family and Children’s Ombuds
OFM	Office of Financial Management
SDM	Structured Decision Making (an element of CA’s Safety Framework model for casework practice)
SIDS	Sudden Infant Death Syndrome
SUID	Sudden Unexpected Infant Death
VSA	Voluntary Service Agreement

SECTION I

OFCO CRITICAL INCIDENT REVIEWS

BACKGROUND

The Department notifies OFCO when a critical incident, such as a child fatality or near fatality, occurs.¹ OFCO then immediately begins 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 twelve months of the child's death, including "information only" referrals; or when the fatality occurred in a CA or Department of Early Learning (DEL) 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 twelve months, including "information only" referrals; or the near fatality occurred in a CA or DEL licensed, certified, or state-operated facility. A near fatality is defined as an act that, as certified by a physician, places the child in serious or critical condition.⁴
- **Recurrent Maltreatment:**⁵ When children in the same family experience recurrent maltreatment — defined as three founded reports of alleged abuse or neglect within the preceding twelve months.
- **Other Critical Incidents:** OFCO is regularly notified of other critical incidents including child abuse allegations in licensed foster homes or residential facilities, high-profile cases, incidents involving CA clients (such as dangerous behavior by foster youth), or incidents affecting CA staff safety. OFCO briefly reviews each of these cases to assess whether there is any unaddressed safety issue, and if so, may conduct a more thorough review.

This report discusses critical incidents occurring from January 1, 2016 – December 31, 2016. Over this one year period, OFCO conducted:

- **63** administrative reviews of child fatalities involving both child abuse or neglect and cases unrelated to child maltreatment;
- **28** administrative reviews of child near fatalities;
- **89** reviews of cases of recurrent maltreatment; and
- Approximately **4-8** brief reviews of other critical incidents per week.

¹ OFCO receives notice through the CA'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 CA 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 74.13.500.

⁵ RCW 26.44.030(15).

In order to more accurately describe and contextualize specific issues such as fatalities caused by abuse or neglect, racial disproportionality, infant fatalities and opioid use, some sections of this report include data from 2013 – 2016.

OFCO'S ADMINISTRATIVE REVIEW PROCESS

OFCO maintains a database of child fatalities, near fatalities, and other critical incidents that organizes relevant case information including: family and child-specific identifying information; current allegations of child abuse or neglect; prior involvement with child welfare agencies, the court, or criminal history; risk factors such as substance abuse or domestic violence; and information about the alleged perpetrator and the relationship to the child. OFCO also creates a chronology for each case describing significant events. Through this process, OFCO identifies common factors and potential systemic issues regarding these critical incidents, as well as areas of concern in specific cases.

OFCO treats each fatality, near fatality, and recurrent maltreatment notification as emergent in order to identify any safety issues regarding children remaining in the home. When conducting critical incident reviews, OFCO focuses on whether child maltreatment was a contributing factor, and whether there were any opportunities for the child welfare system to assist the family and protect the child prior to the incident. This allows OFCO to not only take any needed action to protect the children involved in the critical incident during the aftermath, but also provides an opportunity to conduct systemic investigations and issue recommendations as needed, to better protect our state's most vulnerable population.

SUMMARY OF OFCO CRITICAL INCIDENT DATA

CHILD FATALITIES

- In the 2016 calendar year, 63 child fatality cases met the criteria for OFCO examination. Thirty-five of these fatalities were related to child maltreatment.
- Thirteen child fatalities (37 percent of maltreatment related fatalities) were directly attributed to physical abuse or neglect and of these, nine involved children under the age of three years.
- Fatalities of Native American and African American children are disproportionately high relative to their representation in the state population. Almost 10 percent of fatalities were those of Native American children, while they make up only 2.4 percent of Washington children.
- Unsafe sleep environment continues to be a leading risk factor associated with infant deaths.
- Other major risk factors in fatalities include: substance abuse by and/or mental health problems of a caregiver; and/or a history of domestic violence in the family.
- Opiate use has increased both nationally and across Washington in recent years. From 2013-2016, OFCO identified 33 maltreatment related child fatalities of children ages 0-3 years where a caregiver's opiate use was a known risk factor.

CHILD NEAR FATALITIES

- OFCO reviewed 28 near fatality cases from calendar year 2016, both involving child abuse or neglect and cases unrelated to child maltreatment.
- Children involved in near fatal incidents are older than those involved in fatalities. Sixty-five percent of children involved in near fatalities are over the age of one year compared to only 34 percent of child fatalities.

RECURRENT MALTREATMENT

- OFCO received 89 notifications of recurrent maltreatment in 2016. The number of recurrent maltreatment notifications has dropped each year since 2013.
- The vast majority of founded reports constituted child neglect (72 percent), which is more likely to recur than physical or sexual abuse.
- Caregiver substance abuse remains the most prevalent risk factor in these cases.

CHILD FATALITIES EXAMINED BY OFCO

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

OFCO examines these fatalities to:

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

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

OFCO examined **63 child fatalities in 2016**.⁸ With the exception of 2008, child fatalities meeting OFCO's criteria for further examination have held relatively constant since 2007, as shown in Figure 1. Not all fatalities OFCO receives notice of are related to maltreatment. For example, OFCO may receive notice of an expected medical death of a child whose family has had contact with the Department in the past twelve months.

Maltreatment related fatalities, on the other hand, are those in which:

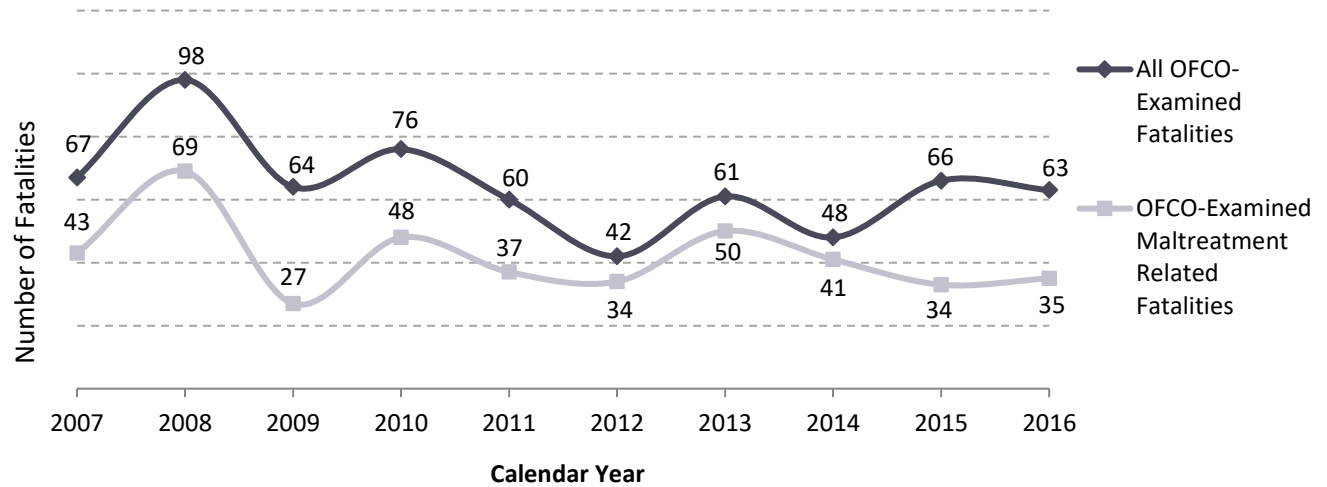
- the child's death was directly caused by abuse or neglect; or
- the child's death was not a direct result of maltreatment, but the family has a history of abuse or neglect of that child and/or other children in the family that may have contributed to the child's death.

⁶ "CA history" may include reports to CPS that were not screened in for investigation.

⁷ State law requires DSHS to conduct an executive child fatality review when the child's death is suspected to be caused by child abuse or neglect, and the child was either in the Department's custody or receiving services in the 12 months before the death.

⁸ Calendar year

Figure 1: OFCO-Examined Child Fatalities by Year
by Calendar Year (January 1st – December 31st)



Child Mortality in Washington

Fatalities of children whose families have had contact with CA in the twelve months prior to death make up a small proportion of child fatalities in Washington in any given year. Of these fatalities, those that are maltreatment related make up an even smaller proportion. The total number of children in Washington from birth to 17 years who died each year is shown below.

Child Fatalities in Washington (ages 0-17)	2008	2009	2010	2011	2012	2013	2014	2015
	777	701	655	624	713	614	625	715

Source: *Death Data*. Washington State Department of Health. Death Tables By Topic – Age by Sex for Residents:
<http://www.doh.wa.gov/DataandStatisticalReports/VitalStatisticsandPopulationData/Death/DeathTablesbyTopic>

In order to identify any possible patterns or trends, OFCO presents demographic data on maltreatment related fatalities covering the last **four years**.⁹ From January 1, 2013 to December 31, 2016, OFCO examined the deaths of 238 children, 78 of which were not related to maltreatment. The following data describes the profile of the remaining **160 maltreatment related child fatalities examined by OFCO** during this four-year period.

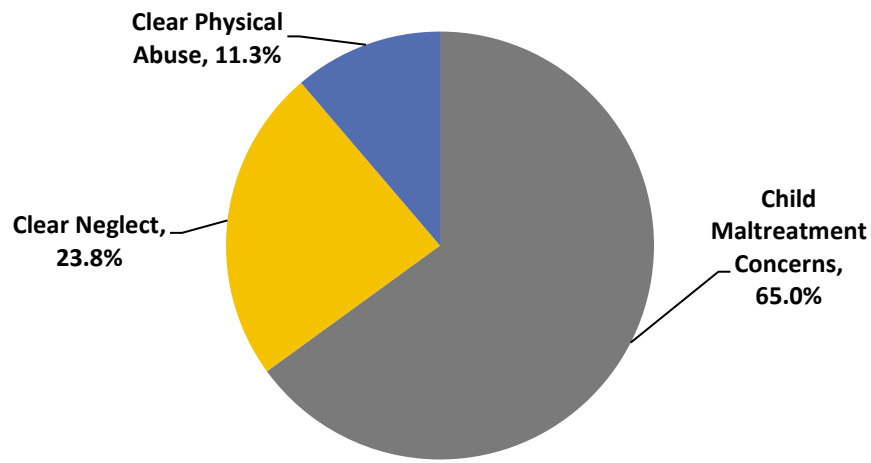
⁹ Data for each calendar year is presented in Appendix A

MALTREATMENT RELATED CHILD FATALITIES

Of the 238 child fatalities reviewed by OFCO from 2013 to 2016, **160 were found to be either directly caused by child abuse or neglect, or cases in which abuse or neglect concerns *may have contributed to the fatality***. Almost a quarter of the children (38, or 23.8 percent) died as a direct result of neglect and 18 children (11.3 percent) died from physical abuse.¹⁰ OFCO found that child abuse or neglect concerns were present and may have contributed to the child’s death in the remaining 104 cases.

Figure 2: **Maltreatment Related Child Fatalities, 2013 – 2016**

(n = 160)



CHILD MALTREATMENT DEFINITIONS

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

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

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

¹⁰ In many cases of clear neglect or physical abuse, the child’s death caused a CPS report to be made, and the CPS investigation resulted in a founded finding for neglect or physical abuse. OFCO data indicates that 50 of the 160 deaths examined during this period resulted in a “founded” finding for maltreatment while 59 investigations concluded as “unfounded” for either abuse or neglect.

FATALITY CASE EXAMPLES BY MALTREATMENT TYPE

Example 1: CLEAR PHYSICAL ABUSE

A 2-year old child was killed as a result of physical injuries inflicted by the mother's partner. The mother left the child with her partner while she left the home and consumed alcohol. The next day the child was found unresponsive and covered in bruises. The medical examiner ruled the death a homicide due to blunt force trauma to the abdomen.

The mother had three older children and her history with the Department included twelve reports made to CPS alleging neglect and physical abuse. Four of these reports were accepted for CPS investigation and three were accepted for FAR. A report made two months before the child's death screened in for the FAR pathway and alleged the mother was not meeting the children's basic needs and would lock herself in her room for days at a time. The case was closed two weeks before the child's death.

The CPS investigation into the fatality resulted in a founded finding of physical abuse by the mother's partner and a founded finding of neglect by the mother.

Example 2: CLEAR NEGLECT

A one-month old infant was found not breathing in the bathtub with the mother. The infant was fussy and the father brought the child to the mother in the bathtub to feed. The mother was drinking alcohol earlier in the evening and fell asleep with the child. The death investigation revealed the manner of death was undetermined, though the medical examiner suggested death was related to either the position the child was in or drowning.

The mother had two older children and her history with the Department included sixteen reports to CPS prior to the infant's birth alleging neglect, lack of supervision, alcohol abuse, and unsanitary living conditions. Of these reports, five assessments resulted in unfounded findings and one resulted in a founding finding of neglect for the mother driving the children while intoxicated. The father of the infant was the subject of one prior report to CPS relating to lack of supervision which resulted in an unfounded finding.

A CPS report made by hospital staff at the time of the infant's birth was accepted for investigation and the case was open when the fatality occurred. The CPS investigation conducted into the fatality incident resulted in a founded finding of neglect against both parents.

Example 3: CHILD MALTREATMENT CONCERNS

A five-month old infant was found unconscious and unresponsive on an adult bed the child was sharing with the mother who was engaged in methadone maintenance treatment. The medical examiner ruled the manner of death was accidental and that the child died from "compressional asphyxia". The likely scenario was that the mother was covering the child's body, restricting the infant's ability to breathe.

At the time of death the mother had four older children who were in care of the Department. The children were removed from the home because of concerns around drug use, lack of supervision and mental health. When the infant was born the mother was engaged with in-patient treatment and the baby was discharged from the hospital to the treatment center with the mother, which she then successfully completed. The mother had a safe sleeping box provided by her Public Health Nurse which was not used the night of the fatality.

The CPS investigation into the fatality resulted in an unfounded finding of neglect by the mother.

MANNER OF DEATH

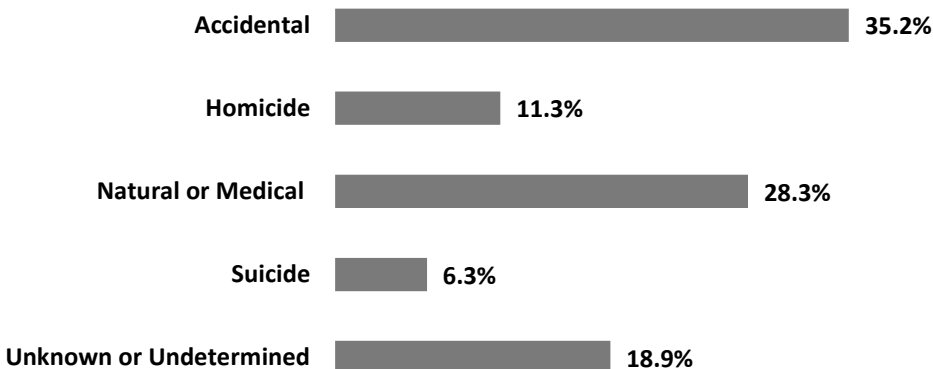
The manner and cause of death is determined by a medical examiner or coroner. The manner of death describes the context or circumstances of the death and is assigned to one of five categories:

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 drug overdose. Based on the scene investigation and other factors, a death caused by drug overdose could also be determined to be suicide.

Figure 3: **Manner of Death, 2013 – 2016**

(n = 159)¹¹



Sudden Unexpected Infant Death (SUID) is a broad category of infant death (birth to twelve months) that includes Sudden Infant Death Syndrome (SIDS) as well as deaths due to accidental suffocation and other infant deaths of unknown cause.¹² SIDS is generally considered a subset of natural or medical death. If significant risk factors were present during the scene investigation however, such as an unsafe sleep environment like co-sleeping or inappropriate bedding, then the manner of death might be classified as accidental or unknown or undetermined.

¹¹ The exact manner of death for one fatality in 2016 was still pending at the time of writing.

¹² Health of Washington State: Infant Mortality. Washington State Department of Health; 2013. <http://www.doh.wa.gov/Portals/1/Documents/5500/MCH-IM2013.pdf>

Figure 3A: Child Fatalities by Manner of Death

Manner of Death	Summary of Fatality	Summary of Case Status
Accidental	A 15 year old dependent youth died from a drug overdose while missing from foster care. There were no signs the overdose was intentional and the manner of death was ruled accidental.	<ul style="list-style-type: none"> • Case History: Open to CFWS at time of death. • Placement: Child was dependent and missing from care, aka “on the run”. It was believed child had been staying with her father while missing from care. • CPS Investigation: Not applicable/none.
Homicide	A 16 year old was shot and killed in the family home by the step-father.	<ul style="list-style-type: none"> • Case History: Family’s history with the Department was one “information only” referral. • Placement: Family home. • CPS Investigation: Resulted in founded finding of physical abuse by step-father.
Natural or Medical	A five month old infant died when placed to sleep by the grandmother in a laundry basket with pillows and blankets. The Medical Examiner ruled the cause of death SIDS.	<ul style="list-style-type: none"> • Case History: Case closed one month before fatality. Mother previously participated in Family Voluntary Services for four months. • Placement: Child in mother’s care – death occurred while grandmother was babysitting. • CPS Investigation: Resulted in a founded finding of neglect on the infant’s mother for allowing the grandmother, who was previously identified as an unsafe caregiver, to care for the child.
Suicide	A 14 year old died by suicide while in the care of his mother and step-father. The family was recently involved with Department due to allegations of not getting their children needed mental health services.	<ul style="list-style-type: none"> • Case History: Case closed three months before fatality. Family recently involved with FAR but their case was transferred to CPS investigations after not participating in FAR. • Placement/Custody: Family home. • CPS Investigation: Mother and step-father received founded finding of neglect.
Unknown or Undetermined	A three month old infant was found deceased on an adult bed surrounded by several pillows and blankets. Two prior “information only” referrals alleged parental drug use. An intake made regarding the death did not meet the criteria for investigation so the official manner of death was unknown to OFCO.	<ul style="list-style-type: none"> • Case History: Only history with Department was two “information only” referrals. • Placement/Custody: Family home. • CPS Investigation: None – intake did not meet the screening criteria for investigation.

CHILD FATALITIES AND RACIAL DISPROPORTIONALITY

Racial disparities exist across all child fatalities in Washington. American Indian and Alaska Native infants, for example, have an infant mortality rate in Washington twice that of Asian and Caucasian infants. Infant mortality for Native American children in Washington has actually *increased* in recent years. African American infants also have higher mortality rates in Washington compared to Asians and Caucasians.¹³ Nationally, infant mortality declined for all racial and ethnic groups from 2005 through 2014 except among Native American women.¹⁴

As in previous years, maltreatment related child fatalities continue to be disproportionately high for Native American and African American children. For example, while Native American children make up 2.4 percent of the children in Washington State, **ten percent of maltreatment related child fatalities examined by OFCO from 2013-2016 were those of Native American children.** Similarly, African American children make up 4.7 percent of the state’s child population, yet represent **ten percent of fatalities** examined by OFCO. It is encouraging to note, however, that the number of maltreatment related fatalities of Native American children examined by OFCO dropped sharply, from 23 percent in 2010-13 to ten percent in the current reporting period. National data also shows significant disparity between maltreatment related fatalities of white children and children of color. For example, although African American children are approximately 16 percent of the child population nationally, they make up 30 percent of the child abuse and neglect fatalities.¹⁵

Table 1: Race and Ethnicity in Maltreatment Related Child Fatalities, 2013 – 2016

(n = 160)

	OFCO Examined Maltreatment Related Child Fatalities		WA Children in Out of Home Care ¹⁶	WA State Children ¹⁷
	#	%		
Caucasian	94	58.8%	63.6%	74.30%
African American	16	10.0%	8.4%	4.70%
Native American	16	10.0%	5.5%	2.40%
Asian or Pacific Islander	7	4.4%	0.9%	7.65%
Other	6	3.8%	0.0%	-
Multi-Racial	21	13.1%	16.3%	10.00%
Latino / Hispanic	17	10.6%	18.8%	21.00%
Non-Hispanic	143	89.4%	81.2%	79.00%

¹³ Health of Washington State: Infant Mortality. Washington State Department of Health. 2013

<http://www.doh.wa.gov/Portals/1/Documents/5500/MCH-IM2013.pdf>

¹⁴ Trends in Infant Mortality in the United States, 2005-2014. US Department of Health and Human Services. Centers for Disease Control and Prevention. <https://www.cdc.gov/nchs/data/databriefs/db279.pdf>

¹⁵ Within our Reach: A National Strategy to Eliminate Child Abuse and Neglect Fatalities, 2016 (page 61).

<http://eliminatechildabusefatalities.sites.usa.gov/files/2016/03/CECANF-final-report.pdf>

¹⁶ Number of children in care on October 1, 2016 was 8901. Information from: Partners for Our Children Data Portal Team. (2017). Children in Out-of-Home Care (Count). Retrieved from <http://www.vis.pocdata.org/graphs/oooh-counts>.

¹⁷ Ages 0-19. Office of Financial Management. Population estimates by age, sex, race and Hispanic origin. 2016. <http://www.ofm.wa.gov/pop/asr/default.asp>

Washington State Disproportionality Advisory Committee

Racial disproportionality is defined as the overrepresentation of children of color in the child welfare system compared to their numbers in the general population.

In January 2016, The Washington State Disproportionality Advisory Committee issued its seventh annual update to the Legislature regarding “the efforts of DSHS to remediate racial disproportionality in the Washington state child welfare system.”¹⁸ This report summarizes the steady progress regarding eight major recommendations made by the committee to reduce disparate outcomes for children of color in the child welfare system. CA has several metrics used to measure changes in racial disproportionality, including rate of disproportionality in CPS intakes and placement stability.

*While the advisory committee tracks data on children of color at various points in the child welfare system, such as intake, investigation, and placement, it has not studied fatalities related to child maltreatment. OFCO suggests that this committee also develop recommendations to reduce racial disproportionality in maltreatment related child fatalities.*¹⁹

The full report can be found at:

<https://www.dshs.wa.gov/sites/default/files/CA/acw/documents/RacialDisproLegislativeReport2016.pdf>

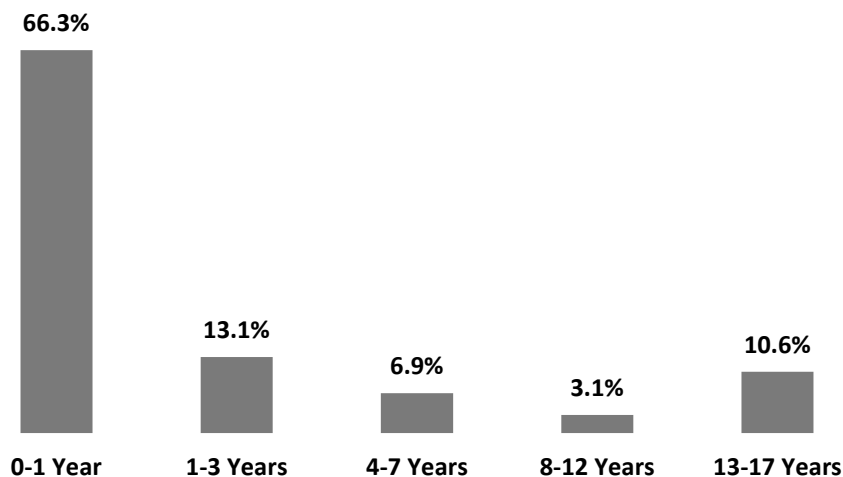
¹⁹ Id. Chapter four of this report discusses strategies to reduce disproportionality in child maltreatment-related fatalities.

CHILD’S AGE AT TIME OF DEATH

As in previous years, an overwhelming majority of maltreatment related fatalities (79 percent) involved very young children, those under the age of three. Infants (birth to twelve months) accounted for 66.3 percent of the fatalities. Infants are the most vulnerable to risk of harm from their caregivers.

Figure 4: **Age of Child at Time of Death, 2013 – 2016**

(n = 160)



Trends in the manner of death differ by age. Table 2 displays the leading manner of death in maltreatment related fatalities for each age group. Infants make up the largest portion of the OFCO-examined child fatalities, but by looking at the manner of death for different age ranges, OFCO can think critically about the needs of and risks facing older children. For example, while deaths by suicide make up only 8.6 percent of all OFCO examined fatalities, they are the leading manner of death for teenagers (59 percent of children ages 13-17).

Table 2: **Leading Manners of Death by Age Group, 2013-2016**

(n = 159)²⁰

Age	Leading Manner of Death in Maltreatment-Related Fatalities	Examples
Less than 12 months	Accidental (37.4%)	suffocation or asphyxiation in unsafe sleep environment
1-3 years	Accidental (40%)	head injury from fall
	Homicide (40%)	physical injury inflicted by caregiver
4-7 years	Natural/Medical (45.5%)	medical condition
	Homicide (45.5%)	physical injury inflicted by caregiver
8-12 years	Accidental (50%)	automobile accident
	Natural/Medical (50%)	medical condition
13-17 years	Suicide (58.8%)	death by suicide

²⁰ The manner of death for one fatality was still awaiting determination by the medical examiner at time of writing.

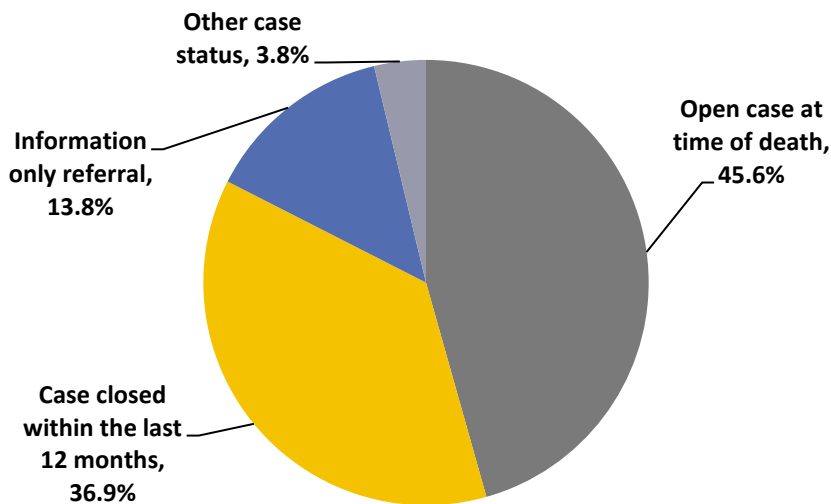
FAMILY CONTACT WITH CHILDREN’S ADMINISTRATION

OFCO examines child fatalities when there is an open case with the family at the time of death or any CA history or contact in the preceding twelve months. This includes referrals made to CA that did not meet the criteria to screen in for intervention or services, also known as “information only” referrals. OFCO also examines fatalities that occur in a CA or Department of Early Learning licensed, certified, or state operated facility.

Just over 45 percent families involved in the maltreatment related fatalities examined by OFCO had an open case with CA at the time of death. Thirty-seven percent of families had a CA case that closed in the previous 12 months.

Figure 5: **CA Case Status within 12 Months of Fatality, 2013 – 2016**

(n = 160)



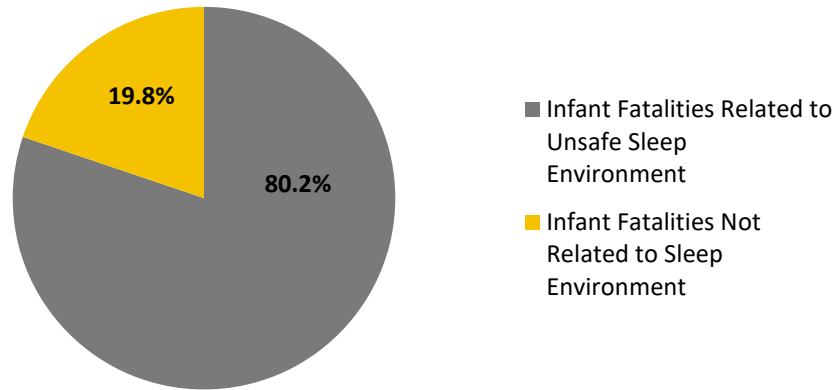
INFANT SAFE SLEEP ENVIRONMENT

An unsafe sleep environment continues to be a significant factor in the vast majority of infant fatalities. Unsafe sleep practices include:

- adults, older children, or pets sleeping with an infant;
- putting an infant to sleep on an adult bed, couch, sofa bed, or other soft surface not designed for an infant; and
- the presence of soft items such as pillows, blankets, or stuffed animals in the infant’s crib.

Over three-quarters (76 percent or 16 deaths) of the infant fatalities related to maltreatment in 2016 were sleep-related. This holds over the entire review period from 2013 to 2016, where 80 percent of the infant fatalities OFCO examined were related to the child’s sleep environment. The average age of infants whose deaths were related to an unsafe sleep environment was four months.

Figure 6: **Infant Fatalities and Sleep Environment, 2013 – 2016**
 (n = 106)



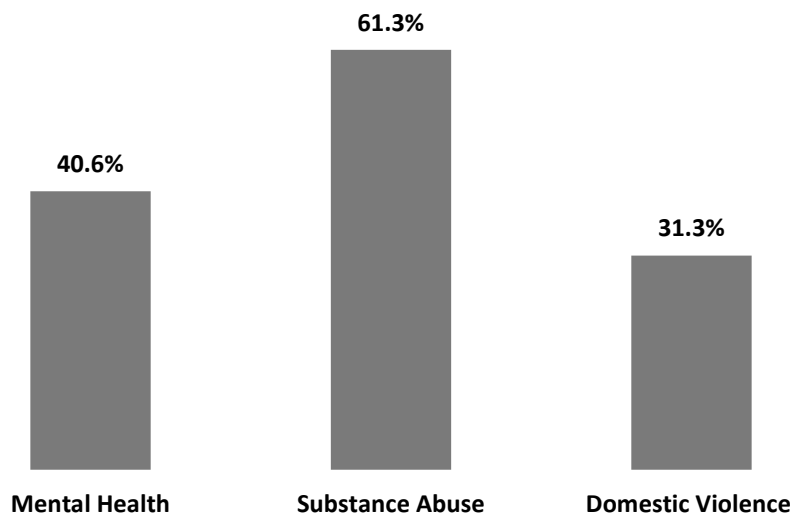
The following examples typify fatalities in which the infant’s sleep environment may have been a contributing factor.

FATALITIES INVOLVING UNSAFE SLEEP
<p>A one month old infant died while sleeping in an adult bed with the mother. The night of the child’s death the mother admitted to consuming several servings of alcohol and falling asleep with the child while breastfeeding. The family had an open CPS-risk only case at the time of death. The mother had prior history with the Department when she was driving under the influence with another child in the car. The medical examiner determined the cause of death to be SIDS, with co-sleeping and possible infection in the infant as potential contributing factors. Circumstances of the infant’s death were referred to CPS and accepted for investigation. CPS determined that the allegation of neglect by the mother was unfounded.</p>
<p>A ten month old infant died while sleeping with both parents in an adult bed with soft bedding. The Medical Examiner’s report indicated that the manner and cause of death were undetermined but that “compressive asphyxia” could not be ruled out. The family had five prior reports to CPS relating to chronic neglect and unsafe living conditions, with the most recent case closing five months before the death. The infant’s death was referred to CPS and accepted for investigation. CPS determined that the allegation of neglect on both parents was unfounded.</p>
<p>A one month old infant died while sleeping in a bed with both parents. The mother fell asleep while breastfeeding the child in bed and the Medical Examiner’s report said the most likely scenario was that the mother rolled over onto the infant. The manner of death was ruled accidental. A CPS report made at the time of the infant’s birth noted the family was experiencing homelessness and that the infant’s cord sample tested positive for Methamphetamine. This report did not meet the criteria to be screened in for CA involvement. The infant’s death was referred to CPS and accepted for investigation. CPS determined that the allegation of neglect on both parents was unfounded.</p>

FAMILY RISK FACTORS ASSOCIATED WITH FATALITIES

The majority of children who died came from families with a history of drug or alcohol abuse (61.3 percent). 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 84 percent of the fatalities examined by OFCO, while all three risk factors were identified in 10 percent.

Figure 7: **Family Risk Factors in OFCO-Examined Child Fatalities, 2013 – 2016**
(n = 160)



The co-occurrence of caregiver substance abuse and infant unsafe sleep is particularly troubling. Of the 85 infant fatalities examined by OFCO from 2013 to 2016 that involved unsafe sleep practices, 58 of them (68.2 percent) also involved substance abuse by at least one of the caregivers. Children ages 0 – 3 years are particularly at risk when their caregivers use drugs or alcohol, even when that substance is prescribed by a doctor, such as methadone, painkillers, or other prescribed narcotics.

ADDRESSING PARENTAL SUBSTANCE ABUSE

Parental substance abuse is a major risk factor for child fatalities, child maltreatment and involvement with the child welfare system. Children removed from their home as a result of parental substance abuse are likely to remain in foster care longer and have significantly higher rates of adoption than those in foster care for other reasons.²¹ Neonatal abstinence syndrome (NAS) can occur in an infant exposed in utero to addictive, illegal or prescription drugs. Babies born with NAS may experience a variety of withdrawal symptoms, medical complications and have prolonged hospital stays. According to the Centers for Disease Control and Prevention, the incidence rate of NAS in Washington State increased from a rate of 1.5 for every 1,000 hospital births in 1999 to a rate of 7.9 for every 1,000 hospital births in 2013. Opioid use has increased both nationally and across Washington and has had a significant impact on our child welfare system. In Washington, prenatal exposure to opioids increased from 11.5 percent

²¹ Family-Based Recovery: An Innovative In-Home Substance Abuse Treatment Model for Families with Young Children, By Hanson, Karen E.; Saul, Dale H.; Vanderploeg, Jeffrey J.; Painter, Mary; Adnopo, Jean

of all drug-exposed neonates in 2000 to 24.4 percent in 2008, and 41.7 percent of infants diagnosed with NAS were exclusively exposed to opioids.²²

From calendar year 2013 to 2016, OFCO identified **33 maltreatment related fatalities of children ages 0 to 3 years where a caregiver's opiate use was a known risk factor**. Of these 33 fatalities, **63.6 percent (21) were related to unsafe sleep conditions for infants**. Some examples include:

- A five-month old infant died while co-sleeping when the mother fell asleep and rolled on the child, restricting the infant's ability to breathe. The mother had recently successfully completed inpatient treatment and was involved in methadone maintenance treatment at the time of death. The infant tested positive for methadone at birth and exhibited signs of withdrawal.
- A one-month old infant died and while the cause of death was determined to be SIDS, the infant had been sleeping on the mother's chest, on a couch. The child spent time in the NICU after birth for methadone withdrawal.
- A three-month old infant died while co-sleeping with the mother who placed the infant next to her in bed, surrounded by pillows. Both the mother and the infant tested positive at delivery for opiates.

Other examples of child fatalities involving opioid use include:

- A two-year old child died by physical abuse perpetrated by a relative. The caregiver was addicted to Oxycodone and was experiencing withdrawals and was reported by family members to get easily frustrated. The caregiver was charged criminally for the abuse.
- A three-year old child died after accidentally ingesting a combination of methadone, opiates, and an anxiety medication. The child also ingested Suboxone, used in the treatment of opioid addiction two years earlier, though a report was not made to CPS at the time.
- An infant was born premature after a high risk pregnancy during which the mother used methamphetamines, crack-cocaine, and opioids. The infant suffered life-threatening medical complications and remained in the hospital, dying several months later.

Methadone is a synthetic opioid used to treat those with opiate addictions. It can prevent withdrawal symptoms and reduce opiate cravings.²³ However, if ingested by children, even a small dose can be potentially lethal. In 2016, OFCO also examined 3 near fatalities of children under the age of three who ingested methadone but were able to receive medical attention in enough time to treat.

Federal and State Laws and Policies Concerning Substance Abuse and Child Maltreatment

The federal Child Abuse and Prevention Treatment Act requires that states have policies and procedures in place to notify child protection agencies when an infant is affected by illicit substance abuse or withdrawal symptoms resulting from prenatal drug exposure. In response, the Washington State

²² Neonatal Abstinence Syndrome: How States Can Help Advance the Knowledge Base for Primary Prevention and Best Practices of Care, (2014) <http://www.astho.org/prevention/nas-neonatal-abstinence-report/>

²³ Lewington, L. E., Shaffer, C., & Ornstein, A. E. (2014). Paediatric methadone ingestions: An under-recognized form of child maltreatment? *Paediatrics & Child Health*, 19(3), 139–140.

Department of Health in collaboration with DSHS published detailed guidelines for health care providers regarding maternal drug screening, testing and reporting of drug exposed newborns to CPS.²⁴

State laws concerning child abuse and neglect also emphasize responding to substance abuse and its co-occurrence with child maltreatment. For example, “when considering whether a clear and present danger exists [to a child suspected to be maltreated], a parent's substance abuse as a contributing factor to negligent treatment or maltreatment shall be given great weight.”²⁵ Furthermore, during a CPS investigation the Department must make a determination whether drug or alcohol abuse contributed to the child abuse or neglect, and if so, obtain a chemical dependency evaluation of the subject.²⁶

When CPS intake receives a report involving a newborn exposed to substances, including alcohol, marijuana and all drugs with abuse potential, the intake report is assigned to one of the following pathways:²⁷

- CPS Investigation or Family Assessment Response when there is an allegation(s) of child abuse or neglect.
- CPS Risk Only when there is no allegation of child abuse or neglect but the newborn is either:
 - Substance affected (as identified by a medical practitioner); OR
 - Substance exposed and risk factors indicate imminent risk of serious harm.

If a newborn is substance affected, the investigator is required to complete a “Plan of Safe Care”, even if the substance is a prescription medication.²⁸ This plan of care is designed to ensure the protection of drug affected newborns, not to punish mothers battling addiction. The “Plan of Safe Care” typically includes the plan for medical care for the infant; safe housing for the family; child care if needed; emergency contacts for the parent to call; and referrals for necessary services and available resources such as substance abuse treatment, nutrition assistance through the federal WIC program, and parenting classes.

OFCO Recommendations

Recommendation: Expand services for expectant mothers, and mothers of newborns such as the Nurse-Family Partnership

Nurse-Family Partnership® (NFP) is a community health program that serves vulnerable mothers pregnant with their first child. Each mother served by NFP is partnered with a registered nurse early in her pregnancy and receives ongoing home visits from a nurse that continue through her child’s second birthday. NFP improves family outcomes including: increased time between births and fewer children; more stable partner relationships; less engagement in risky behaviors, less substance abuse during pregnancy and reduced role impairment; mothers are less reliant on welfare; children are less likely to

²⁴ Guidelines for Testing and Reporting Drug Exposed Newborns in Washington State, revised July 2015.

<http://here.doh.wa.gov/materials/guidelines-drug-exposed-newborns>

²⁵ RCW 26.44.020(16)

²⁶ RCW 26.44.170

²⁷ CA Practices & Procedures Manual 2200.

²⁸ CA Practices & Procedures Manual, 2552. CPS Response to Newborns Identified by a Medical Practitioner as Substance Affected. The Child Abuse Prevention and Treatment Act (CAPTA) requires States to have policies and procedures in place to notify child protective services (CPS) agencies of substance-exposed newborns (SENs) and to establish a plan of safe care for newborns identified as being affected by illegal substance abuse or having withdrawal symptoms resulting from prenatal drug exposure. (42 U.S.C. § 5106a(b), as amended by the CAPTA Reauthorization Act of 2010 (P.L. 111-320).)

be maltreated or abused; and the program leads to reductions in emergency room visits, hospital days and reduced childhood mortality.²⁹

NFP currently serves clients in 14 of Washington's 39 counties: Clark, Cowlitz, Franklin, Jefferson, Kitsap, King, Mason, Pierce, Skagit, Snohomish, Spokane, Thurston, Yakima and Whatcom.³⁰ However, these existing programs report demand for services far exceeds existing resources. In one of the fatalities OFCO examined, a county's lack of a strong public health nurse program was noted to be a barrier to engaging with and providing services to prevent child maltreatment in that particular family, as well as a large number of families in the community.

NURSE-FAMILY PARTNERSHIP GOALS

1. Improve pregnancy outcomes by helping women engage in good preventive health practices, including prenatal care; improving their diets; and reducing their use of cigarettes, alcohol and illegal substances;
2. Improve child health and development by helping parents provide responsible and competent care; and
3. Improve the economic self-sufficiency of the family by helping parents develop a vision for their own future, plan future pregnancies, continue their education and find employment.

Recommendation: Provide DCFS caseworkers with additional training and support resources addressing substance abuse by parents, and assessing child safety.

Several child fatality and near fatality review recommendations over the years identified the need for additional training for caseworkers on issues related to parental chemical dependency, in particular, opiate use and methadone treatment, and assessing child safety in these situations.³¹ Related recommendations suggest that a chemical dependency professional should be located in DCFS offices to provide case consultation, guidance for client engagement, and information on community resources. The Department should continue efforts to provide ongoing training to caseworkers and assure that professional case consultation regarding substance abuse is available, either located in the DCFS office, or through community partners.

²⁹ Olds DL, Kitzman H, Hanks C, et al. *Effects of nurse home visiting on maternal and child functioning: Age-9 follow-up of a randomized trial.* *Pediatrics.* 2007;120(4):e832-45; Olds DL, Kitzman HJ, Cole RE, et al. *Enduring effects of prenatal and infancy home visiting by nurses on maternal life course and government spending: Follow-up of a randomized trial among children at age 12 years.* *Archives of Pediatrics & Adolescent Medicine.* 2010;164(5):419-24; Small SA, Reynolds AJ, O'Connor C, Cooney SM. *What works, Wisconsin: What science tells us about cost-effective programs for juvenile delinquency prevention: A report to the Wisconsin governor's juvenile commission and the Wisconsin Office of Justice Assistance.* Madison: University of Wisconsin-Madison; 2005; and Aroly LA, Kilburn MR, Cannon JS. *Early childhood interventions: Proven results, future promise.* Santa Monica: RAND Corporation; 2005: Monograph Report 341.

³⁰ Nurse-Family Partnership, State Profile 2014. http://www.nursefamilypartnership.org/assets/PDF/Communities/State-profiles/WA_State_Profile.aspx

³¹ See Appendix C for the full text of these recommendations.

Recommendation: Expand Substance Abuse Treatment Resources for Parents Struggling with Addiction

Washington State should build on programs that have proven to reduce involvement with the child welfare system. For example, the Parent Child Assistance Program (PCAP)³² is an evidence based intensive case management model serving over 1,000 of the highest-risk pregnant and parenting mothers who have alcohol and/or drug use disorders. PCAP case managers each work with 16 families for three years, beginning during pregnancy or postpartum. Case managers visit client homes approximately weekly for the first 6 weeks, then twice a month for three years and help clients obtain treatment, connect with comprehensive community services and stay in recovery. PCAP currently serves families in 12 Washington county areas: King, Pierce, Yakima, Spokane, Grant, Cowlitz, Skagit, Clallam, Kitsap, Grays Harbor/Pacific, Clark and Thurston.

³²Parent-Child Assistance Program (PCAP) 1991 — Present, (February 2017)
http://depts.washington.edu/pcapuw/inhouse/PCAP_Summary_of_Evidence_2.8.17.pdf

CHILD NEAR FATALITIES EXAMINED BY OFCO

State law requires DSHS to notify OFCO of the near fatality³³ of any child who has been in the Department’s custody, or receiving services, within the last 12 months.³⁴

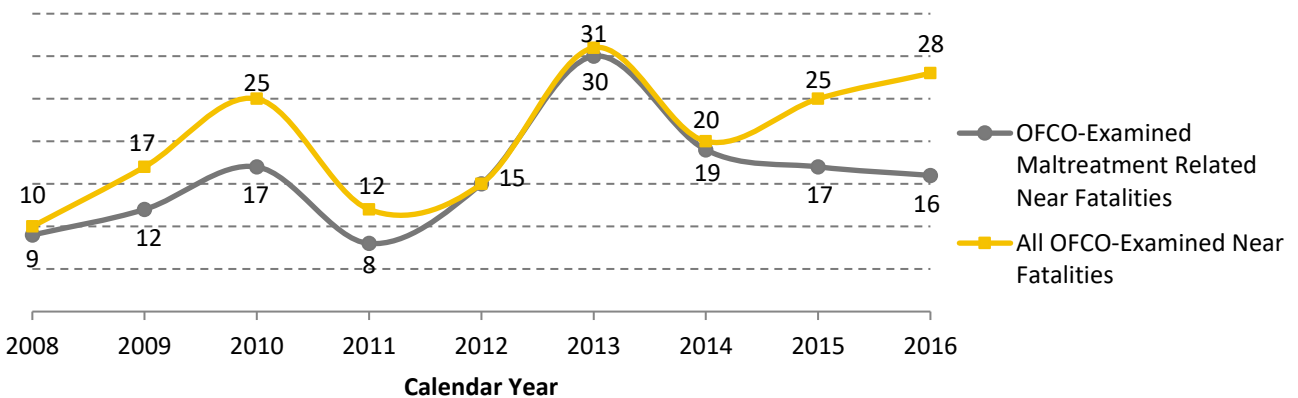
OFCO conducts preliminary review of all near fatalities involving alleged child abuse or neglect when the family had an open case with CA at the time of the near fatality or in the twelve months prior, even if the subject child was not the recipient of Department services and including “information only” referrals. OFCO examined **28 near fatalities in 2016**.

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 DSHS 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 these near fatalities.

Figure 8: **OFCO-Examined Near Fatalities by Year**

By Calendar Year (January 1st – December 31st)



MALTREATMENT RELATED NEAR FATALITIES

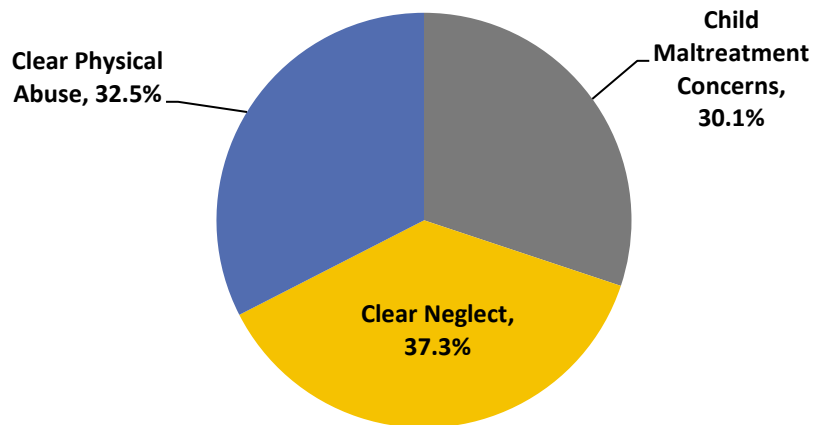
OFCO identifies child near fatalities reported to CPS that were directly caused by child abuse or neglect, as well as those in which abuse or neglect concerns may have contributed to the incident, and the family had CA history in the previous 12 months. Of the 28 near fatalities examined by OFCO in 2016, 16 were determined to either be caused by abuse or neglect, or abuse or neglect concerns were present. **OFCO**

³³ RCW 74.13.500 defines “near fatality” as “an act that, as certified by a physician, places the child in serious or critical condition.”

³⁴ RCW 74.13.640(2).

examined a total of 83 maltreatment related near fatalities from calendar year 2013-2016. During this period, child neglect caused slightly more near fatalities than physical abuse (37.3 percent and 32.5 percent respectively).

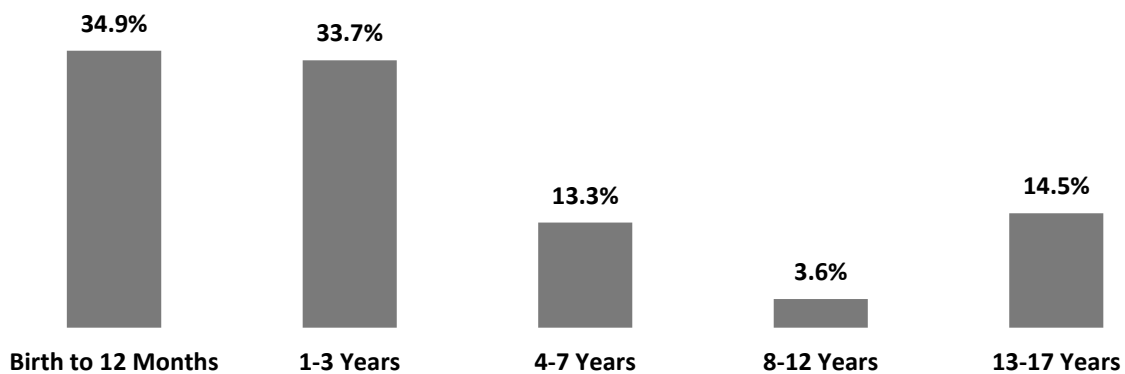
Figure 9: **Maltreatment Related Child Near Fatalities, 2013-2016**
(n = 83)



CHILD'S AGE AT TIME OF NEAR FATALITY

Over two-thirds of the 83 maltreatment related near fatalities examined by OFCO from 2013 to 2016 involved children under the age of three years old. Very few near fatality incidents involved children eight to twelve years of age. While the majority of infant fatalities were related to unsafe sleep practices, only 17 percent of near fatalities were. One-quarter (25 percent) of infant near fatalities resulted from neglect and 46 percent from physical abuse. Attempted suicide is the leading cause of near fatal incidents in teenagers: of the twelve near fatalities of children ages 13 – 17 years, two thirds were suicide attempts.

Figure 10: **Child Age at Time of Near Fatality, 2013-2016**
(n = 83)



EXAMPLES OF NEAR FATALITIES

Abusive Head Trauma

A six month old infant presented at the hospital with new and old bleeding in the head at various stages. The infant was determined to have suffered cardiac arrest, swelling in the brain, blood clots, and retinal bleeding. Medical providers believed these injuries were highly concerning for abusive head trauma, previously referred to as "Shaken Baby Syndrome". While the infant survived this event, he now has life changing medical needs and limitations from it. Circumstances of the near fatal incident were referred to CPS and accepted for investigation. It was found that the injuries most likely occurred while the child was in the parents' care. Perhaps due to difficulty pinpointing exactly who caused the injuries, the Department was unable to make a finding for physical abuse on the parents but did make a finding for neglect.

The parents did not have recent history with the Department, however the near fatality came to OFCO's attention because the child's daycare provider was also a licensed foster parent. The child was in the day care provider/foster parent's care at the time of the incident and was initially investigated as a possible perpetrator of the abuse. Law enforcement later ruled the licensed provider out as a suspect.

Methadone Ingestion

A two year old child was taken to the emergency room, presenting with respiratory failure. The child tested positive at the hospital for methadone, the cause of the respiratory failure. The mother was enrolled in methadone maintenance treatment, as was her roommate. Medical providers said that event would have been fatal had the child not received timely medical care.

The referral from the hospital was accepted for CPS investigation. The CPS investigation determined that the allegation of neglect was founded as to the mother. A referral made on the family eight months prior was accepted for a CPS-Risk Only response. The hospital reported that the mother gave birth to an infant who was showing signs of withdrawal from methadone.

Near Drowning in Bathtub

A nineteen month old child was brought to the hospital following a near drowning in the family home. A bathtub was left filled with water. At some point during the day the family realized the child was missing. The child was then found fully clothed, face down in the bathtub.

The circumstances of the incident were referred to and accepted for CPS investigation. The CPS investigation determined that the allegation of neglect on the mother was founded because the mother had not supervised the young child near running water. The family's history with the Department included an information only referral (screened out as it did not meet the criteria for investigation) that alleged possible neglect and physical abuse by the mother towards a teenage child in her care.

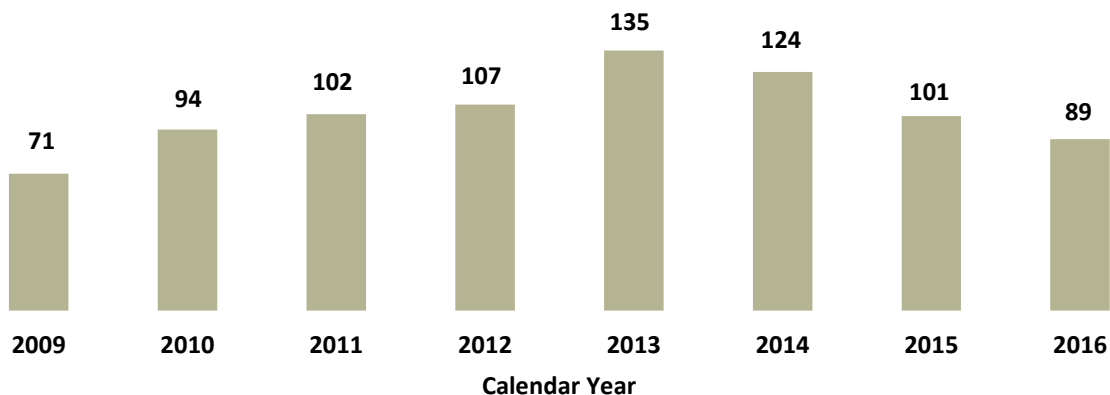
RECURRENT MALTREATMENT

CA is required to notify OFCO of all families or children who experience three or more founded reports³⁵ of abuse or neglect in the last twelve months.³⁶ This notification enables OFCO to review cases involving chronic child maltreatment and intervene as needed. A close review of recurrent maltreatment cases can indicate whether Washington’s child welfare system is effectively reducing the recurrence of child maltreatment, and inform practice to further reduce this problem.³⁷

OFCO began receiving these notifications in mid-2008. The number of cases meeting this criterion steadily increased from 2009 through 2013 but decreased every year since. In the first couple years the Department began sending notices, CA also transitioned to a new electronic records keeping system. The lower number of recurrent maltreatment notifications in the onset may have been due to notification process errors rather than a steady increase over the years in recurrent maltreatment cases.

Governor Inslee’s *Results Washington* initiative brings increased attention to recurrent maltreatment. A leading indicator under Goal 4 of this initiative, to build “Healthy and Safe Communities”, is to decrease the percentage of children with a founded allegation of abuse or neglect who have a new founded allegation within twelve months, from 9.7% to 6% by July 31, 2017.³⁸ Although this is a slightly different measure than three or more founded reports within the last twelve months, the common goal is to reduce the number of children experiencing recurrent maltreatment in Washington.

Figure 11: **Number of Recurrent Maltreatment Notifications Made to OFCO, 2009-2016**
Calendar Year (January 1st – December 31st)



³⁵ “Founded” means the determination following an investigation by the Department that, based on available information, it is more likely than not that child abuse or neglect did occur - see RCW 26.44.020(8). In this context, “report” means a “referral” to Child Protective Services, which DSHS/CA calls an “intake.”

³⁶ RCW 26.44.030(13)

³⁷ “Repeat Maltreatment” was identified as an area needing improvement in the 2010 Washington State Child and Family Services Review (CFSR). The CFSR also noted that there has been a significant drop in re-victimization rates since 2005. *July 2010 State Assessment*.

³⁸ The initial goal was to decrease the percentage of children with founded allegations of abuse or neglect who have a new founded allegation within six months. It was recently changed to twelve months, excluding reports in the first 14 days. More information can be found at : <http://www.results.wa.gov/whatWeDo/measureResults/documents/communitiesGoalMap.pdf>

Neglect is by far the most common type of maltreatment recurrently experienced by children, comprising 72 percent of all founded reports reviewed by OFCO in 2016. Twenty-one percent of the founded reports were physical abuse allegations, and 6.5 percent were sexual abuse allegations. By the time OFCO received notice of the third founded report the Department had taken legal action to ensure the safety of the children in 76 percent of cases.³⁹

It is difficult to identify the precise factors driving these increases and decreases in recurrent maltreatment, but there are some factors that might be expected to affect the recurrence rates. All else equal, if the number of intakes made to CPS or the number of opened investigations and assessments increase, the number of founded allegations of abuse or neglect would be expected to increase as well. The number of opened investigations and assessments matches the trend seen in OFCO's recurrent maltreatment reviews. Investigations increased from 2009 through 2013 and then dropped in 2014 and 2015, the latest year data is available.⁴⁰

Some factors may inflate or deflate the number of founded findings and may not reflect the actual rate of abuse or neglect. For example, beginning in 2014, a differential response system, Family Assessment Response (FAR), was incrementally implemented across the state. As of June 2017, all offices have implemented FAR. In FAR cases, while CPS still conducts a comprehensive assessment of child safety, an administrative finding as to whether child abuse or neglect occurred is not made. With the full implementation of FAR, all else being equal, the number of cases screening in for a CPS investigation resulting in a finding of child maltreatment would be expected to decrease.

³⁹ The legal status of the children involved in the recurrent maltreatment cases was either in shelter care status or dependency.

⁴⁰ Partners for Our Children, Data Portal. <http://partnersforourchildren.org/>

SECTION II

IMPLEMENTATION STATUS OF FATALITY AND NEAR FATALITY RECOMMENDATIONS

INTRODUCTION

The Department of Social and Health Services (DSHS) Children’s Administration (CA) conducts a child fatality review when the death of a child was suspected to be caused by child abuse or neglect, and the child was in the care of or receiving services from DSHS/CA at the time of death, or in the year prior.⁴¹ 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**⁴² who was in the care of or receiving services from the Department at the time of the incident or in the preceding twelve months.⁴³ Even if these criteria are not met, DSHS may conduct a review of any fatality or near fatality at its discretion, or at the request of OFCO.⁴⁴

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.⁴⁵ 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 CA staff, OFCO staff, and community professionals selected from diverse disciplines 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 records and files regarding the child or otherwise relevant to the review that have been produced or retained by the supervising agency.⁴⁶

⁴¹ See RCW 74.13.640. Prior to the passage of SHB 1105 in 2011, CA was required to review any unexpected deaths of children who were in the care of or receiving services from CA, or had received care or services in the last year. As amended, DSHS 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.

⁴² RCW 74.13.500 defines “near fatality” as “an act that, as certified by a physician, places the child in serious or critical condition.”

⁴³ 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.

⁴⁴ 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.

⁴⁵ See DSHS CA Operations Manual, Section 5200 at http://www.dshs.wa.gov/ca/pubs/mnl_ops/chapter5.asp#5200

⁴⁶ RCW 74.13.640(3)

DSSH must issue a report on child fatality review results within 180 days following the fatality, unless granted an extension by the Governor.⁴⁷ These reports are subject to public disclosure and must be posted on the Department’s public website. The Department is authorized to redact confidential information contained in these reports to protect the child’s privacy, as well as the privacy of siblings and any other information protected by law (e.g., HIPPA protected information).⁴⁸

In order to promote accountability and the consistent implementation of recommendations from fatality reviews, OFCO is required to issue an annual report to the Legislature on the implementation of recommendations issued by fatality review committees.⁴⁹ **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 CA between August 1, 2015 and June 29, 2016.⁵⁰ During this period, CA conducted reviews in the deaths of **13 children**⁵¹ and **eight** near fatalities.⁵² **Thirteen** fatality reviews resulted in **28 recommendations**, while the 8 near fatality reviews resulted in **13 recommendations**.

OFCO reviewed information provided by CA, and found that **78 percent of the recommendations were either completely implemented or in the process of implementation**, while 14.6 percent were considered, but not implemented. The majority of recommendations addressed statewide issues (63.4 percent). Thirty-four percent addressed local office concerns while only one recommendation was tailored to remedy regional concerns.

Table 3: 2015-2016 Child Fatality and Near Fatality Review Recommendations by Implementation Status and Targeted Organizational Level

(n=41)

	Number of Recommendations	Percent	Statewide (#)	Region (#)	Office (#)
Implemented	20	48.8%	14	1	5
In Process	12	29.3%	6	--	6
Considered, Not Implemented	6	14.6%	4	--	2
Status Unknown or Not Applicable to CA	3	7.3%	2	--	1

⁴⁷ Id.

⁴⁸ Individual child fatality reports are available at: www.dshs.wa.gov/ca/pubs/fatalityreports.asp.

⁴⁹ RCW 43.06A.110. OFCO reports are available at: www.ofco.wa.gov

⁵⁰ To allow the Department sufficient time to consider and implement fatality recommendations, child fatality reviews that occurred July 1, 2016 – December 31, 2016 are not included in this report. The implementation status of recommendations from fatality reviews occurring before July 2, 2015 are included in past OFCO reports and can be found at: <http://ofco.wa.gov/reports/>

⁵¹ Eleven of these reviews were executive child fatality reviews and two were internal reviews.

⁵² All eight reviews were internal reviews.

The most prominent topic areas identified by fatality recommendations were:

- **Training** for caseworkers, supervisors, or community professionals (39 percent of recommendations);
- **Casework practice**, including risk assessment and safety planning (36.6 percent of recommendations); and
- **Operations and administration**, including the processes, tools and technology used to administer services (19.5 percent of recommendations).

Part 1 of this report takes a closer look at recommendations concerning these three major themes.

Part 2 examines why certain recommendations were considered, but not implemented.

Part 3 discusses select recommendations worthy of further consideration and recommendations with notable implementation results.

MAJOR THEMES OF RECOMMENDATIONS

The majority of recommendations aimed to improve training, casework practice, or the Department’s processes for operating and administering services. Recommended training topics include: safety assessment and planning, casework and supervision skills, and chemical dependency. Recommendations regarding casework practice spanned a wide range of topic areas from collaborating with service providers, to internal consultation services, to assessing safety. Recommendations addressing operations and administration of services identified the need for easier mechanisms to share and receive information and request referrals across CA divisions. Recommendations targeting operations and administration of services appeared to be slightly more complicated to implement than those relating to casework practice and training.

Table 4: **2015-2016 Child Fatality and Near Fatality Review Recommendations by Topic**
(n=41)

Topic	Number	Percent
Provide Training <i>(Training on child safety)</i>	16 <i>(9)</i>	39.0%
Improve Casework Practice <i>(Internal practice consultation)</i>	15 <i>(7)</i>	36.6%
Operations and Administration	8	19.5%
Other	2	4.9%

A. TRAINING FOR CASEWORKERS, SUPERVISORS OR COMMUNITY PROFESSIONALS

Sixteen review recommendations (39%) address training issues for caseworkers, supervisors or other professionals involved with the child welfare system. Ten of these recommendations have been implemented and five are in the process of implementation. One recommendation was considered but not implemented with the reason given that the identified topic is already covered in existing trainings. The most prevalent training topics involved safety assessment and planning (nine recommendations). Other topics included social work practice and supervision skills and dealing with secondary trauma.

Child Safety – Nine recommendations identify the need for further training on assessing child safety and developing plans to ensure the safety of children in the home. Safety planning is a collaborative process between the family and the Department, as well as any other key extended family members, support persons, and community professionals involved with the family.

Common themes in child safety recommendations are:

- *Safety assessment and planning*: Six recommendations targeted this area of needed training for CA staff, and included assessing child safety when a parent is on Opiate Replacement Therapy or other substances, incorporating questions about mental health and chemical dependency use

into conversations with families, and expectations for comprehensive investigations. – *Five completed or in process; one considered but not implemented*

- *Family history*: Two recommendations addressed the need for staff to be proficient in working with the Department’s case management system to quickly and efficiently access a family’s historical CA case information. – *Completed*
- One review identified a need to remind caseworkers and care providers about water safety precautions. – *Completed*

Casework Practice and Supervision Skills – Five training recommendations related to social work practice skills and clinical supervision. Two of the recommendations were for specific local offices and training needs related to the Interstate Compact on the Placement of Children and working with and engaging tribal entities.⁵³ Other recommendations included reminding staff of timeframe requirements for home study and courtesy supervision requests; training on the difference between SUID and SIDS to inform investigations of unsafe sleep allegations; and supervisor training on child abuse and critical thinking. – *All completed or in process*

Other Trainings – One committee recognized the stress and trauma experienced by staff that have been exposed to critical incidents and wanted to make sure training was offered to help individuals deal with secondary trauma or “compassion fatigue” (*completed*). Another recommendation identified the need for training to identify when clients are receiving services from the Developmental Disabilities Administration (DDA). – *in process*

B. CASEWORK PRACTICE

Fifteen fatality and near fatality review recommendations sought to improve casework policies, procedures or practices. All but three of these recommendations are reported to be implemented or in the process of implementation. The remaining three were considered by CA but not implemented. While these recommendations touch on a wide range of topics, several were clustered in the following areas of practice:

Internal Practice Consultation – Seven casework practice recommendations addressed better use of the agency’s internal resources for consultation regarding case plans and other issues. CA was urged to remind and connect staff with practice consultants, regional medical consultants and other internal resources (four recommendations). Two recommendations focused on using practice consultants to clarify practice expectations with Family Voluntary Services cases. Communication issues between DLR and DCFS were discussed in one recommendation that sought to increase consultation with DLR when foster homes have more children in their homes than they are licensed for.

Safety Assessment and Planning – Five recommendations addressed the need for thorough child safety assessments and effective safety plans for families.

- *Engaging clients*: Two recommendations focused on providing clarification and identifying strategies for engaging families to assess child safety. – *Completed*

⁵³ Interstate Compact on the Placement of Children (ICPC) is a procedure for seeking placement and supervision for a child placed out of state. For more information see Practice and Procedures Guide, #5601.

- *Children ages 0-3: Two* recommendations specifically targeted the safety of children under the age of 3 years. One called for a requirement that cases alleging physical injuries to a child under three years of age be staffed with the area administrator prior to granting an extension of the time frame to see the child (*in process*). A recommendation focusing on safe sleep environments for infants placed in licensed homes was *considered but not implemented*.
- **One** recommendation addressed the need for a particular office to review strategies for obtaining necessary investigative reports from the critical incident in order to better assess the safety of the surviving children in the home. – *In process*

Multidisciplinary Collaboration -- **Three** recommendations related to improving collaboration with service providers to CA clients. Two recommendations addressed the need for improved communication with service providers – one targeted a specific office, recommending they seek weekly reports for clients participating in family treatment court (*completed*) and the other recommended guidelines for collaborating with DDA (*in process*). One recommendation called for access to identified experts to thoroughly and accurately assess parents with *chemical dependency*. – *Completed*

C. OPERATIONS AND ADMINISTRATION

Eight recommendations focused on the processes, tools and technology CA uses to deliver services to families. Two recommendations called for very specific changes to the Department’s case management system, while four others related to Department’s processes for assigning or transferring cases and making service referrals. One recommendation called for obtaining expanded access to background information to assess caregivers. Five of the recommendations were implemented or in the process of implementation. Two were considered but not implemented and the progress on one remains unknown at the time of writing.

Two recommendations were made that do not fall under CA’s jurisdiction and instead were aimed at community professionals. One fatality committee saw benefit to a Med-Con reaching out to a local hospital to conduct training on identifying child abuse and mandatory reporting. Another fatality committee recommended CA collaborate with law enforcement to consider criminal charges in child neglect cases. While CPS conducts its own investigation into allegations of neglect this is entirely separate from law enforcement investigations and decisions to file criminal charges.

REVIEW RECOMMENDATIONS CONSIDERED BUT NOT IMPLEMENTED

A handful of child fatality recommendations (n = 6, or just above fourteen percent) were not implemented.⁵⁴ OFCO examined each of these six recommendations to determine why they were not, as described below. Some of the recommendations were not implemented due to workload or other insufficient resources. In other instances, recommendations were made that were outside the scope and responsibility of the division it was aimed at. One recommendation was case specific and case circumstances had changed by the time the recommendation was reviewed.

Three of the six recommendations emanated from one fatality review, in which the committee identified concerns with DLR and trainings or resources made available to licensed care providers:

1. **Recommendation:** *“DLR should create a form for the licensed provider to sign stating each person applying for a home study has reviewed and understands the Period of Purple Crying and safe sleep instructions. This form must be signed and dated by each person included in the home study/license. DLR should also reconsider the training hours and how they are required per license. The Committee believes each person on a license should receive training at some point during the time they are licensed.”*

Agency Response: “Home study workers are [already] expected to provide information to caregivers intending to care for infants, and document this conversation in the home study. Information on safe sleep has also been added to the caregiver core curriculum for licensed providers. CA considered requiring each caregiver to complete training during the licensing period, during development of the training policy. Given the shortage of homes, this was seen as a barrier to licensing and retention.”

2. **Recommendation:** *“The Committee identified consistent overcapacity situations occurring with this specific foster family and a failure to engage DLR prior to those decisions occurring. This led to the Committee’s recommendation that if an overcapacity is considered during business hours, DLR and all assigned social workers (i.e. primary, courtesy supervision, licensor, etc.) must be consulted prior to the placement occurring. If the placement occurs afterhours, DLR and all assigned social workers must be consulted and provide approval for ongoing placement by the end of the following business day.”*

Agency Response: “DLR currently has expectations for consultation related to overcapacity. It seems that this is not a DLR function, but a DCFS function to staff with DLR.”

3. **Recommendation:** *“CA should identify a concise, clear path for who should share information with out-of-home care providers regarding supportive services, such as grief and loss counseling, and have a clear and consistent way for the payments to occur even if there are no children placed in the home.”*

⁵⁴ All near fatality recommendations were either implemented or were in process.

Agency Response: “This is outside the scope for DLR, who has no availability to pay for services.”

The remaining recommendations that were not implemented emanated from two different fatality reviews:

4. **Recommendation:** *“CA should continue to pursue integrating the courtesy supervision referral and home study request processes in FamLink so that there is connection to the case management system that is easily reviewed and tracked electronically.”*

Agency Response: “A FamLink change request was submitted but not prioritized for approval.”

5. **Recommendation:** *“CA should procure training for all case-carrying staff regarding opiate replacement therapy. The training should address how child safety is assessed through the life of a case while a parent is on an Opiate Replacement Therapy.”*

Agency Response: “This should be incorporated into substance abuse training and assessing safety.”

6. **Recommendation:** *“The Committee believed that the medical examiner’s report raised the possibility of risk of neglect by the parent and that further evaluation is needed to assess the safety of the surviving children. The Committee made the following suggestions as possible strategies for the local CA office to consider in order to obtain needed investigative reports.*
 - a. *Contact the prosecuting attorney to obtain an updated copy of the investigative protocol, and ensure that law enforcement agencies who are within this office’s catchment area have a copy.*
 - b. *Consider consultation with the Attorney General’s Office to elicit its advocacy to obtain reports needed to assess child safety.*
 - c. *Consider working with local law enforcement agencies within the office’s catchment area to develop a memorandum of understanding regarding the exchange of information.”*

Agency Response: “Not implemented due to children already placed [out of home].”

DISCUSSION OF SELECT REVIEW RECOMMENDATIONS

A. RECOMMENDATIONS RESULTING IN SUBSTANTIVE POLICY AND PRACTICE CHANGES

The implementation of several fatality review recommendations resulted in tangible and significant changes in policy and practice. These recommendations were notable for their clarity and the Department's practical implementation.

1. **Recommendation:** *"The Committee noted areas of strong local office practice when co-assigning cases between CPS and FVS but also heard from staff that they would like to see additional clarification and guidance from Program and Policy about co-assignment responsibilities, role clarification and practice expectations for FVS."* – Completed

Implementation: "Specific FVS policy developed and rolled out."⁵⁵

The FVS policy clarifies which cases are assigned to FVS and what the supervisor and caseworker roles and responsibilities are.

2. **Recommendation:** *"When an intake is assigned that includes alleged injuries to a child under three years of age and that requires an extension or exception to meeting the face-to-face timeframe, the case should be staffed with the area administrator prior to granting the extension. This staffing should be documented in a case note."*

Implementation: "CA Program and Policy Division will seek to modify policy disallowing any IFF extensions for children 0-3 years old when physical or sexual abuse allegations have been made." – In Process

3. **Recommendation:** *"The Committee recommends that CA continue its current efforts to streamline the courtesy supervision process, to reduce delays in courtesy supervision case assignment, and to make clear the division of duties and required communications between the sending and receiving offices."*

Implementation: "Courtesy supervision referral form was streamlined and implemented – rolled out in July, 2016." – Completed

⁵⁵ See Practices and Procedures Guide: <https://www.dshs.wa.gov/ca/practices-and-procedures-guide/3000-family-voluntary-services>

4. **Recommendation:** *“The Committee recommended that CA provide training to staff about the difference between SUID⁵⁶ and SIDS⁵⁷ and continue to develop practice guidelines for the investigation of unsafe sleep allegations with parents who are suspected of substance abuse.”*

Implementation: *“Safety Bootcamp rolled out statewide in April, 2016 and completed October, 2016. Subsequent training to be offered in each region on an on-going basis by quality practice specialists and Alliance.” – Completed*

5. **Recommendation:** *“CA has removed the mandatory usage of the GAIN-SS tool in CPS assessments. The expectation was that staff would incorporate the areas of mental health (to include suicidal ideation) and chemical dependency use in their assessment process. The Committee recommends CA provide training for case carrying staff on how to incorporate those questions into their contact with families, including youth. CA should consider making this training mandatory. It should be noted that prior to this review, the office was working with the regional practice consultation team to provide trainings to staff regarding assessments, how to ask the difficult questions and incorporation of the GAIN-SS questions into the gathering questions.”*

Implementation: *“Workload Reduction Task force has created a new CPS assessment for use in investigations and FAR. This assessment incorporates the SDM questions with the gathering questions from the Safety Framework to strengthen the assessment and connect risk and safety.” – Completed*

6. **Recommendation:** *“CA should develop ongoing supervisor training to discuss the dynamics of child abuse, working with community partners and critical thinking. This training should include all supervisors regardless of how long they have been employed by CA.”*

Implementation: *“Supervisor core training implemented in [fiscal year] 2016. All supervisors have attended training.” – Completed*

B. IMPROVED COLLABORATION AND CASEWORK PRACTICE AT THE LOCAL LEVEL

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

1. **Recommendation:** *“The Committee recommends that the CFWS unit (workers, supervisor and Area Administrator) involved in this case be provided additional learning and guidance regarding ICPC cases. The learning opportunity should focus on ICPC related issues identified in this report and should provide clarity as to roles, responsibilities, tasks and decision options related to ICPC that affected case actions. The Committee suggests that the curriculum for this training be developed with significant input from the CA Headquarters ICPC Unit. This would be additional to ICPC training already available statewide.” – In process, training is scheduled to be provided to the local office in June 2017*

⁵⁶ Sudden Unexpected Infant Death

⁵⁷ Sudden Infant Death Syndrome

2. **Recommendation:** “The [local] office should request the weekly Hope Court treatment reports. This would help document case activity and support decisions made by the assigned CA staff.” – *Completed*
3. **Recommendation:** “The Committee recommended that this unit receive training on how to access historic CA case information in MODIS.” – *Completed*
4. **Recommendation:** “The Committee recommended that the regional office identify a chemical dependency expert to help CA staff understand and interpret the results of evaluations and advocate for comprehensive services for their clients.” – *Completed*

C. RECOMMENDATIONS THAT LACK FOLLOW-THROUGH

Three recommendations from one near fatality review in August 2015 were reported by CA to be “in process” of implementation, with no details provided on the work being done or what the challenges to implementation may be. Two of the recommendations targeted a specific local office and one was suggested for social workers and supervisors statewide. These substantive and specific recommendations beg further information regarding CA’s plans to implement them (or not).

- **Recommendation:** “The Committee recommended that the [local office] DCFS social workers receive refreshed training on Washington state policy regarding service delivery to Indian children, placement preferences, and requirements for engaging tribal entities in case planning. The Committee recommended this be a very concise, abbreviated training specific to these issues and may even be addressed through distribution of memorandum to staff. Discussion of placement preferences should be included in monthly supervisory case reviews.”
- **Recommendation:** “The Committee recommended identification of a regional ICW expert with knowledge and experience in working with the [tribe] and court system, to serve as a practice consultant when working with ICW cases.”
- **Recommendation:** “When parental ambivalence toward the child could be a safety concern, social workers and supervisors should consider consultation with outside support such as regional practice consultant or program manager when developing transition or reunification plans.”

CONCLUSION

The work of the Executive Child Fatality and Near Fatality Review committees advance our understanding of the circumstances contributing to these tragedies and develop strategies to improve child health and safety, and to prevent deaths and injuries in the future. For example, the fatality and near fatality review process has provided valuable information regarding unsafe sleep environments and infant fatalities which has impacted child welfare practices and procedures and public awareness.

OFCO thanks the many professionals, both within CA and the broader child welfare community, for their participation in child fatality and near fatality reviews and their contributions to better protect children in Washington State.

APPENDICES

APPENDIX A:

Maltreatment Related Child Fatality Data

APPENDIX B:

Maltreatment Related Child Near Fatality Data

APPENDIX C:

Child Fatality and Near Fatality Review Recommendations
2015-2016

APPENDIX D:

The Role of OFCO

APPENDIX A: MALTREATMENT RELATED CHILD FATALITY DATA

Table 5: **Number of Maltreatment Related Child Fatalities per Year**

(n = 160)

	2013	2014	2015	2016
Clear Physical Abuse	4	6	5	3
Clear Neglect	13	7	8	10
Child Maltreatment Concerns	33	28	21	22

Table 6: **Manner of Death per Year**

(n = 159)

	2013	2014	2015	2016
Homicide	4	5	5	4
Accidental	21	16	8	11
Natural / Medical	11	13	14	7
Suicide	5	0	2	3
Unknown / Undetermined	9	7	5	9

The manner of death for one maltreatment related fatality in 2016 is unknown at the time of writing and is not included in the table above

Table 7: **Child Age at Time of Death per Year**

(n = 160)

	2013	2014	2015	2016
12 Months or Less	32	30	24	21
1-3 Years	4	6	3	7
4-7 Years	4	4	3	0
8-12 Years	3	0	1	1
13-17 Years	7	1	3	6

Table 8: Manner of Death by Age Group, 2013-2016

(n = 159)

Less than 12 months	#	%
Accidental	40	37.4%
Homicide	5	4.7%
Natural/Medical	36	33.6%
Suicide	0	0.0%
Unknown/Undetermined	26	24.3%

1 - 3 Years	#	%
Accidental	8	40.0%
Homicide	8	40.0%
Natural/Medical	0	0.0%
Suicide	0	0.0%
Unknown/Undetermined	4	20.0%

4 - 7 Years	#	%
Accidental	5	45.5%
Homicide	1	9.1%
Natural/Medical	5	45.5%
Suicide	0	0.0%
Unknown/Undetermined	0	0.0%

8 - 12 Years	#	%
Accidental	2	50.0%
Homicide	0	0.0%
Natural/Medical	2	50.0%
Suicide	0	0.0%
Unknown/Undetermined	0	0.0%

13 - 17 Years	#	%
Accidental	1	5.9%
Homicide	4	23.5%
Natural/Medical	2	11.8%
Suicide	10	58.8%
Unknown/Undetermined	0	0

Table 9: **Child Race and Ethnicity in Maltreatment Related Fatalities per Year**
 (n = 160)

Race and Ethnicity	2013	2014	2015	2016
American Indian or Alaska Native	6	2	1	7
Asian or Pacific Islander	2	1	3	1
African American	5	6	3	2
Caucasian	28	22	21	23
Multi-Racial	8	5	6	2
Other or Unknown	1	5	0	0
Latino / Hispanic	6	6	3	2

APPENDIX B: MALTREATMENT RELATED CHILD NEAR FATALITY DATA

Table 10: **Maltreatment Related Child Near Fatalities per Year**

(n = 83)

	2013	2014	2015	2016
Clear Neglect	7	4	11	9
Clear Physical Abuse	14	5	5	3
Child Maltreatment Concerns	9	10	2	4

Table 11: **Child Age at Time of Near Fatality per Year**

(n = 83)

	2013	2014	2015	2016
12 Months or Less	12	6	3	8
1-3 Years	11	4	7	6
4-7 Years	3	4	4	0
8-12 Years	0	0	2	1
13-17 Years	4	5	2	1

APPENDIX C: CHILD FATALITY AND NEAR FATALITY REVIEW RECOMMENDATIONS 2015-2016

The recommendations made by representatives from the community, OFCO and CA participating in child fatality and near fatality reviews are forwarded to a CA administrator or CA'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 was not implemented.

Listed below by topic are the 41 recommendations made in child fatality and near fatality reviews conducted from August 2015 through June 2016 and the implementation status for each recommendation. Recommendations that were considered and not implemented are also listed separately, with the Department's explanation why no further action was taken on the recommendation.

PROVIDE TRAINING	
<p><i>Safety</i> – CA has removed the mandatory usage of the GAIN-SS tool in CPS assessments. The expectation was that staff would incorporate the areas of mental health (to include suicidal ideation) and chemical dependency use in their assessment process. The Committee recommends CA provide training for case carrying staff on how to incorporate those questions into their contact with families, including youth. CA should consider making this training mandatory. It should be noted that prior to this review, the office was working with the regional practice consultation team to provide trainings to staff regarding assessments, how to ask the difficult questions and incorporation of the GAIN-SS questions into the gathering questions.</p>	<p>Status: Completed Level: Statewide</p>
<p><i>Safety</i> - The Committee recommended that the Department continue to provide training on the Child Safety Framework specifically aimed at assessing child safety. The Committee identified the need for training on the mechanics of childhood injuries, the importance of gathering information throughout the life of a case and guidance about how to assess caregivers when there are multiple adults in a caregiving role in the household.</p>	<p>Status: Completed Level: Statewide</p>

PROVIDE TRAINING

<p><i>Safety</i> – CA should provide a training to educate its staff on MedCon which should include when, why and how to use them. This training should also include skills training on how to converse with and professionally question a professional within the medical community regarding his or her assessment of a child or situation. An integral piece of the training should also include the dynamics of child abuse. This training should be offered every two years for all staff regardless of how long they have been employed by CA.</p>	<p>Status: Completed Level: Statewide</p>
<p><i>Safety</i> – The Committee recommended that this unit receive training on how to access historic CA case information in MODIS. Note: Action has already been taken on this identified training need for this unit.</p>	<p>Status: Completed Level: Local</p>
<p><i>Safety</i> – CA should look at ways to remind social work staff and placement providers about water safety precautions, particularly around the summertime swim season. This might include use of the Quick Tip to remind social workers to go over swimming safety with children and their caregivers. For both licensed and unlicensed caregivers, such reminders could be incorporated in the Caregiver Connection Monthly Newsletter that is available via the internet.</p>	<p>Status: Completed Level: Statewide</p>
<p><i>Safety</i> – CA should procure training for all case-carrying staff regarding opiate replacement therapy. The training should address how child safety is assessed through the life of a case while a parent is on an Opiate Replacement Therapy.</p>	<p>Status: Considered but not implemented Level: Statewide</p>
<p><i>Safety</i> – The Committee recommended that local office staff receive training about the key elements of a comprehensive investigation and about practice expectations for drug-exposed and drug-affected newborns including developing plans of safe care.</p>	<p>Status: In process Level: Local</p>
<p><i>Safety</i> – The Committee recommended that staff in this office seek training from regional program staff about how to collaborate with medical and mental health providers to develop effective aftercare and discharge plans with clients who are in inpatient settings.</p>	<p>Status: In process Level: Local</p>
<p><i>Casework Practice & Supervision Skills</i> – The Committee recommended that CA provide training to staff about the difference between SUID and SIDS and continue to develop practice guidelines for the investigation of unsafe sleep allegations with parents who are suspected of substance abuse.</p>	<p>Status: Completed Level: Statewide</p>

PROVIDE TRAINING

<p><i>Casework Practice & Supervision Skills</i> – CA Policy and Program staff develop and initiate “Quick Tip” practice suggestions to serve as reminders for staff regarding the timeframes for courtesy supervision and home study requests.</p>	<p>Status: Completed Level: Statewide</p>
<p><i>Casework Practice & Supervision Skills</i> – CA should develop ongoing supervisor training to discuss the dynamics of child abuse, working with community partners and critical thinking. This training should include all supervisors regardless of how long they have been employed by CA.</p>	<p>Status: Completed Level: Statewide</p>
<p><i>Casework Practice & Supervision Skills</i> – The Committee recommends that the CFWS unit (workers, supervisor and Area Administrator) involved in this case be provided additional learning and guidance regarding ICPC cases. The learning opportunity should focus on ICPC related issues identified in this report and should provide clarity as to roles, responsibilities, tasks and decision options related to ICPC that affected case actions. The Committee suggests that the curriculum for this training be developed with significant input from the CA Headquarters ICPC Unit. This would be additional to ICPC training already available statewide</p>	<p>Status: In process Level: Local</p>
<p><i>Casework Practice & Supervision Skills</i> – The Committee believes that staff need to be able to access important information in the historical file quickly and efficiently. They recommended that CA develop clear guidelines about electronic document storage so there is consistency about which documents are uploaded directly into FamLink and duplicative information is not put into MODIS.</p>	<p>Status: Completed Level: Statewide</p>
<p><i>Casework Practice & Supervision Skills</i> –The Committee recommended that the [local] DCFS social workers receive refreshed training on Washington state policy regarding service delivery to Indian children, placement preferences, and requirements for engaging tribal entities in case planning. The Committee recommended this be a very concise, abbreviated training specific to these issues and may even be addressed through distribution of memorandum to staff. Discussion of placement preferences should be included in monthly supervisory case reviews.</p>	<p>Status: In process Level: Local</p>
<p><i>Other</i> – Children's Administration should consider offering training in how to effectively deal with secondary trauma or compassion fatigue to offices whose staff have experienced critical incidents.</p>	<p>Status: Completed Level: Statewide</p>

PROVIDE TRAINING	
<p><i>Other</i> – The Committee recommended that CA train staff, either through memo or a “Practice Tip,” about how to use the FamLink system to recognize when their clients are receiving services from the Developmental Disabilities Administration (DDA).</p>	<p>Status: In process Level: Statewide</p>

CASEWORK PRACTICE	
<p><i>Practice Consultation</i> – The Committee noted areas of strong local office practice when co-assigning cases between CPS and FVS but also heard from staff that they would like to see additional clarification and guidance from Program and Policy about co-assignment responsibilities, role clarification and practice expectations for FVS.</p>	<p>Status: Completed Level: Statewide</p>
<p><i>Practice Consultation</i> - The Committee identified consistent overcapacity situations occurring with this specific foster family and a failure to engage DLR prior to those decisions occurring. This led to the Committee’s recommendation that if an overcapacity is considered during business hours, DLR and all assigned social workers (i.e. primary, courtesy supervision, licensor, etc.) must be consulted prior to the placement occurring. If the placement occurs afterhours, DLR and all assigned social workers must be consulted and provide approval for ongoing placement by the end of the following business day.</p>	<p>Status: Considered not implemented Level: Local</p>
<p><i>Practice Consultation</i> – The Committee recommended that the Region One Practice Consultant review with the staff in this office the benefits of conducting an FTDM when a family is not compliant with Family Voluntary Services.</p>	<p>Status: Completed Level: Local</p>
<p><i>Practice Consultation</i> – The Committee recommended that the assigned social worker consult with CA’s Regional Medical Consultant in order to better understand the terminology and findings in the medical examiner’s report.</p>	<p>Status: In process Level: Local</p>

CASEWORK PRACTICE

<p><i>Practice Consultation</i> – The Committee believed that when social workers are dealing with cases with extensive medical or mental health histories that are directly related to child safety, it is best practice to consult with a regional medical consultant for guidance about standards of care, safety and risk. The Committee recommended that CA develop a “Practice Tip” about this for staff</p>	<p>Status: In process Level: Statewide</p>
<p><i>Practice Consultation</i> – When parental ambivalence toward the child could be a safety concern, social workers and supervisors should consider consultation with outside support such as regional practice consultant or program manager when developing transition or reunification plans.</p>	<p>Status: In process Level: Statewide</p>
<p><i>Practice Consultation</i> – The Committee recommended identification of a regional ICW expert with knowledge and experience in working with the [tribe] and court system, to serve as a practice consultant when working with ICW cases.</p>	<p>Status: In process Level: Local</p>
<p><i>Safety Assessment & Planning</i> – Children's Administration needs to continue to clarify expectations for the FAR program regarding key elements relating to child safety. Those issues are: the confusion among CA staff that FAR workers need to ask the client’s permission to speak with collateral contacts, children and referrers; clarification about policy-supported reason for extensions on case closure; and the appropriateness of un-announced home visits in the context of the FAR program.</p>	<p>Status: Completed Level: Statewide</p>
<p><i>Safety Assessment & Planning</i> – DLR should create a form for the licensed provider to sign stating each person applying for a home study has reviewed and understands the Period of Purple Crying and safe sleep instructions. This form must be signed and dated by each person included in the home study/license. DLR should also reconsider the training hours and how they are required per license. The Committee believes each person on a license should receive training at some point during the time they are licensed.</p>	<p>Status: Considered not implemented Level: Statewide</p>

CASEWORK PRACTICE

<p><i>Safety Assessment & Planning</i> – The Committee believed that the medical examiner’s report raised the possibility of risk of neglect by the parent and that further evaluation is needed to assess the safety of the surviving children. The Committee made the following suggestions as possible strategies for the local CA office to consider in order to obtain needed investigative reports:</p> <ul style="list-style-type: none"> • Contact the prosecuting attorney to obtain an updated copy of the investigative protocol, and ensure that law enforcement agencies who are within this office’s catchment area have a copy. • Consider consultation with the Attorney General’s Office to elicit its advocacy to obtain reports needed to assess child safety. • Consider working with local law enforcement agencies within the office’s catchment area to develop a memorandum of understanding regarding the exchange of information. 	<p>Status: In process Level: Local</p>
<p><i>Safety Assessment & Planning</i> – When an intake is assigned that includes alleged injuries to a child under three years of age and that requires an extension or exception to meeting the face-to-face timeframe, the case should be staffed with the area administrator prior to granting the extension. This staffing should be documented in a case note.</p>	<p>Status: In process Level: Statewide</p>
<p><i>Safety Assessment & Planning</i> – CA should incorporate into the direct questioning of teen and adult clients as to whether or not they have thought of committing suicide within the last 30 days.</p>	<p>Status: Completed Level: Statewide</p>
<p><i>Multidisciplinary Collaboration</i> – The [local] office should request the weekly Hope Court treatment reports. This would help document case activity and support decisions made by the assigned CA staff.</p>	<p>Status: Completed Level: Local</p>
<p><i>Multidisciplinary Collaboration</i> – The Committee recommended that the regional office identify a chemical dependency expert to help CA staff understand and interpret the results of evaluations and advocate for comprehensive services for their clients.</p>	<p>Status: Completed Level: Regional</p>
<p><i>Multidisciplinary Collaboration</i> – The Committee recommended that CA provide guidance to staff about best practice guidelines for collaboration with DDA, including accessing client assessments and services and the importance of including DDA workers in Family Team Decision Making Meetings (FTDM) and permanency planning hearings.</p>	<p>Status: In process Level: Statewide</p>

OPERATIONS AND ADMINISTRATION

<p><i>Case Assignment or Service Referrals</i> – The Committee recommended that the [local] office create a case transfer process that includes the presence of both the sending and receiving worker and supervisor.</p>	<p>Status: Completed Level: Local</p>
<p><i>Case Assignment or Service Referrals</i> – The Committee recommends that CA continue its current efforts to streamline the courtesy supervision process, to reduce delays in courtesy supervision case assignment, and to make clear the division of duties and required communications between the sending and receiving offices.</p>	<p>Status: Completed Level: Statewide</p>
<p><i>Background Checks</i> – Noting that one of the challenges in this case was that the relatives did not cooperate with efforts to conduct background checks, the Committee recommended that the Department expand worker access to databases like LexisNexis so that more workers can use this to assess caregivers in cases where program restrictions do not allow access to NCIC.</p>	<p>Status: Completed Level: Statewide</p>
<p><i>Case Assignment or Service Referrals</i> – The Committee noted that the Richland CA office form used for chemical dependency referrals is out-of-date and that the referral process is inconsistent throughout the office. The Committee recommended the office consider using a LEAN or other CQI process to update their referral process for chemical dependency evaluations and treatment to insure accuracy and consistency from staff when requesting chemical dependency evaluations from their clients.</p>	<p>Status: Completed Level: Local</p>
<p><i>Supporting Care Providers</i> – CA should identify a concise, clear path for who should share information with out-of-home care providers regarding supportive services, such as grief and loss counseling, and have a clear and consistent way for the payments to occur even if there are no children placed in the home.</p>	<p>Status: Considered not implemented Level: Statewide</p>
<p><i>Case Assignment or Service Referrals</i> – CA should continue to pursue integrating the courtesy supervision referral and home study request processes in FamLink so that there is connection to the case management system that is easily reviewed and tracked electronically.</p>	<p>Status: Considered not implemented Level: Statewide</p>
<p><i>Case Assignment or Service Referrals</i> – The Committee recognized the emotional challenges faced by workers who deal with child fatalities and recommended that the local office explore the possibility of assigning fatality investigations to workers who were not assigned to the case at the time of the child’s death.</p>	<p>Status: Unknown Level: Statewide</p>

OPERATIONS AND ADMINISTRATION

Case Management System – When a child in an out-of-home placement is adopted, CA should have a mechanism to update the member tab. This mechanism needs to ensure that the appropriate household composition is reflected on the member page. This will aid in decreasing erroneous overcapacity situations.

Status: In process
Level: Statewide

PARTNERSHIPS WITH COMMUNITY PROFESSIONALS

Law Enforcement – In cases where there is extensive history indicating neglect, the Committee recommended that CA consider collaborating with local law enforcement for consideration of criminal charges of child neglect.

Status: N/A to
Children’s
Administration

Medical Professionals – The Committee believes that a MedCon should reach out to [local hospital] to conduct child abuse identification and subsequent mandatory reporter training.

Status: N/A to
Children’s
Administration

APPENDIX D: THE ROLE OF OFCO

The Washington State Legislature created the Office of the Family and Children’s Ombuds⁵⁸ (OFCO) in 1996 in response to two high profile incidents that indicated a need for oversight of the child welfare system.⁵⁹ OFCO provides citizens an avenue to obtain an independent and impartial review of Department of Social and Health Services (DSHS) decisions. OFCO is also empowered to intervene to induce DSHS to change problematic decisions that are in violation of the law or that have placed a child or family at risk of harm, and to recommend system-wide improvements to the Legislature and the Governor.

- **Independence.** One of OFCO’s most important features is independence. OFCO’s ability to review and analyze complaints in an independent manner allows the office to maintain its reputation for integrity and objectivity. Although OFCO is organizationally located within the Office of the Governor, it conducts its operations independently of the Governor’s Office in Olympia. OFCO is a separate agency from DSHS.
- **Impartiality.** The Ombuds acts as a *neutral investigator* and not as an advocate for individuals who file complaints, or for the government agencies investigated. This neutrality reinforces OFCO’s credibility.
- **Confidentiality.** OFCO must maintain the confidentiality of complainants and information obtained during investigations. This protection makes citizens, including DSHS professionals, more likely to contact OFCO and speak candidly about their concerns.
- **Credible review process.** OFCO has a credible review process that promotes respect and confidence in OFCO’s oversight of DSHS. Ombuds are qualified to analyze issues and conduct investigations into matters of child welfare law, administration, policy, and practice. OFCO’s staff has a wealth of collective experience and expertise in child welfare law, social work, mediation, and clinical practice and is trained in the United States Ombudsman Association Governmental Ombudsman Standards. OFCO and DSHS operate under an inter-agency agreement that guides communication between the two agencies and promotes accountability.⁶⁰

AUTHORITY

Under chapter RCW 43.06A, the Legislature enhanced OFCO’s investigative powers by providing it with broad access to confidential DSHS records and the agency’s computerized case-management system. It also authorizes OFCO to receive confidential information from other agencies and service providers,

⁵⁸ State law requires that all statutes must be written in gender-neutral terms unless a specification of gender is intended. Pursuant to Chapter 23 Laws of 2013, the term “ombudsman” was replaced by “ombuds”.
<http://apps.leg.wa.gov/documents/billdocs/2013-14/Pdf/Bills/Session%20Laws/Senate/5077-S.SL.pdf>

⁵⁹ The death of the three year old Lauria Grace, who was killed by her mother under the supervision of DSHS, and the discovery of years of sexual abuse between youths at the DSHS-licensed OK Boys Ranch. The establishment of the office also coincided with the growing concerns about DSHS’s role and practices in the Wenatchee child sexual abuse investigations.

⁶⁰ The inter-agency agreement is available online at http://ofco.wa.gov/documents/interagency_ofco_dshs.pdf

including mental health professionals, guardians ad litem, and assistant attorneys general.⁶¹ OFCO operates under a shield law which protects the confidentiality of OFCO's investigative records and the identities of individuals who contact the office. This encourages individuals to come forward with information and concerns without fear of possible retaliation. Additional duties have been assigned to OFCO by the Legislature over the years regarding the reporting and review of child fatalities, near fatalities, and cases of children experiencing recurrent maltreatment.⁶²

OFCO derives influence from its close proximity to the Governor and the Legislature. The Director is appointed by and reports directly to the Governor. The appointment is subject to confirmation by the Washington State Senate. The Director-Ombuds serves a three-year term and continues to serve in this role until a successor is appointed. OFCO's budget, general operations, and system improvement recommendations are reviewed by the Legislative Children's Oversight Committee.

WORK ACTIVITIES

OFCO performs its statutory duties through its work in four areas, currently conducted by *6.8 full time employees*:

- **Listening to Families and Citizens.** Individuals who contact OFCO with an inquiry or complaint often feel that DSHS or another agency is not listening to their concerns. By listening carefully, the Ombuds can effectively assess and respond to individual concerns as well as identify recurring problems faced by families and children throughout the system.
- **Responding to Complaints.** The Ombuds impartially investigates and analyzes complaints against DSHS and other agencies. OFCO spends more time on this activity than any other. This enables OFCO to intervene on citizens' behalf when necessary, and accurately identify problematic policy and practice issues that warrant further examination. Impartial investigations also enable OFCO to support actions of the agency when it is unfairly criticized for properly carrying out its duties.
- **Taking Action on Behalf of Children and Families.** The Ombuds intervenes when necessary to avert or correct a harmful oversight or mistake by DSHS or another agency. Typical interventions include: prompting the agency to take a "closer look" at a concern, facilitating information sharing, mediating professional disagreements, and sharing OFCO's investigative findings and analyses with the agency to correct a problematic decision. These interventions are often successful in resolving legitimate concerns.
- **Improving the System.** Through complaint investigations and reviews of critical incidents (including child fatalities, near fatalities, and cases of children experiencing recurrent maltreatment), OFCO works to identify and investigate system-wide problems, and publishes its findings and recommendations in public reports to the Governor and the Legislature. This is an effective tool for educating state policymakers and agency officials about the need to create, change or set aside, laws, policies or agency practices so that children are better protected and cared for and families are better served by the child welfare system.

⁶¹ See also RCW 13.50.100(6).

⁶² See RCW 74.13.640(1) (b); 74.13.640(2); and 26.44.030(15).