Washington State Department of Social and Health Services

Transforming Lives

REPORT TO THE LEGISLATURE

Quarterly Child Fatality Report

RCW 74.13.640

January –March 2018

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Washington State Department of Social & Health Services
Transforming lives

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Executive Summary

This is the Quarterly Child Fatality Report for January through March 2018 provided by the Department of Social and Health Services (DSHS) to the Washington State Legislature. RCW 74.13.640 requires DSHS to report on each child fatality review conducted by the department and provide a copy to the appropriate committees of the legislature:

Child Fatality Review — Report

(1)(a) The department shall conduct a child fatality review in the event of a fatality suspected to be caused by child abuse or neglect of any minor who is in the care of the department or a supervising agency or receiving services described in this chapter or who has been in the care of the department or a supervising agency or received services described in this chapter within one year preceding the minor's death.

(b) The department shall consult with the office of the family and children's ombudsman to determine if a child fatality review should be conducted in any case in which it cannot be determined whether the child's death is the result of suspected child abuse or neglect.

(c) The department shall ensure that the fatality review team is made up of individuals who had no previous involvement in the case, including individuals whose professional expertise is pertinent to the dynamics of the case.

(d) Upon conclusion of a child fatality review required pursuant to this section, the department shall within one hundred eighty days following the fatality issue a report on the results of the review, unless an extension has been granted by the governor. A child fatality review report completed pursuant to this section is subject to public disclosure and must be posted on the public web site, except that confidential information may be redacted by the department consistent with the requirements of RCW 13.50.100, 68.50.105, 74.13.500 through 74.13.525, chapter 42.56 RCW, and other applicable state and federal laws.

(2) In the event of a near fatality of a child who is in the care of or receiving services described in this chapter from the department or a supervising agency or who has been in the care of or received services described in this chapter from the department or a supervising agency within one year preceding the near fatality, the department shall promptly notify the office of the family and children's ombuds. The department may conduct a review of the near fatality at its discretion or at the request of the office of the family and children's ombuds.

In April 2011, SHB 1105 was passed by the legislature and signed into law by Governor Gregoire. The revised child fatality statute (RCW 74.13) became effective April 22, 2011 and requires the department to conduct fatality reviews in cases where a child death is suspected to be caused by abuse or neglect. This eliminated conducting formal reviews of accidental or natural deaths unrelated to abuse or neglect. The revised statute requires the department to consult with the Office of Family and Children's Ombuds (OFCO) if it is not clear that the fatality was caused by abuse or neglect. The department can conduct reviews of near-fatalities or serious injury cases at the discretion of the department or by recommendation of OFCO. The statutory revision allows the department access to autopsy and post mortem reports for the purpose of conducting child fatality reviews.

This report summarizes information from completed reviews of four (4) child fatalities and one (1) near fatality that occurred in the first quarter of 2018. All child fatality review reports can be found on the DSHS website: https://www.dshs.wa.gov/ca/publications/childrens-administration-child-fatality-reports

The reviews in this quarterly report include child fatalities and a near fatality from all three regions.

Region	Number of Reports
1	2
2	2
3	1
Total Fatalities and Near-Fatalities Reviewed During 1st Quarter 2018	5

This report includes Child Fatality Reviews conducted following a child's death that was suspicious for abuse and neglect and the child had an open case or received services from the Children's Administration (CA) within 12 months of his/her death or injury. A critical incident review consists of a review of the case file, identification of practice, policy or system issues, recommendations and development of a work plan, if applicable, to address any identified issues. A review team consists of a larger multi-disciplinary committee including community members whose professional expertise is relevant to the family history. The review committee members may include legislators and representatives from the Office of the Family and Children's Ombuds.

The charts below provide the number of fatalities and near-fatalities reported to CA and the number of reviews completed and those that are pending for calendar year 2018. The number of pending reviews is subject to change if CA discovers new information through reviewing the case. For example, CA may discover that the fatality or near-fatality was anticipated rather than unexpected, or there is additional CA history regarding the family under a different name or spelling.

Child Fatality Reviews for Calendar Year 2018			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2018	4	0	4

Child Near-Fatality Reviews for Calendar Year 2018			
Year	Total Near-Fatalities Reported to Date Requiring a Review	Completed Near-Fatality Reviews	Pending Near-Fatality Reviews
2018	1	0	1

The child fatality reviews referenced in this Quarterly Child Fatality Report are subject to public disclosure and is posted on the DSHS website.
https://www.dshs.wa.gov/ca/publications/childrens-administration-child-fatality-reports

Near-fatality reports are not subject to public disclosure and are not posted on the public website and are not included in this report.

Notable First Quarter Findings

Based on the data collected and analyzed from the four (4) fatalities and one (1) near fatality during the 1st quarter, the following were notable findings:

- Three (3) of the five (5) cases referenced in this report were open at the time of the child's death.
- All four (4) of the child fatalities in this report resulted from infants dying in unsafe sleep environments.
- Safe sleep was discussed with the parents, prior to the death of their children, in all of the cases involving infants who died in unsafe sleep environments.
- In the four (4) fatality cases, medical examiners were unable to determine the cause of death. However, all cases the child's death were highly suspicious for abuse or neglect. Three (3) of the CPS investigations into the children's deaths were closed with founded findings. In all of these cases, the children died in unsafe sleep environments.
- The near fatality case involved an infant who sustained a serious head injury after being dropped by her mother.
- All of the children referenced in this report were 10 months old or younger when the fatality or near fatal incident occurred.
- Three (3) of the five (5) cases referenced in this report were the result of abuse or neglect by the children's parents or caregivers.
- Four (4) children referenced in this report were African-American and one (1) was Caucasian.
- Children's Administration received intake reports of abuse or neglect in the each of the cases in this report prior to the death or near fatal injury of the child. In one (1) of the fatality cases, there were 18 prior intakes reported to CA prior to the fatality; in the other fatality cases, there was one (1), two (2) and four (4) intakes prior to the children's deaths. In the one (1) near fatality case, there was one (1) intake on the family prior to the near fatal injury incident.
- Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

Child Fatality Review

L.R.

RCW 74.13.515 2016
Date of Child's Birth

October 16, 2017
Date of Fatality

February 1, 2018
Child Fatality Review Date

Committee Members
Elizabeth Bokan, Ombuds, Office of the Family and Children's Ombuds
Jenna Kiser, M.S.W, Intake, Safety and Domestic Violence Program Manager, Children's Administration
Joshua Jewell, Supervisor, Children's Administration
Debi Keenan, King County Court Appointed Special Advocate

Observers
Esther Shin-Kirkendall, Central Intake Area Administrator, Children's Administration
Tom Soule, Central Intake Supervisor, Children's Administration

Facilitator
Libby Stewart, Critical Incident Review Specialist, Children's Administration

Executive Summary

On February 1, 2018, the Department of Social and Health Services (DSHS or Department), Children's Administration (CA) convened a Child Fatality Review (CFR)[1] to assess the Department's practice and service delivery to L.R. and RCW 74.13.515 family.[2] The child will be referenced by RCW 74.13.515 initials in this report.

On October 16, 2017, CA received an intake stating L.R. had passed away. L.R.'s mother reported she placed RCW 74.13.515 face down on the bed where she was also sleeping. She woke in the morning to find her son unresponsive. The referent reported that the mother's statements regarding the death were inconsistent, but no additional detail was provided by the referent. Law enforcement was present at the scene but did not place L.R.'s surviving sibling into protective custody. At the time of L.R.'s death, RCW 74.13.515 lived with RCW 74.13.515 mother and older sister. CA closed a Family Voluntary Services (FVS) case on September 19, 2017, after the mother completed services.

The Child Fatality Review Committee (Committee) included members selected from diverse disciplines within the community with relevant expertise including individuals from the Office of the Family and Children's Ombuds, a Court Appointed Special Advocate (CASA) as well as child welfare. There were two observers from CA. Neither the Committee members nor observers had previously been involved with or had contact with this family.

Prior to the review, each Committee member received a case chronology, a summary of CA involvement with the family and unredacted CA case documents (e.g., intakes, investigative assessments and case notes). Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included relevant state laws and CA policies.

The Committee interviewed a Child Protective Services (CPS) supervisor, the FVS worker and the FVS worker's supervisor during the last round of FVS services.

Family Case Summary

The CA case history for this family includes ten intakes received between May 2010 and February 2013 pertaining to the mother's first child. The majority of allegations in those ten intakes were regarding RCW 13.50.100. On February 24, 2016, and June 8, 2016, CA received intakes regarding L.R.'s sister. The allegations in these two intakes included RCW 13.50.100 by the

[1] Given its limited purpose, a Child Fatality Review (CFR) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the near death of a child. The CFR Committee's review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers. The committee has no subpoena power or authority to compel attendance and generally only hears from DSHS employees and service providers. It does not hear the points of view of the child's parents and relatives, or of other individuals associated with the child. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's fatal injury. Nor is it the function or purpose of a Child Fatality Review to recommend personnel action against DSHS employees or other individuals.

[2] L.R.'s family members are not named in this report because they have not been charged in an accusatory instrument with committing a crime related to a report maintained by the department in its case and management information system. [Source-Revised Code of Washington 74.13.500(1)(a)]

mother to [redacted] RCW 13.50.100 [redacted], concerns regarding the mother's [redacted] RCW 13.50.100 as well concerns about the [redacted] RCW 13.50.100 [redacted].

There was a CPS investigation pertaining to the February 24, 2016, intake as to L.R.'s sister, which resulted in the mother agreeing to work voluntarily with CA. During the time that the FVS case was open the mother and L.R.'s sister [redacted] RCW 13.50.100 [redacted]. There were multiple other service providers from other agencies working to support the mother and her child. The FVS worker referred the mother for Family Preservation Services (FPS).[3] After the completion of the FPS services the case closed in July of 2016.

Another intake was received on February 8, 2017. The intake alleged the mother was living with her two children, an RCW 74.13.515 old daughter and a RCW 74.13.515 -old son, L.R. The allegations included neglect and lack of supervision. A CPS/Family Assessment Response (FAR) worker was assigned to complete an assessment.[4]

During that assessment, another intake was received on March 21, 2017. The intake alleged neglect, concerns for bed sharing and concerns that the mother is depressed but noted the mother has had some appropriate interactions with the children and is working with a housing advocate. This intake was screened in for a CPS/FAR assessment.

On April 6, 2017, three more intakes were received. These intakes had new allegations of neglect including leaving her children unattended in the emergency shelter, bed sharing and RCW 13.50.100 of L.R.'s sister. Two of the intakes were screened in for CPS investigation.

The mother was referred to and engaged with FPS, housing advocates and was attending school. Collateral contacts provided positive feedback and did not identify any safety threats to the children. The mother failed to attend a family team decision making meeting but she did ultimately accept an offer to engage again in FVS.

There was a staffing to discuss whether it was appropriate to legally intervene and possibly remove the children. A determination was made that based on the mother's willingness to engage in voluntary services, that legal intervention was not appropriate at that time.

During the second round of FVS, another intake was received and screened out. The intake on June 1, 2017, did not provide any current allegations of child abuse or neglect and was therefore closed at screening. On September 19, 2017, CA closed the FVS case. Prior to the closure, the mother obtained independent housing, engaged in services with a public health

[3] Family Preservation Services, http://apps.leg.wa.gov/RCW/default.aspx?cite=74.14C.010, Definitions (3)a, b, c

[4] Family Assessment Response (FAR) is a Child Protective Services (CPS) alternative response to an investigation of a screened-in allegation of child abuse or neglect. FAR focuses on child safety along with the integrity and preservation of the family when lower risk allegations of child maltreatment have been reported.

nurse, was connected to Women Infants and Children (WIC), the children were up to date with medical care and the mother was involved with a local church for added support. Before the case was closed, the FVS worker discussed safe sleeping and risks of bed sharing with the mother on multiple occasions.

On October 16, 2017, CA received a call from the Medical Examiner's office indicating L.R. had passed away. The details surrounding the events of that evening were inconsistent. Law enforcement was notified and on scene but did not place L.R.'s sister in protective custody. CA RCW 13.50.100 for L.R.'s sister shortly after L.R.'s death, and the RCW 13.50.100 She was placed in relative care.

Committee Discussion

For purposes of this review, the Committee mainly focused on case activity from the time L.R. was born until he passed away. The Committee discussed the CA case file content prior to L.R.'s birth, but the focus of the review was to evaluate the contact and service delivery to the family between the birth and passing of L.R.

During the RCW 13.50.100 as to the mother's oldest child, there was mention of the mother having RCW 74.13.520 The Committee speculated that further assessment and corroboration regarding this medical condition may have assisted CA in understanding the mother's stability and ability to make adequate parenting decisions regarding her children. Fully understanding how untreated or inconsistent treatment of RCW 74.13.520 can affect the cognitive stability of a parent may be beneficial when assessing for child safety.

There was a discussion that CA should have made increased collateral contacts to include relatives, fathers of the children and sharing information with mental health providers. The Committee speculated that this may have provided a clearer understanding of the mother's needs regarding parent education and her ability to provide safe and adequate care for her children either independently or through a network of natural supports.

The Committee identified that the CA staff involved in this case provided good insight into what could have been done differently and had prepared well for the interviews. The professionalism, empathy and vulnerability shown by CA staff during this review was acknowledged by the Committee.

The Committee also identified that the FVS worker's continued discussion and education with the mother regarding safe sleep based on the eldest child's small size and bed sharing with the mother went above and beyond the expectations outline by CA's policies.

Findings

Based on the review of the case documents and interviews with staff, the Committee did not identify any critical errors that contributed to the death of L.R. The Committee did identify missed opportunities within the assessment and case work with this family as well as a systemic barrier to consistent supervision and case practice.

The Committee discussed that the history relating to the care that L.R.'s mother provided to children born before L.R. was not consistently included in decisions made regarding the safety of L.R. and RCW 74.13.515 sister. Had full inclusion of the history been considered, CA staff may have identified the need for more in-depth collateral contacts and corroboration of information provided by the mother regarding concerns for substance abuse and mental health needs and how those interacted with the mother's ability to safely care for her children. The Committee noted that the mother's prior **RCW 74.13.520** provided information regarding RCW 74.13.520 issues that were relevant to her ability to provide independent, safe care to children as well as **RCW 13.50.100** that could inform future engagement and service needs for the mother. By not including historical information and utilizing curiosity regarding the pattern of information shared in prior intakes, the CPS interventions became incident focused.

After reviewing the records and listening to the staff interviews, it appeared as though staff believed the mother was trying hard to make positive changes in her life, and staff focused on providing in-home services and supports. There were some concerns about confirmation bias and the workers trying so hard to support keeping the children in the mother's care that prior history was given less weight than current impressions of the mother. Her desire to complete college, obtain independent housing and employment as well as the mother's presentation to staff led staff to conclude that the mother had made significant improvements and could safely parent.

The Committee also identified that the consistent turnover of staff within CA, including the office involved in this review, is a systemic barrier to consistent supervision for field staff. The Committee discussed how newer staff need guidance and mentoring from established staff and/or supervisors, and this cannot occur if CA continues to have such a high staff turnover. Without consistent supervision and with large spans of supervision, the Committee discussed how staff are often not afforded sufficient time to discuss their assigned cases, which can lead to more incident-focused assessments and investigation as well as missed opportunities to provide comprehensive assessments of child safety.

Recommendations

CA should consider developing a training for both Assistant Attorney Generals (AAG's) and field offices regarding legal sufficiency for intervention, identification of safety threats, CA's Domestic Violence Guide and how it directs staff to interact with families when domestic violence is alleged or identified. This training could be a joint endeavor between CA and the Alliance and delivered to all CA and AAG field offices.

CA headquarters and the AAG's headquarters office should consider creating a training regarding communication between the staff of each agency when staffing cases for legal sufficiency, preparing for testimony and presentation and expectations at dependency hearings.

Nondiscrimination Policy
The Department of Social and Health Services does not discriminate and provides equal access to its programs and services for all persons without regard to race, color, gender, religion, creed, marital status, national origin, sexual orientation.

Washington State Department of Social & Health Services
CA Children's Administration

A.W.

RCW 74.13.500 2017
Date of Child's Birth

September 27, 2017
Date of Death

February 15, 2018
Child Fatality Review Date

Committee Members
Erin Summa, MPH, CPST-I, Mary Bridge Center for Childhood Safety, Health Promotion Coordinator
Mary Anderson Moskowitz, JD, Office of Family and Children's Ombuds
Janet Peterson, PHN 1, Tacoma-Pierce County Health Department, Strengthening Families, Nurse-Family Partnership
Robert Hamilton, MHA, CDP, MultiCare Behavioral Health Services, Substance Use Disorder Services Manager
Colette McCully, Children's Administration, Policy Manager

Facilitator
Bob Palmer, Children's Administration, Critical Incident Case Review Specialist

Executive Summary

On February 15, 2018, the Department of Social and Health Services, Children's Administration convened a Child Fatality Review (CFR)[5] to examine the department's practice and service delivery to RCW -month old A.W. and RCW 74.13.500 family.[6] The incident initiating this review occurred on September 27, 2017 when the mother, her boyfriend, A.W., and the child's toddler sibling took a nap together on a full size bed. When the adults awoke, they found A.W. unresponsive. Emergency responders called to the residence transported A.W. to a local hospital where continued resuscitation efforts were unsuccessful. Child Protective Services (CPS) had an open case at the time of the fatality. At the completion of the autopsy examination and post-mortem ancillary studies, the RCW 74.13.515 County Medical Examiner ascertained both cause and manner of death to be undetermined.

The CFR Committee included professionals with expertise in child and family advocacy, child abuse, child health and development, infant care and child safety and chemical dependency. None of the Committee members had any direct involvement with the family. In advance of the review, each Committee member received a summarized chronology of the family's CPS involvement. Also provided were un-redacted CA documents and law enforcement reports. Supplemental information and resource materials were available to the Committee at the time of the CFR, including RCW 74.13.515 County Medical Examiner's Office records.

During the review, the Committee interviewed two CA caseworkers and their supervisor; the current caseworker also gave a brief update on the case. Following review of the case record, staff interviews and discussion regarding department policies, activities and decisions, the Committee made several findings and recommendations presented at the end of this report.

Family Case Summary

CA first became aware of A.W. and RCW 74.13.500 family in RCW 74.13.500 2017, when A.W. and RCW 74.13.500 mother were admitted to a local hospital after the child's spontaneous

[5] Given its limited purpose, a Child Fatality Review should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The Child Fatality Review Committee's review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers. The Committee has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. It does not hear the points of view of a child's parents and relatives, or those of other individuals associated with a deceased child's life or fatality. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's death. Nor is it the function or purpose of a Child Fatality Review to recommend personnel action against DSHS employees or other individuals.

[6] The names of the adult caregivers are not used in this report as neither has been identified in an accusatory instrument with committing a crime related to this incident. A.W.'s sibling is not identified in this report due to privacy laws. [See RCW 74.13.500]

delivery at a residence. Although the newborn appeared healthy, the hospital determined RCW 74.13.500 was RCW 74.13.520, but there were no signs RCW 74.13.500 was RCW 74.13.520.[7] The hospital RCW 13.50.100 reported concerns for RCW 13.50.100 lack of a stable living situation and indications that the mother was unprepared to meet A.W.'s basic needs at discharge. The information provided to CA resulted in a CPS Risk Only intake.[8]

Prior to hospital discharge, CPS made contact with both mother and A.W. and gathered information from multiple family members and hospital staff. This information was used to assess child safety and risk and identify the family's potential service needs. This included completing a Plan of Safe Care[9] as well as reviewing infant safe sleep recommendations[10] and the Period of Purple Crying[11] with the mother. After verifying the mother's plan to move with her two children to a relative's home and assessing the newborn's sleep environment at the home, CPS provided numerous concrete resources to support the newborn's care. CPS also recommended the mother complete a urinalysis (UA) and participate in a Family Team Decision Making Meeting (FTDM).[12] During the FTDM, the mother agreed to Family Voluntary Services (FVS)[13] and, if the UA result was positive, a chemical dependency assessment . Results of her RCW 13.50.100 UA completed on May 25, 2017 were RCW 13.50.100 for drugs.

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[7] " RCW 13.50.100 [Source: CA Practices and Procedures Guide – Appendix A: Definitions]

[8] Children's Administration will screen in a CPS Risk Only intake when information collected gives reasonable cause to believe that risk or safety factors exist that place the child at imminent risk of serious harm.

[9] Children's Administration caseworkers must complete a "Plan of Safe Care" as required by the Child Abuse Prevention and Treatment Act (CAPTA) when a newborn is identified as substance affected by a medical practitioner. [See: CA Practice and Procedures Guide 1130. Safety Plan]

[10] Safe Sleep is a nationwide campaign to promote safe sleeping habits for children. In October 2014, CA instituted a policy that requires social workers to discuss Safe Sleep guidelines with all families caring for children under the age of one year. The guidelines are based on recommendations from the American Academy of Pediatrics Task Force.

[11] The Period of Purple Crying is a method of helping parents understand the time in their baby's life where there may be significant periods of crying. [Source: What is the Period of Purple Crying?]

[12] Family Team Decision Making Meetings (FTDM) bring people together who are involved with the family to make critical decisions regarding the removal of a child from their home, changes in out-of-home placement, and reunification or placement into a permanent home. [Source: CA Practices and Procedures Guide 1720. Family Team Decision Making Meetings]

[13] Family Voluntary Services is a child welfare services program for families not involved in dependency matters. FVS social workers offer the parent(s) services designed to reduce the safety threats while the children remain in the care and custody of their parent(s). [See: CA Practices and Procedures Guide 3000. Family Voluntary Services]

The case transferred to FVS and a referral was made for contracted Family Preservation Services (FPS).[14] During several contacts with the family in June and July of 2017, neither the FVS worker nor the FPS provider observed any safety concerns for the children. Both infant safe sleep and the Plan of Safe Care were re-reviewed with the mother. The mother RCW 13.50.100 for all subsequent UAs and when confronted by the FVS worker, declined any further services or CA contact with her children. Following inter-departmental discussions regarding case planning options, including legal intervention, the case was closed.

On September 14, 2017, CPS again became involved after receiving information about suspected RCW 13.50.100 to A.W. and her toddler sibling. A CPS worker and two Tacoma Police Department (TPD) officers went to the residence where the family was staying. The mother appeared upset by the allegations, but allowed the children to be examined for RCW 13.50.100. RCW 13.50.100 . PD detectives followed up several days later and PD again did not observe RCW 13.50.100. The Multi-Disciplinary Team with the local Child Advocacy Center (CAC)[15] recommended medical examinations of the children at RCW 74.13.515 Children's Hospital. The examinations, which occurred a week prior to A.W.'s passing, showed RCW 13.50.100. Based on those results, the allegations of RCW 13.50.100 were later determined to be unfounded.[16]

On September 27, 2017, CA received notification that A.W. had passed away following unsuccessful resuscitation efforts by first responders and hospital emergency department staff. Reportedly, the mother, her boyfriend, A.W. and RCW 74.13.515 toddler sibling were napping together on a full size bed. When the adults awoke, they reported A.W. appeared to be "wrapped in a blanket" and unresponsive. Noted during the death scene investigation were concerns regarding unsanitary conditions of the home

[14] Family Preservation Services are short-term, family-based services designed to assist families in crisis by improving parenting and family functioning while keeping children safe. FPS is aimed at preventing out of home placements for children and is generally authorized for a limited period. [See: CA Practices and Procedures Guide 4502. Intensive Family Preservation Services, Family Preservation Services]

[15] The CAC of RCW 74.13.515 County is a member of the Washington State Chapter of the National Children's Alliance (NCA), which is the accrediting organization. The NCA has established standards for CACs that include (1) child-focused, child-friendly facilities for children and their non-offending family members, (2) multidisciplinary team case staffing participation by law enforcement, prosecution, medical experts, social work, and advocacy, (3) medical evaluation onsite or through referral, (4) therapy onsite or through referral, (5) onsite forensic interviews, (6) and case tracking. [Source: Children's Advocacy Centers of Washington]

[16] CA findings are based on a preponderance of the evidence. RCW 13.50.100 Findings are determined when the investigation is complete. 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. Unfounded means the determination following an investigation by the department that available information indicates that, more likely than not, child abuse or neglect did not occur, or that there is insufficient evidence for the department to determine whether the alleged RCW 13.50.100 did or did not occur.

environment, bed sharing (co-sleeping, surface sharing), and possible aspiration of formula due to bottle propping. The department RCW 13.50.100 on the sibling, who was RCW 13.50.100

The postmortem examination report regarding A.W., finalized in late January 2018, indicated no evidence of injury, no anatomic findings to account for the death and toxicology test results that were negative for alcohol or drugs. However, due to the possibility of asphyxiation during bed sharing, the cause and manner were both classified as undetermined.

Committee Discussion

For purposes of this review, the Committee mainly focused on actions taken and decisions made during the CPS and FVS interventions (RCW 74.13.515 2017). Only limited discussion took place as to the CPS investigation of unsubstantiated RCW 13.50.100 allegations reported in mid-September. The Committee also reviewed the law enforcement and Medical Examiner information relating to the September 27, 2017 fatality incident, but did not dedicate much discussion time to the department actions post-fatality.

Committee members discussed the CA documentation and the additional recollections presented by the CA staff who were interviewed during the CFR. The Committee considered relevant CA practice and procedural standards for intervention and service response, including policy and required timelines for documentation and completion of work. Overall, the caseworkers appeared to meet policy and expected practice standards. Although several situations were noted where CA policies were not followed, they appeared to have no direct connection to the circumstances of the fatality. For example, the FVS worker said the contracted FPS provider conducted consecutive health and safety monitoring visits. Those visits may not have followed CA child and caregiver visit requirements.[17]

Given that the circumstances of the fatality involved the infant sleep environment, the Committee took a close look at the caseworkers' activities regarding infant safety education and intervention. The documented efforts by the caseworkers to reinforce infant safe sleep recommendations, including cautions regarding bed sharing, appeared to follow policy. It was noted that CPS initially provided the family with a co-sleeper/baby box for the newborn, as permitted by the policy at that time (RCW 74.13.515 2017). The Committee discussed the fact that such devices do not meet federal safety

[17] For FVS cases, with children age five or younger and residing in the home, two in-home health and safety visits must occur every calendar month. One of the two visits may be conducted by a qualified CA staff or contracted provider. [See: CA Practices and Procedures Guide 4420. Health and Safety Visits with Children and Monthly Visits with Caregivers and Parents]

standards.[18] Subsequent to the review, it was confirmed that CA revised policy in November 2017.[19] Noted during the review was that fact that the infant was not in a co-sleeper/baby box at the time of RCW 74.13.515 death but was instead sharing a full size bed with RCW 74.13.515 mother, the mother's boyfriend and the child's toddler sibling.

As a balance to simply reviewing policy-directed practice, the Committee spent considerable time discussing the qualitative nature of the information gathering, assessment, analysis and service planning. This included reviewing and discussing the quality of the critical thinking, curiosity, collateral contacts, corroboration of information, collaboration with outside agencies, communication (internal and external) and comprehensiveness of the understanding of the family.[20] Thus, the Committee discussed whether the caseworkers, in the process of conducting safety and family assessments, sufficiently gathered, probed and understood the family member's individual and collective needs prior to service planning.

A key area of Committee discussion involved issues of safety and risk.[21] Significant discourse occurred around the collection of risk factors associated with the family, such as unstable housing, RCW 13.50.100, RCW 13.50.100 and behaviors common to substance abusers. The Committee was not convinced that the caseworkers were sufficiently aware of the mother's history of RCW 13.50.100 RCW 13.50.100 or the potential implications of such Adverse Childhood Experiences[22] on human social, emotional and cognitive development. The Committee recognized that the mother had no prior CPS history as a parent prior to A.W.'s birth and had not demonstrated any behaviors that clearly indicated her children were in present or imminent danger.

The Committee dedicated significant discussion to the decision to wait to refer the mother for a Chemical Dependency assessment. The Committee listened to the caseworkers' and supervisor's reasons to wait for the follow-up UA (which was

[18] According to the United States Consumer Product Safety Commission, cardboard boxes for babies are currently not subject to any mandatory safety standards. These products do not meet the federal definition of a crib, bassinet, play yard, or handheld carrier. [Source: CPSC Statement on Cardboard Baby Boxes]

[19] CA staff must engage the parent or caregiver to create a safe sleep environment if one does not exist. This includes DCFS staff providing parents and unlicensed caregivers with a pack and play or bedside co-sleeper that meets the Consumer Product Safety Commission Standard as soon as possible if the child does not have a safe and separate sleeping area. [See: CA Practices and Procedures Guide 1135. Infant Safety Education and Intervention]

[20] In 2015, these domains, known as The Seven Cs, were incorporated into the statewide Children's Administration Lessons Learned Training to guide discussions about key areas for qualitative evaluation of practice.

[21] Risk factors are family behaviors and conditions that suggest caregivers are likely to maltreat their child in the future. A safety threat refers to a specific family situation or behavior, emotion, motive, perception or capacity of a family member that is out-of-control, imminent, and likely to have severe effects on a vulnerable child. Safety threats are essentially risk influences that are active at a heighten degree and greater level of intensity. Safety threats are risk influences that have crossed a threshold in terms of controllability that has implications for dangerousness.

[22] The CDC's Adverse Childhood Experiences Study revealed a direct link between childhood trauma and onset of chronic disease, depression, suicide, violence, and other social and emotional problems.

RCW 13.50.100 for drugs) before making a referral for a comprehensive CD assessment. The Committee also considered the significance of the mother's explanation that she did not have RCW 13.50.100 , yet by her own admission, knew it was RCW 13.50.100 . When the case transferred to FVS, all subsequent UAs were RCW 13.50.100.

According to the FVS worker, she was not initially aware of the RCW 13.50.100 UAs as the notifications initially went to the CPS worker.[23] The Committee found little documentation of conversations with the mother about scheduled UAs, or any consequences regarding RCW 13.50.100 , thus raising questions about communication between the FVS worker and the mother. No significant conversations occurred between the FVS worker and the relatives with whom the mother was residing, as they were surprised to hear the mother was in not in RCW 13.50.100 with UAs when the FVS case closed.

In evaluating whether the services offered by CA were the most appropriate to meet the needs of the family, some brief discussion occurred about services that were available but not referred. For example, the contracted Early Intervention Program (EIP)[24] is available to CA caseworkers in RCW 74.13.515 County through the RCW 74.13.515 County Health Department. However, the Committee focused more on the services provided by the contracted FPS provider and had concern about the lack of any documented substantive client engagement. The majority of the FPS contact appeared to have been conducted in public areas and was very brief. While there were phone updates provided by the FPS provider to the FVS caseworker, there was no evidence that the contract requirements for completing written reports were satisfied. The CA staff interviewed during the CFR reported ongoing concerns for the failure of the particular FPS provider to provide expected services; staff had reported this to the Regional Contracts Unit. The CPS/FVS supervisor was aware of the CA Contracts Unit Complaint Form which is available online via survey monkey format but also indicated that in the past there had been occasional glitches in the survey monkey process.[25]

[23] CA moved to an all-electronic reporting system in 2016-17. Caseworkers are e-mailed client UA results (including no-shows) in PDF form as reported in the drug testing portal. CA is currently working on improving the no-show notification options and other recommendations to the UA collection reporting out process.

[24] Early Intervention Program contractors provide direct services to families and link families to community resources. Goals include reducing risk of abuse or neglect of children in the home and the likelihood of referral to CPS, reduction of family stress, and enhancing parenting skills, family functioning, and the health status of family members.

[25] The Contracts Complaint tool was implemented by CA in 2015 to get feedback from the field and other key participants in the public child welfare process. Subsequent to this review, concern for glitches in the complaint process was passed onto the Regional Contracts Manager Unit and the CA Headquarters Contracts Manager.

The Committee devoted significant time looking at the decision to close the FVS case at the end of July. The Committee examined the actions taken and decisions made by the department in reaction to the mother's declining of further voluntary services. The Committee reviewed the inter-department discussions regarding case planning options, including disagreements regarding sufficiency to proceed with legal intervention. While there was clear indication that the caseworkers involved felt strongly about pursuing dependency based on identified risks (rather than safety threats), there appeared reluctance to pursue the matter up the chain of command. There was some indication during the interviews with staff that such reluctance is not uncommon in CA offices in RCW 74.13.515 County.

The Committee explored the possible impact of caseworker caseload/workload[26] and caseworker inexperience. At the time of initial involvement with the family (RCW 74.13.515 2017), the CPS investigator's caseload was low due to being new to CA. At the time of the second investigation in September 2017, the CPS worker's assignments were consistent with the state average.[27] The FVS worker to whom the case transferred, was new to FVS but experienced in other CA programs. At the time of assignment, she was assigned more than the recommended number of cases. The Committee found it difficult to come to any substantive conclusions about caseload.

However, the inexperience of the CPS worker appeared to contribute to errors initially made in the Structured Decision Making Risk Assessment® (SDMRA) tool.[28] This conclusion was supported by the CPS worker's admission that she had only a marginal understanding of the tool at the time of completing the SDMRA. The initial underestimation of some risk factors did not affect the overall assessed risk level and or the decision to offer services to the family in RCW 74.13.515 2017.

Findings

The Committee did not identify any critical errors made by CA that were directly associated with the fatality event. The Committee was limited in its ability to draw conclusions regarding any practice or system failures that directly contributed to the death of A.W., especially given the indeterminate cause and manner of A.W.'s death.

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[26] Caseload and workload are not synonymous. While a worker's caseload generally equates to the number of assigned cases, workload involves the complexity of cases requiring intensive intervention and additional administrative requirements. [Source: Child Welfare Information Gateway]

[27] According to Children's Administration current data, the average caseload size for CPS investigators is 18. For investigative workers in child protective services, the Council on Accreditation (COA) recommends that caseloads do not exceed 15 investigations or 15-30 open cases. The Child Welfare League of America (CWLA) recommends a caseload size of 12 intake reports per month per worker and workers providing on-going services have no more than 17 active families.

[28] The Structured Decision Making Risk Assessment® (SDMRA) is an evidence-based actuarial tool from the Children's Research Center (CRC) implemented by Washington State Children's Administration in October 2007. It is one source of information used by CPS when making decisions to provide ongoing services to families. [See: CA Practices and Procedures Guide 2541: Structured Decision Making Risk Assessment® (SDMRA)]

However, the Committee did identify instances where additional or alternative social work activity may have been beneficial to the assessment of the family situation and service delivery. Again, while the Committee did not identify any critical errors, the Committee deemed these issues worthy of consideration for improved practice.

- The Committee questioned the early decision to wait to refer the mother for a Chemical Dependency assessment. Given that the first CA intake was designated Risk Only and largely based on concern for RCW 13.50.100by the mother, the Committee speculated that more immediate and more in-depth assessment would have been reasonable and beneficial. The mother appeared to become less receptive and more resistant as the case went on and opportunities to assess chemical dependency/co-occurring issues essentially evaporated.
- While recognizing instances of collateral contacts being made by the workers, in general they seemed relatively tangential inquiries. The Committee believed there were missed opportunities for more probative conversations with relatives and other family supports to corroborate the mother's statements of individual and family progress with services.
- In consideration of both written documentation and worker interview responses, the Committee seriously questioned whether or not the contracted FPS provider satisfied the expected service delivery per the FPS contract.
- Overall, the level of activity toward client engagement under Family Voluntary Services appeared reserved and too easily conceding, and might have more actively involved family supports.

Recommendations

- CA re-initiate the Chemical Dependency Professional (CDP) liaison program. This program previously allowed for CDPs to be located in CA field offices. CDPs were available for substance abuse related consultation and providing information about substance use, client engagement and community resources. The Committee is aware that current state budget constraints may pose a barrier to this recommendation.
- To improve accountability of contracted providers, CA should pursue different ways to inform CA staff about contractor expectations and the process for reporting concerns about contracted provider service delivery.
- Continue to re-evaluate chemical dependency trainings offered to CA staff to include presenting specific substance abuse/use issues surfacing from child fatality and near-fatality reviews.

- Region 3 management should consider meeting with the local Attorney's General Office about the process and protocol for disagreements with legal advice.[29]

[29] Note: Children's Administration Dependency Petition Process policy is currently under revision. Included in the proposed revision is procedural guidance for situations where there is disagreement about the legal sufficiency to file a dependency.

Washington State Department of Social & Health Services
CA Children's Administration

Child Fatality Review

P.C.

RCW 74.13.515 2017
Date of Child's Birth

October 20, 2017
Date of Child's Death

February 01, 2017
Date of the Fatality Review

Committee Members
Patrick Dowd, Director, Office of the Family & Children's Ombuds
Roy Simms, M.D., Acting Chief Medical Director, Coordinated Care of Washington; Primary Care Pediatrician, Yakima Pediatrics, Community Health of Central WA
Michelle Wolfe, Field Services Administrator, Developmental Disabilities Administration
Tia Amich, Supervisor, Children's Administration
Christy Stretch, CPS Quality Assurance Program Manager, Children's Administration

Facilitator
Cheryl Hotchkiss, Critical Incident Review Specialist, Children's Administration Headquarters

Observer
Paul Smith, Critical Incident Program Manager, Children's Administration

Executive Summary

On February 01, 2018, the Department of Social and Health Services (DSHS), Children's Administration (CA), convened a Child Fatality Review (CFR)[30] to assess CA's practice and service delivery to RCW 74.13.515-month-old P.C. and RCW 74.13.515 family.[31] The child will be referenced by the initials P.C. in this report. The incident initiating this review occurred on October 20, 2017, when P.C.'s mother reportedly found P.C. in bed with RCW 74.13.515 twin sibling and not breathing around 12:35 p.m. P.C.'s mother called 911 and P.C. was subsequently transported to a local hospital by paramedics where RCW 74.13.515 was pronounced dead at 1:39 p.m. At the time of RCW 74.13.515 death, P.C. was residing with RCW 74.13.515 mother and twin sibling.

The Review Committee included members selected from diverse disciplines within the community with relevant expertise including the Office of the Family and Children's Ombuds, a Developmental Disabilities Administration(DDA) administrator, a pediatric and child abuse medical expert, a CA quality assurance CPS program manager and a CPS supervisor with CA. Neither CA staff nor any other Committee members had previous direct involvement with this family.

Prior to the review, each Committee member received a family genogram, a case chronology, a summary of CA involvement with the family and the un-redacted CA case documents (e.g., intakes, investigative assessments and case notes). Supplemental sources of information and resource materials were available to the Committee at the time of the review. These included medical reports, relevant state laws and CA policies.

During the course of this review, the Committee interviewed the Child Protective Services investigators. Following the review of the case file documents, completion of interviews and discussion regarding department activities and decisions, the Committee discussed possible areas for practice improvement. The Committee did not conclude with any findings related to CA's response or CA systems, but it developed one recommendation for CA to consider.

Family Case Summary

[30]Given its limited purpose, a Child Fatality Review (CFR) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of the child. The CFR Committee's review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers. The Committee has no subpoena power or authority to compel attendance and generally only hears from DSHS employees and service providers. It does not hear the points of view of the child's parents and relatives or of other individuals associated with the child. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's fatal injury, nor is it the function or purpose of a Child Fatality Review to recommend personnel action against DSHS employees or other individuals.

[31] The parents are not identified by name in this report as no criminal charges were filed relating to the incident. The names of P.C.'s sibling are subject to privacy law. [Source: RCW 74.13.500(1)(a)]

Prior to P.C.'s death, CA received three intake[32] reports as to P.C.'s mother. One intake screened out[33] in 2016 prior to P.C.'s birth; CA received two subsequent reports resulting in investigations[34] twice between April 2017 and July 2017. The first report that was investigated came in to CA on April 15, 2017. CA was notified that P.C. and RCW 74.13.515 twin sibling were born on January 3, 2017. P.C. was born with RCW 74.13.515 and was medically fragile.[35] The report included concerns for RCW 13.50.100. Further, the report indicated that the mother was RCW 13.50.100. The investigator completed a Plan of Safe Care[36] with the mother and was able to verify from medical providers that they did not believe any of their concerns rose to a level that would make the children unsafe in their mother's care. Moreover, the investigator was able to assess the mother's behaviors and was not able to identify specific behaviors or obvious indicators related to RCW 13.50.100. CA closed this case after the CA investigator completed collateral contacts, assessments and provided the mother with safe sleep[37] information including a warning of the suffocation/smothering risks of

[32] An "intake" is a report received by CA in which a person or persons have reasonable cause to believe or suspect that a child has been abused or neglected. A decision to screen out an intake is based on the absence of allegations of child abuse or neglect as defined by Washington Administrative Code (WAC) 388-15-009.

[33] CA will generally screen out the following intakes: 1) Abuse of dependent adults; 2) Allegations where the alleged perpetrator is not acting in loco parentis; 3) Child abuse and neglect that is reported after the victim has reached age 18, except that alleged to have occurred in a licensed facility; 4) Child custody determinations in conflictual family proceedings or marital dissolution, where there are no allegations of child abuse or neglect; 5) Cases in which no abuse or neglect is alleged to have occurred; and 6) Alleged violations of the school system's statutory code or administrative code

[33] Washington state law does not authorize CA to screen in intakes for a CPS response or initiate court action on an unborn child. [Source: CA Practice Guide to Intake and Investigative Assessment]

[34] CA will accept for investigation a risk-only intake when information collected gives reasonable cause to believe that risk or safety factors exist that place the child at imminent risk of serious harm. In assessing imminent risk of serious harm, the overriding concern is a child's immediate safety. Imminent is defined as having the potential to occur at any moment, or that there is a substantial likelihood that harm will be experienced. Risk of serious harm is defined as: a high likelihood of a child being abuse or experiencing negligent treatment or maltreatment that could result in one of more of the following outcomes: death; life endangering illness; injury requiring medical attention; substantial risk of injury to the physical; emotional and/or cognitive development of a child. [Source: CA Practices and Procedures Guide 2220. Intake Process and Response]

[35] A child is considered "medically fragile" when meeting the following criteria: (1) Child has medical conditions that require the availability of 24-hour skilled care from a health care professional or specially trained family or foster family member; (2) These conditions may be present all the time or frequently occurring; (3) If the technology, support, and services provided to a medically fragile child are interrupted or denied, the child may, without immediate health care intervention, experience death. [Source: CA Practices and Procedures Guide 45171. Medically Fragile Children]

[36] CA caseworkers must complete a "Plan of Safe Care" as required by the Child Abuse Prevention and Treatment Act (CAPTA) when a newborn has been identified as substance affected by a medical practitioner. Substances are defined as alcohol, marijuana and all drugs with abuse potential; including prescription medications. [Source: CA Practice and Procedures Guide 1135. Infant Safety Education and Intervention]

[37]Current CA policy requires CA staff to conduct a safe sleep assessment when placing a child in a new placement setting or when completing a CPS intervention involving a child aged birth to one year, even if the child is not identified as an alleged victim. [Source: CA Practice and Procedures Guide 1135. Infant Safety Education and Intervention] * Safe Sleep is a nationwide campaign to promote safe sleeping habits for children. Safe sleep practice can reduce the risk of SIDS. According to the National Institute of Child Health and Human Development the top 10 safe sleep guidelines are: 1) Always place your baby on his or her back to sleep, for naps and at night. 2) Place your

the observed bumpers in the crib as well as the risk of overlay suffocation associated with P.C. sharing a sleeping area with RCW 74.13.515 sibling. The mother indicated to the investigator that she had a separate sleeping bassinette for P.C.'s sibling and that she was not going to remove the bumpers; however, she removed them while the investigation was open. Additionally, the CA investigator provided the mother with a pack and play portable crib and the Period of Purple Crying[38] video and information. The investigation was closed without identified safety threats[39] at the closure.

On July 12, 2017, CA received a report concerning P.C. and RCW 74.13.515 twin sibling being RCW 13.50.100 . The referent reported that P.C. had a RCW 13.50.100 , was mobile, and was RCW 13.50.100 . Further, the mother was suspected of using RCW 13.50.100 and possibly RCW 13.50.100 . During the course of the investigation, the assigned investigator found that the recommended medical care for P.C. had not been scheduled or received as needed since the closure of the previous investigation. The investigator observed unsafe sleeping practices and warned the mother against using bumpers and against P.C. sharing a crib with RCW 74.13.515 sibling. The mother refused to remove the bumpers and relayed to the assigned investigator that as a parent she would make the daily sleeping and medical decisions. Another safety risk included persons the mother allowed around the children, associates with current and past criminal and violent behavior. They frequented the home and were around the children.

CA filed a dependency petition as to P.C. and RCW 74.13.515 sibling and both children were removed from their mother's care by court order pending a shelter care hearing. After a contested shelter care hearing, the judge ordered the children returned to the mother's physical care against CA's recommendation. The dependency petition was not dismissed

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baby on a firm sleep surface, such as on a safety-approved crib mattress, covered by a fitted sheet. 3) Keep soft objects, toys, and loose bedding out of your baby's sleep area. 4) Do not allow smoking around your baby. 5) Keep your baby's sleep area close to, but separate from, where you and others sleep. 6) Think about using a clean, dry pacifier when placing the infant down to sleep, 7) Do not let your baby overheat during sleep. 8) Avoid products that claim to reduce the risk of SIDS because most have not been tested for effectiveness or safety. 9) Do not use home monitors to reduce the risk of SIDS. 10) Reduce the chance that flat spots will develop on your baby's head: provide "Tummy Time" when your baby is awake and someone is watching; change the direction that your baby lies in the crib from one week to the next; and avoid too much time in car seats, carriers, and bouncers.

[38] The Period of Purple Crying is a method of helping parents understand the time in their baby's life where there may be significant periods of crying. During this phase of a baby's life they can cry for hours and still be healthy and normal. The Period of Purple Crying begins at about 2 weeks of age and continues until about 3-4 months of age.

[39] A threat of danger is a specific family situation or behavior, emotion, motive, perception or capacity of a family member that threatens child safety. The danger threshold is the point at which family functioning and associated caregiver performance becomes perilous enough to be perceived as a threat or produce a threat to child safety. The safety threshold determines impending danger. Safety threats are essentially risk influences that are active at a heightened degree and greater level of intensity. Safety threats are risk influences that have crossed a threshold in terms of controllability that has implications for dangerousness. Therefore, the safety threshold includes only those family conditions that are judged to be out of a caregiver's control. [Source: Safety Threshold]

at the shelter care hearing and with court oversight and CA's constant monitoring and support over a two-month period, the mother was able to minimally complete or initiate court ordered services and set up P.C.'s needed medical appointments. After consultation and assessment, the assigned worker and CA supervisor working the dependency case did not find sufficient evidence to proceed to a fact finding hearing. CA then voluntarily dismissed the dependency petitions for both of the children. The cases were dismissed in September 2017 and the mother immediately moved to another city with her children.

On October 20, 2017, the local Deputy Medical Examiner notified CA of the child's death and surrounding circumstances. The cause and manner of death is unexplained. According to the autopsy, the circumstances surrounding P.C.'s death remained unclear, partly because the mother gave conflicting stories. There was no evidence of injury to P.C.'s brain or significant internal evidence of injury; however, the mother could or would not provide authorities with explanations for the contusion and abrasions of the frontal scalp and forehead associated with subgaleal hemorrhage.[40] Microscopic examination of the forehead showed that injuries were acute. Additionally, the examiner documented in the autopsy that P.C. (who was an infant with **RCW 74.13.520**) was bed-sharing with **RCW 74.13.515** twin sibling; therefore, unintentional overlaying cannot be excluded.

Committee Discussion

The Committee agreed with the investigator and CA's assessed safety concerns in July 2017 and the decision to petition for dependency and request removal of the children from the mother's care. Danger to P.C. was especially great based on **RCW 74.13.515** special needs and the mother's medical neglect of the child. The Committee noted that the language in the petition was highly focused on the mother's personal behaviors versus P.C.'s medical needs and the medical neglect that was a result. The CPS investigator was able to inform the Committee that the pertinent information related to P.C.'s medical needs, the medical neglect and threat to P.C.'s safety was relayed to the court in the shelter care testimony. Regardless of the information the CPS investigator reported to the court, the children were returned to their mother's against CA's recommendation. The Committee noted that the CPS investigator assigned in July 2017 was very well versed in the case and with the needs of the child. The investigator was able to clearly articulate the issues of child safety and medical neglect to the Committee. Based on the

[40] Subgaleal hemorrhage is a rare but potentially lethal condition found in newborns.[1] It is caused by rupture of the emissary veins, which are connections between the dural sinuses and the scalp veins. Blood accumulates between the epicranial aponeurosis of the scalp and the periosteum. This potential space extends forward to the orbital margins, backward to the nuchal ridge and laterally to the temporal fascia. In term babies, this sub aponeurotic space may hold as much as 260 mL of blood.[2] Subgaleal hemorrhage can therefore lead to severe hypovolemia, and up to one-quarter of babies who require neonatal intensive care for this condition die. [Source: Neonatal subgaleal hemorrhage: diagnosis and management Deborah J. Davis CMAJ. 2001 May 15; 164(10): 1452–1453]

investigator's presentation to the Committee, they wondered what more the court might have needed to know in order keep the children in the state's custody. Some Committee members wondered if CA might have been able to articulate a stronger argument to the court for keeping P.C. in out-of-home care while allowing RCW 74.13.515 sibling, who did not have the same medical needs as P.C., to remain with the mother. Some Committee members thought the court might have been more amenable to keep P.C. in the state's care based on RCW 74.13.515 medical needs not being met in comparison to lesser-documented concerns for RCW 74.13.515 sibling.

One area of debate among the Committee members was if a new intake report should have been generated based on P.C.'s physician's assessed risk to P.C. on August 1, 2017. The doctor stated that it was his professional opinion that P.C. was at high risk of neglect due to RCW 74.13.515 developmental needs, medical needs and due to the mother's noted anger and outbursts. This information was not part of testimony or information presented to the court at the shelter care hearing. The Committee discussed further that the mother had sought the required medical care for her child per the court order and the Committee understood the challenges CA investigators face trying to persuade judicial officers to keep children in out-of-home care when the parent is compliant with the order. The Committee recognized the challenges the investigator faced in articulating child safety concerns when the parent is cooperative with court ordered services in the required timeframes and shows minimal progress. The Committee recognized that CA and its attorney cannot substitute their judgment for that of the court and that the agency cannot assume responsibility for the court's decision if DCFS communicated information available to it to the court.

The Committee heard that CA believed both children to be at risk for harm based on the mother's lack of care, age of the children and the mother's observed and documented inability to take responsibility for her inactions as well as her hostile and/or deceptive interactions with CA and other community providers. The Committee did not find fault with CA's response to the needs of P.C. Alternately, members discussed possible gaps in the medical community communicating and assessing the child's needs as well as the role of the court.

The Committee heard from the assigned CA staff that multiple case staffings occurred during both investigations. CA staff also stated they communicated with CA program managers, the Area Administrator, law enforcement and medical providers throughout the assigned 2017 investigations. The Committee considered the importance of case consultation and shared decision-making when dealing with complex cases like this one and that CA and the community benefit from such consultations. The Committee believed that information gathering, assessment and analysis is amplified when CA

seeks a medical consultation,[41] connects with Developmental Disabilities Administration (DDA) and other DSHS programs, as well as CA staff at all levels in the chain of command.

The Committee discussed a lack of communication with DDA. The Committee wondered if periodic training was available for staff to learn when it is appropriate to refer clients to DDA, how to connect clients with DDA as well as assessing children with disabilities or developmental delays. The Committee discussed that CA investigators' knowledge on such topics varies by caseworker depending on previous education, training, and practice. The Committee identified that there have been liaisons working between CA and DDA and that it might be helpful to reconnect CA staff with their resources in hopes of increasing resource connections, the quality of assessments, and child safety.

Also, the Committee believed that a CA medical consultation and a medical assessment could have occurred in response to either intake in 2017. However, the Committee did not find this as an error on the part of CA as CA acted quickly to remove the child and sought medical care once it was identified that the child had not received necessary medical care for an extended period of time.

Further, the Committee members questioned access and use of electronic information systems available to CA from within DSHS. The Committee discussed limited training on available outside computer information systems and how it would be beneficial for all CA staff to have access to a brief overview of navigating information systems that the Community Services Office has available. The Committee believed that this may have been helpful to understand the mother's needs, as she was receiving **RCW 13.50.100** and she indicated to the investigator that she had a **RCW 13.50.100** diagnosis. However, the mother declined offered services or to have a comprehensive discussion about her daily life and how the diagnosis may or may not impact her functioning and parental abilities. The Committee believed that the mother's communication was affected by

[41] The purpose of the Consultation Network is to provide statewide consultation and training regarding medical findings in cases of alleged child abuse and neglect. It provides quick, cost free access to a physician with expertise in the diagnosis of complex cases of child abuse and neglect to professionals such as CA social workers and supervisor, physicians and other medical providers, prosecutors and Attorney's General, law enforcement, other professionals in child abuse and neglect and tribal social workers. Child Abuse Consultants are a team of physicians who provide statewide consultation and training regarding medical findings in cases of alleged child abuse and neglect. The Child Protection Medical Consultants (CPMCs) are a team of physicians who provide statewide consultation and training regarding medical findings in cases of alleged child abuse and neglect. The tasks of the statewide CPMC network include providing telephonic consultations, case staffing/case review, training, court testimony, and written consults to CA staff, law enforcement officials, prosecuting attorneys, and physicians regarding child maltreatment cases. Secure medical evaluation and/or treatment. The social worker considers utilizing a medical evaluation in cases when the reported, observable condition or the nature and severity of injury cannot be reasonably attributed to the claimed cause and a diagnostic finding would clarify assessment of risk. Social workers may also utilize a medical evaluation to determine the need for medical treatment. [Source: CA Practices and Procedures Guide 2331. Child Protective Services (CPS) Investigations]

deceptiveness or possible mental health influences, which could have prohibited the mother from communicating effectively for safety assessment of the children. The Committee also wondered if further time spent during the initial contacts, with collateral sources and in attempting to contact extended family may have improved the quality of information gained for a more thorough understanding of the daily life and safety of the children. The Committee wondered if and how effectively these important considerations were articulated to the court.

The Committee did not find any critical errors on the part of CA, noting that the decision to place the children back with the mother was made by the court over CA's objection. Additionally, the Committee did not make any findings, and only generated a recommendation below in hopes to enhance practice.

Recommendations

CA make training available to staff regarding the importance of connections with DDA, available information systems within DSHS including navigation, as well as provide CA staff with periodic reminders of such trainings and local resources or liaisons. The Committee believed that CA should continue to be allowed access to all DSHS computer systems and information for thorough safety assessments.

Washington State Department of Social & Health Services
CA Children's Administration

Child Fatality Review

J.V.

RCW 74.13.515 2017
Date of Child's Birth

October 2, 2017
Date of Child's Death

February 26, 2018
Date of the Fatality Review

Committee Members
Patrick Dowd, Director, Office of the Family & Children's Ombuds
Amy Serrano, Registered Nurse, Confluence Health Clinic
Paula Gormon, Licensed Chemical Dependency Professional (CDP), Social Service Specialist, Children's Administration
Steven Bryant, CPS Quality Assurance Program Manager, Children's Administration

Facilitator
Cheryl Hotchkiss, Critical Incident Review Specialist, Children's Administration

Executive Summary

On February 26, 2017, the Department of Social and Health Services, Children's Administration (CA) convened a child fatality review (CFR)[42] to assess the department's practice and service delivery to an infant child, J.V., and RCW 74.13.515 family.[43] At the time of RCW 74.13.515 death, J.V. resided with RCW 74.13.515 mother, father, uncle, the uncle's girlfriend and J.V.'s older sibling. The department had an open Child Protective Services (CPS) investigation at the time of J.V.'s death. On October 2, 2017, J.V. died while in RCW 74.13.515 parent's care. Law enforcement reports indicate J.V. died in an unsafe sleep environment.

The CFR Committee included CA staff and community members selected from diverse disciplines with relevant expertise, including child welfare, chemical dependency, the Office of the Family and Children's Ombuds and medical expertise. The participating community members had no previous direct involvement with this family.

Prior to the review, each Committee member received a case chronology, a family genogram, a summary of CA involvement with the family and un-redacted case documents including case notes, referrals for services, assessments and medical records. The hard copy of the file was available to Committee members at the time of the review. Supplemental sources of information and resource materials were also available to the Committee, including copies of state laws and CA policies relevant to the review.

The Committee interviewed CA social workers and supervisors who had previously been assigned to the case. Following the review of the case file documents, review of case assignment and workload report information taken from FamLink[44] for the staff involved, completion of staff interviews and discussion regarding department activities and decisions, the Committee made findings and recommendations that are presented at the end of this report. The Committee did not find any critical errors but recommended practice improvements for future cases.

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[42] Given its limited purpose, a Child Fatality Review (CFR) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of the child. The CFR Committee's review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers. The Committee has no subpoena power or authority to compel attendance and generally only hears from DSHS employees and service providers. It does not hear the points of view of the child's parents and relatives or of other individuals associated with the child. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's fatal injury, nor is it the function or purpose of a Child Fatality Review to recommend personnel action against DSHS employees or other individuals

[43] The parents are not identified by name in this report as no criminal charges were filed relating to the incident. The names of J.V.'s sibling are subject to privacy law. [Source: RCW 74.13.500(1)(a)]

[44] FamLink is the case management information system that CA implemented on February 1, 2009; it replaced CAMIS, which was the case management system used by the agency since the 1990s.

Case Overview

On RCW 74.13.515, CA received a report from Othello Community Hospital stating that J.V. and RCW 74.13.515 mother both tested RCW 13.50.100 at the child's birth. When hospital staff discussed this with the mother, she admitted to RCW 13.50.100 use but did not reveal any additional substance usage. The mother had not realized that she tested RCW 13.50.100, as the hospital had not informed her of the results prior to her response. The mother also denied the use of cigarettes, though hospital staff observed her smoking. Hospital staff stated that J.V. showed RCW 74.13.520 and was being monitored for a possible RCW 74.13.5

CA opened an investigation and responded to the hospital on RCW 74.13.515, 2017; the investigation was assigned to an investigator the same day. This investigator made initial contact with the family at the hospital, discussed safe sleep[45] and the Period of Purple Crying[46] with the mother, and scheduled an Family Team Decision Making Meeting (FTDM)[47] the following day on RCW 74.13.515, 2017. Because this investigator was

[45] CA caseworkers must complete a "Plan of Safe Care" as required by the Child Abuse Prevention and Treatment Act (CAPTA) when a newborn has been identified as substance affected by a medical practitioner. Substances are defined as alcohol, marijuana and all drugs with abuse potential; including prescription medications. [Source: CA Practice and Procedures Guide 1135. Infant Safety Education and Intervention]

[45]Current CA policy requires CA staff to conduct a safe sleep assessment when placing a child in a new placement setting or when completing a CPS intervention involving a child aged birth to one year, even if the child is not identified as an alleged victim. [Source: CA Practice and Procedures Guide 1135. Infant Safety Education and Intervention] * Safe to Sleep is a nationwide campaign to promote safe sleeping habits for children. Safe sleep practice can reduce the risk of SIDS. According to the National Institute of Child Health and Human Development the top 10 safe sleep guidelines are: 1) Always place your baby on his or her back to sleep, for naps and at night. 2) Place your baby on a firm sleep surface, such as on a safety-approved crib mattress, covered by a fitted sheet. 3) Keep soft objects, toys, and loose bedding out of your baby's sleep area. 4) Do not allow smoking around your baby. 5) Keep your baby's sleep area close to, but separate from, where you and others sleep. 6) Think about using a clean, dry pacifier when placing the infant down to sleep, 7) Do not let your baby overheat during sleep. 8) Avoid products that claim to reduce the risk of SIDS because most have not been tested for effectiveness or safety. 9) Do not use home monitors to reduce the risk of SIDS. 10) Reduce the chance that flat spots will develop on your baby's head: provide "Tummy Time" when your baby is awake and someone is watching; change the direction that your baby lies in the crib from one week to the next; and avoid too much time in car seats, carriers, and bouncers. [Safe to Sleep]

[46] The Period of Purple Crying is a method of helping parents understand the time in their baby's life where there may be significant periods of crying. During this phase of a baby's life they can cry for hours and still be healthy and normal. The Period of Purple Crying begins at about 2 weeks of age and continues until about 3-4 months of age. [Source: The Period of Purple Crying]

[47] Family Team Decision Making meeting (FTDM) is a facilitated team process, which can include birth/adoptive parents, guardians, extended family members, youth (as appropriate), community members, service providers, child welfare staff and/or caregivers. These meeting are held to make critical decisions regarding the placement of children following and emergent removal of child(ren) from their home, changes in out-of-home placement, and reunification or placement into a permanent home. There may be instances when a FTDM can be held prior to placement if there is not an immediate safety threat such as a child who is on a hospital hold and a FTDM could provide placement options. Permanency planning starts the moment children are placed out of their homes and are discussed during a Family Team Decision Making meeting. Am FTDM will take place in all placement decisions to achieve the least restrictive, safest placement in the best interests of the child. By utilizing this inclusive process, a network of support for the child(ren) and adults who care for them are assured. [Source: Washington State Family Team Decision Making Meeting Practice Guide]

transitioning out of her position with CA, the FTDM was attended by another social worker who reported to the Committee that she had limited knowledge about the case at the time and was not aware that the mother and infant tested [redacted] RCW 13.50.100 [redacted], in the hospital. This newly assigned social worker was not aware of the mother's discrepancy in her reported use versus what was in the medical record. The FTDM was attended by the mother, the CA FTDM facilitator and the newly assigned social worker. The mother informed CA staff at the FTDM that J.V.'s father was disabled and could not get to the meeting. The facilitator attempted to have the father attend the FTDM telephonically, however he did not answer or respond to the calls.

During the FTDM, the mother denied that she had intentionally used [redacted] RCW 13.50.100 and that the RCW 13.50.100 [redacted], which she later found out was RCW 13.50.100 [redacted]. According to the social worker, the mother did not appear under the influence during the FTDM and the mother noted her lack of prior CPS involvement with her eldest child. She also identified multiple supportive family members living in her home. A consensus was reached that J.V. would remain in the care of RCW 74.13.515 parents while the mother agreed to complete chemical dependency assessments and a mental health assessment, participate with in-home parenting supports and programs, take the older sibling to dental appointments and attend and report all cardiologist and medical appointments for J.V. to CA. Though the father was not present, the mother stated that he would participate in the same services and take the children to the agreed-upon appointments. After the FTDM, and prior to the child's release from the hospital, the newly assigned social worker assessed the family home, observed the older sibling and determined that the home appeared safe. The social worker reviewed safety guidelines with the mother and observed the children's sleep environment. The social worker did not report seeing any concerns with the sleeping environment.

On September 8, 2016, the investigation was transferred to another worker, who was primarily assigned to FAR[48] cases, to continue working with the mother and J.V. The worker had been with the department for five months and J.V.'s case was his first CPS investigation. Prior to J.V.'s case, he was assigned to CPS-FAR cases. The social worker made contact with the mother on September 15, 2017 and conducted a home visit on September 16, 2017. The social worker reported that he observed the sleeping areas and noted that the parents stated that J.V. was sleeping in a bassinette. During this home visit, the social worker observed the father and the approximately one-and-a-half-

[48] Family Assessment Response (FAR), is a Child Protective Services alternative response to a screened in allegation of abuse or neglect that focuses on the integrity and preservation of the family when less severe allegations of child maltreatment have been reported. [Source: CA Practices and Procedures Guide 2332. Child Protective Services Family Assessment Response]

year-old sibling napping in the same bed. The worker reportedly discussed co-sleeping and the dangers of overlay, but the mother stated the sibling was only taking a short nap and did not believe it to be an issue. The following week, the worker assisted the parents in obtaining necessary medical appointments and purchased some infant items for the family. The worker attended a medical appointment with the mother and J.V. on September 27, 2017 and did not note concerning behaviors by the mother. The worker completed collateral contacts with medical providers and referred the family for Intensive Family Preservation Services (IFPS)[49] on September 28, 2017.

On October 2, 2017, CA was notified by law enforcement that J.V. had died while in the care of RCW 74.13.515 parents. Upon initial assessment, the coroner reported there were no obvious concerns or signs of injuries to J.V. Additionally, there was some speculation to the child having a **RCW 74.13.520** that may have contributed to J.V.'s death.

Both parents were interviewed by law enforcement and CPS about the sequence of events prior to the infant's death. Both parents denied having anything to do with the death of their infant. The mother stated that she woke up and fed J.V. the morning of October 2, 2017 at 6:00 a.m. and put RCW 74.13.515 back to bed in the crib, facing up, at about 7:15 a.m. The mother reported she was woken up by a family member at about 10:30 a.m. and prepared a bottle for J.V. When she went to feed J.V., she found that the child was not breathing. She called 911 and attempted C.P.R. J.V. was transported by ambulance to the local hospital where RCW 74.13.515 was declared dead.

Immediately after J.V.'s death, law enforcement inspected the family home and noted that the crib had blankets and a small pillow used for propping J.V.'s head and upper back. The father had also reported this but the mother denied it. The final Coroner's report received by CA on January 16, 2018 revealed that the cause of death was "unexplained infant death" and that "unsafe sleep environment with soft bedding was a significant condition."

Committee Discussion

The Committee acknowledged the legal barriers CA faces when trying to remove children from their parents' care when a child or parent tests positive for substances at the child's birth. The Committee wondered what CA or the legislature might do in response to the challenges CA faces when responding to hospital reports of children who have been exposed to or affected by drugs in utero. Some Committee members discussed the possibility of the legislature amending the current laws to allow CA the

[49]Intensive Family Preservation Services (IFPS) are short-term, family-based services designed to assist families in crisis by improving parenting and family functioning while keeping children safe. IFPS is generally authorized for 30 days. [Source: CA Practices and Procedures Guide 4502. Intensive Family Preservation Services, Family Preservation Services]

authority place children into care where an infant has been exposed to or affected by substances in utero.

Considerable Committee discussion focused on CA's assessment of the mother's alleged substance abuse. Conversation developed around CA making possible changes to procedures related to response to high risk infant cases when substance use is identified at the child's birth. Some Committee members would like to see CA develop a system to ensure the parents' drug issues are fully explored, corroborated and consulted on prior to the child being released from the hospital. The Committee questioned whether the assigned social workers and supervisors fully considered the impacts of the mother's self-reported RCW 13.50.100 use in correlation to her ability to safely care for her children. The Committee was concerned that the workers may have taken the mother's statements about her drug use at face value and that further corroboration and collateral contacts may have improved the worker's assessment of the mother's ability to care for her children. Considering the mother's denial of intentional use of RCW 13.50.100 in the face of contradictory evidence, the Committee agreed it would have been appropriate to request subsequent and ongoing urinalysis of the mother starting at the initial contact. Urinalysis would also have possibly given CA a clearer picture as to the amount of RCW 13.50.100 and/or other drug use post-delivery. The Committee speculated that it could have been beneficial to consult with medical and chemical dependency providers for their expert opinions on issues surrounding medical conditions and treatment options. The Committee noted that the investigators accepted the majority of the mother's statements regarding substance use at face value and did not seek out collateral sources to corroborate her statements, which led to an incomplete assessment of risk and safety. The Committee discussed whether or not there had been an active safety threat[50] and acknowledged that the limited collateral information made this difficult to ascertain. The Committee speculated that additional information may have been available to CA to evaluate whether or not the mother's substance abuse and father's disabilities impacted their ability to safely care for their children. Overall, the Committee believed there was a lack of curiosity, verification, corroboration and consultation while assessing safety and completing the investigation. There were missed opportunities to understand the daily functioning in the home and the caregivers' ability to care for the children. The Committee noted that there was limited information gathered on the father in the home and in regard to his ability to safely care for or protect the children.

[50] A threat of danger is a specific family situation or behavior, emotion, motive, perception or capacity of a family member that threatens child safety. The danger threshold is the point at which family functioning and associated caregiver performance becomes perilous enough to be perceived as a threat or produce a threat to child safety. The safety threshold determines impending danger. Safety threats are essentially risk influences that are active at a heighten degree and greater level of intensity. Safety threats are risk influences that have crossed a threshold in terms of controllability that has implications for dangerousness. Therefore, the safety threshold includes only those family conditions that are judged to be out of a caregiver's control. [Source: Safety Threshold Handout]

The Committee discussed the importance of collateral contacts in conducting a comprehensive assessment of risk and safety and noted missed opportunities to gather additional clarifying information from the hospital and medical providers, relatives, from DSHS databases and from other sources within the family's community, including the landlord and neighbors.

The Committee discussed that best practice guidelines would suggest that the social workers complete a "Plan of Safe Care"[51] when children have been exposed to substances in utero regardless of whether it can be determined if the child has been affected from substances. The supervisors should verify that a Plan of Safe Care has been completed in a case note in all circumstances. It was unclear if a Plan of Safe care was completed by the originally assigned investigator.

The Committee believed that CA demonstrated good practice by holding an FTDM prior to the child's release from the hospital but believed that the FTDM could have been more productive if the attending worker or supervisor had been more familiar with the case. The Committee noted that there was about a month of inactivity after the FTDM and the services identified as a need were not initiated until the end of September 2017. The Committee recognized that the supervisor of the unit was significantly understaffed and had limited resources to achieve the required tasks on multiple cases. However, the Committee maintained that it is the responsibility of a supervisor to attend an FTDM in high-risk cases and with such staffing limitations to ensure effective and thorough measures are taken to ensure child safety.

The Committee discussed case assignment information that was provided in order to gain insight as to the functioning of the office. The Committee was informed that this office is struggling with a high level of worker turnover. During this investigation, the office experienced staffing shortages that necessitated the supervisor of the investigative unit to take on a caseload and request assistance from the other CPS unit in the office. This high turnover presented struggles for staff to complete their tasks in a timely and thorough manner. The Committee discussed how the investigative supervisor in this particular office was also asked to stretch her supervision capabilities to a level which may have led to less than ideal clinical supervision of the casework by line-staff. The supervisors informed the Committee that the area administrator provided direction on the case prior to transfer to both the transferring supervisor and the receiving supervisor. Nonetheless, transferring cases between programs was a focus of conversation for the Committee. The Committee heard from the supervisors that in

[51] CA caseworkers must complete a "Plan of Safe Care" as required by the Child Abuse Prevention and Treatment Act (CAPTA) when a newborn has been identified as substance affected by a medical practitioner. Substances are defined as alcohol, marijuana and all drugs with abuse potential; including prescription medications. [Source: CA Practice and **Procedures** Guide 1135. Infant Safety Education and Intervention]

regular situations with full staffing levels, the local office generally follows a transfer process that includes an in-person staffing to ensure all parties are aware of and understand their responsibilities related to case activity and gathering subsequent information related to child safety. The Committee expressed the importance of supervision and communication in such instances of high risk cases so that newly assigned and especially inexperienced workers understand casework expectations as well as policy and procedures related to that program. The Committee speculated that it did not seem as if the receiving investigator fully understood the necessary duties and next steps for a global safety assessment. The Committee further discussed how the receiving investigator was very focused on obtaining a medical appointment for J.V. but missed opportunities to gather information for global assessment of the home and for child safety. The Committee believed that the relative inexperience of the receiving investigator pointed to a need for increased clinical guidance and supervision.

Findings

After a review of the case chronology, interviews with staff and discussion, the Committee did not identify any critical errors. Acknowledging the difficulties and challenges CA faces when there is a high rate of staff turnover and minimally trained staff available to perform at the desired and required levels, the Committee identified possible areas for practice improvement.

Missed opportunities to gather information:

- The Committee believed that had further information been gathered to assess child safety during the investigation, there may have been an identified safety threat early on in the response. The Committee recognized that there were limited contacts with the family and the latter part of the investigation was focused primarily on J.V.'s possible **RCW 74.13.5** . The investigation lacked more comprehensive information from collateral sources that may have improved CA's assessment of risk and safety. The Committee believed that the CA staff should have gathered information on all of the children in the home. Had this information been sought out, it would have assisted the CA staff in completing a more comprehensive safety assessment and investigation. Sources of information or areas of corroboration that CA could have used during its assessment are:
    - Explore and gather information about all the children in the home and their functioning.
    - Obtain medical and records for all of the children in the home and communicate with providers for explanations of the records as well as consultation.

- Consult with chemical dependency professionals, medical staff, and/or experts to analyze statements made regarding parental use of drugs in comparison to physical evidence.
- Obtain criminal history for the caregivers in the home or people living in or who frequent the home.
- Contact the father and relatives of the children.

Supervision:

- FTDM
  The Committee believed that the supervisor should have participated in the FTDM as J.V.'s case was high-risk and ensured all necessary information was being relayed and safety concerns were addressed.
- Case Transfer
  While acknowledging the challenges associated with staff shortages, the Committee felt that important information as to the mother's drug use was not emphasized and impressed upon to the newly assigned worker at case transfer. The receiving unit seemed to focus primarily on a possible medical need of J.V. rather than a global assessment and follow up or inquiry regarding the mother's **RCW 13.50.100** use as well as assessing others in the home or individuals who have access to the children. The Committee believes that the supervisor should have worked more closely with assigned worker due to the worker's inexperience.

Recommendations

The committee recommends that CA consider utilizing a roving unit statewide or in Region 1 to assist in circumstances where staffing levels impact the office and assist with child safety assessments or completing investigations in a thorough manner.
The Committee recommends that CA consider changing its response to high risk infants exposed to or affected by substances to include a mandatory plan of safe care. A parent's statements regarding their use should not be taken at face value and should encompass collateral contacts. The CA workers and supervisors should ensure that they have consulted and verified the parent's statements in relation to the toxicology reports. Due to infant's vulnerability, CA should have a thorough understanding of the parent's drug use, the dynamics of the household and functioning within the home, verified protective factors and verified sleeping arrangements for the infant prior to discharge of the infant from the hospital.