

CHILD FATALITY REVIEW



Washington State Department of
CHILDREN, YOUTH & FAMILIES

March 2020



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CHILDREN, YOUTH & FAMILIES

Contents

Full Report.....	1
Executive Summary.....	2
Case Overview.....	2
Committee Discussion	6
Findings	9
Recommendations	10

Nondiscrimination Policy

The Department of Children, Youth, and Families (DCYF) 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, age, veteran’s status, or the presence of any physical, sensory, or mental disability.

Full Report

Child

- H.H.

Date of Child's Birth

- 74.13.515 2016

Date of Fatality

- December 4, 2019

Child Fatality Review Date

- March 4, 2020

Committee Members

- Patrick Dowd, JD, Ombuds Director, Office of the Family and Children's Ombuds
- MaShelle Hess, MSW, LICSW-A, CFWS & Guardianship Program Manager, DCYF
- Lisa Ball, MSW, Curriculum Coordinator, University of Washington School of Social Work
- Stan Atkins, MSW, SUDP Lead, Stillaguamish Tribe of Indians
- Michelle McKibbin-Kable, Family Advocate, Domestic Violence Services of Snohomish County
- Karen Erickson, Central Case Review Program Specialist, DCYF

Observer

- Paul Smith, Critical Incident Practice Consultant, DCYF

Facilitator

- Leah Mattos, MSW, Critical Incident Review Specialist, DCYF

Executive Summary

On March 4, 2020, the Department of Children, Youth, and Families (DCYF) convened a Child Fatality Review (CFR)¹ to examine DCYF's practice and service delivery to H.H. and [74.13.51] family.² [74.13.51] will be referenced by [74.13.51] initials throughout this report.

On November 27, 2019, H.H. was admitted to the hospital following a 911 call and found unresponsive while in the sole care of [74.13.51] father's paramour, Kamee Dixon.³ H.H. was admitted to the local hospital, stabilized and transferred to [74.13.515] Hospital, and then transferred to the [74.13.515] Hospital's pediatric intensive care unit. H.H. was placed on life support while at [74.13.515] Hospital. [74.13.51] was diagnosed with bilateral subdural hemorrhage⁴ and anoxic brain injury.⁵ The child's other injuries included 4 broken bones from various time frames, cigarette burns and multiple bruises. The specific cause of the brain injury was not initially identified by doctors, but was considered non-accidental trauma.

Two brain death assessments were conducted, and on November 30, 2019, H.H. was pronounced brain dead. On December 4, 2019, H.H. was removed from life support. [74.13.51] father was present at the hospital. H.H.'s biological mother's whereabouts were unknown and she could not be reached for notification. As a result of H.H.'s death, Ms. Dixon was arrested on December 5, 2019, for second degree felony murder. Criminal charges are pending.

¹"A child fatality or near fatality review completed pursuant to [RCW 74.13.640] is subject to discovery in a civil or administrative proceeding, but may not be admitted into evidence or otherwise used in a civil or administrative proceeding except pursuant to [RCW 74.13.640(4)]." RCW 74.13.640(4)(a). Given its limited purpose, a child near fatality review (CNFR) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the near death of a child. The CNFR Committee's review is generally limited to documents in the possession of or obtained by DCYF or its contracted service providers. A CNFR 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 near fatal injury. Nor is it the function or purpose of a CNFR to recommend personnel action against DCYF employees or other individuals.

²The names of H.H.'s parents are not disclosed in this report because neither parent has been charged with a crime in connection with the fatality incident. The name of H.H. is not used in this report because they are subject to privacy laws. See RCW 74.13.500.

³Kamee Dixon is named in this report because she was charged with committing a crime that is related to the information described under the Executive Summary section above. RCW 74.13.500(1)(a).

⁴"Subdural hematoma (SDH) forms when there is hemorrhage into the potential space between the dura and the arachnoid membranes. SDH in children differs significant from SDH in adults because inflicted head injury is a common etiology, especially in pediatric patients under two years of age [1]. In contrast to epidural hematoma (EDH), indications for operative management of SDH are less clear, and surgery is less likely to prevent morbidity and mortality."

<https://www.uptodate.com/contents/intracranial-subdural-hematoma-in-children-epidemiology-anatomy-and-pathophysiology>. "Nearly one fifth of infant and toddler SDH resulted from unintentional trauma. Of those without obvious unintentional trauma, 76% were corroborated to have been abused. Abused children were younger, more likely to have chronic SDH, and more likely to have multiple associated injuries. Their injury history usually was minor or absent."
<https://pediatrics.aappublications.org/content/108/3/636>

⁵"Anoxic brain injury is defined by a one-time event that causes harm to the brain. This harm can cause oxygen deprivation to the brain, which leads to brain cell death within minutes. This can lead to complications with a variety of brain functions, including cognitive (mental), physiological (physical) and emotional." Reference: <https://www.childrens.com/specialties-services/conditions/anoxic-brain-injury>.

The CFR Committee includes members with relevant expertise selected from diverse disciplines within DCYF and the community. Committee members have not had any involvement or contact with H.H.'s family either before or after H.H.'s death. The Committee received relevant case history, including CPS history, case notes and on-going case planning.

On the date of the CFR, the Committee interviewed prior CFWS⁶ caseworkers and supervisors who had involvement with the case. The CFWS caseworker that held the case from March 2018 to June 2019 is no longer employed by DCYF, therefore did not participate with the CFR.

Case Overview

H.H. and [REDACTED] family came to DCYF's attention in May 2017 when a report was made to DCYF about H.H.'s mother. She was at the emergency room presenting with 74.13.520 [REDACTED]. She reported she had a one-year old child, H.H., who was being cared for by the paternal grandparents and who visits [REDACTED] father weekly. No investigation was generated from this report.

In November 2017, law enforcement notified DCYF that they placed H.H. into protective custody due to a RCW 13.50.100 incident that occurred in the home between the mother and father. H.H. was present at the time. According to law enforcement, there was known RCW 13.50.100 by both parents, as well as the father RCW 13.50.100. H.H.'s father was arrested. H.H. was placed in [REDACTED] paternal grandparent's care and they were [REDACTED] sole caregivers during [REDACTED] time in out-of-home placement.

DCYF initiated a dependency action on the basis that there was no available parent to safely care for H.H., and there was a danger that the child would be at risk of being abused or neglected if left in the home with the parents. Both parents denied law enforcement's RCW 13.50.100 and RCW 13.50.100 allegations. The court found H.H. to be a dependent child as to both parents and required them to engage in court-ordered services to ameliorate the concerns that led to the initial out-of-home placement.

Throughout the case, DCYF believed that H.H.'s mother continued to struggle with RCW 13.50.100, leading to a lack of engagement and participation with the dependency process. Initially, she denied the RCW 13.50.100 allegations and refused RCW 13.50.100 services offered by DCYF. She eventually attended one session, but later said she would not return. DCYF had significant concerns for the mother's safety because there were indications she continued to have contact with the father, despite a no-contact order being in place. She was referred for RCW 13.50.100 services and agreed to participate with an evaluation, treatment and urinalysis samples. DCYF made efforts to assist the mother by offering transportation for some of her treatment appointments. Despite DCYF's offers of assistance, the mother struggled to follow through with the completion of treatment.

Visitation with H.H. proved difficult as the child was placed in another county and the mother often failed to follow through with pre-arranged travel plans. DCYF did arrange and fund travel for visitation

⁶ Child and Family Welfare Services case workers assume responsibility of a child welfare case after the children have been removed from their caregivers and a dependency petition filed.

and communicate the plans with the mother, but she often missed visits due to reported illness or inability to attend due to a scheduling conflict. The grandparents made efforts to assist with the visitation and facilitated video chat in order to maintain a relationship between H.H. and [74.13.51] mother.

In the fall of 2018, the mother entered a [RCW 13.50.10] program and transitioned to an [RCW 13.50.100] program where she could learn parenting skills and access treatment for [RCW 13.50.100] and mental health. She left the program approximately one week after entry. DCYF believed that she may have moved to [74.13.515] to live with H.H.'s maternal grandmother. Continued efforts were made to locate the mother but she did not engage further with DCYF after she left the [RCW 13.50.100] program.

At the beginning of the case, the father contested the dependency action and initially failed to engage in services or regularly communicate with DCYF. In March 2018, the father was arrested based on a [RCW 13.50.100] allegation. In April 2018, he made himself available to begin communicating with DCYF and the Court Appointed Special Advocate (CASA). He also agreed to participate with court-ordered services. He stated his intention to have [74.13.515] return to his care. In May 2018, he requested that Kamee Dixon, with whom he was in a relationship, be allowed to attend visitation with him and [74.13.515]. DCYF completed a background check on Ms. Dixon that included a child abuse history check. Due to [RCW 13.50.100] issues, Ms. Dixon [RCW 13.50.100]. She did successfully [RCW 13.50.100] work through [RCW 13.50.100] treatment, and obtained independent housing and employment. Her [RCW 13.50.100]. She [RCW 13.50.100]. DCYF allowed her to attend supervised visitation.

In July 2018, [RCW 13.50.100] charges against the father were dismissed due to a lack of cooperation by the mother. The father completed a chemical dependency evaluation and the evaluator reported the father [74.13.520]. The evaluator was unable to recommend treatment based on the information provided. The father was referred to and completed a one-day [RCW 13.50.100] class. In December 2018, a permanency planning staffing was held to review progress and address H.H.'s permanency needs. Both parents were invited to the staffing but only the father participated. Although H.H.'s father had previously agreed to services, DCYF reviewed his lack of consistent and measurable progress over the prior 12 months. Taking into consideration the length of time H.H. had been in out-of-home placement, the staffing participants discussed alternate permanent plans. Following this meeting DCYF noted a marked change in the father and he began to consistently participate with court-ordered services.

The following month, the father completed a [RCW 13.50.100] assessment with recommendations to [74.13.520]. In addition, he was continuing to provide clean urinalyses as reported by his probation officer, maintain full time employment and obtained safe and stable housing. He also requested increased visitation time with H.H. In February 2019, DCYF completed a walk-through of the father's home to conduct a home environment safety and suitability assessment. Also present during the walk-through was Ms. Dixon and her son, who said they did not reside there full time but would be a part of the household. The couple stated they had intentions to marry. In March 2019, visitation was expanded by agreement of DCYF and CASAs to include overnight and weekend visits in the father's home.

In May 2019, a family team decision meeting was held to discuss the possible reunification of H.H. with [74.13.51] father. The father was found to be making progress based on making significant life changes, demonstrating continued stability and ability to provide for himself and his family. He had not been

charged with any new crimes, and DCYF and his extended family did not have any RCW 13.50.100 concerns with regard to his current relationship. The father completed one RCW 13.50.100 treatment session; and he was also on a wait list for mental health services that were being offered in lieu of completing a psychological evaluation. Visitation had been expanded to overnights in the home and appeared to be going well. The CASAs and CFWS caseworker reportedly made unannounced home visits and reported things were going well. There were no safety concerns identified at this time. The father was working to set up all of H.H.'s medical care providers and had an identified childcare plan for 74.13.51. The relative caregivers reported no concerns and also supported reunification. DCYF identified the father's paramour as a support to him and the family.

Effective June 19, 2019, H.H. was returned to 74.13.51 father's care on a trial return home. The court order shows that both DCYF and CASA supported the trial return home. Following the start of the trial return home, the case transferred to a different CFWS caseworker. This worker promptly got to know the family and H.H. Due to H.H.'s age, two health and safety visits per month were required. Because of the father's limited availability, the majority of the visits occurred with H.H. and Ms. Dixon. There were no health and safety concerns noted during the health and safety visits. H.H. was attending childcare and receiving all necessary routine medical care. After completing 11 sessions, the RCW 13.50.100 provider whom the father had been seeing, closed the provider business. There was no other local provider available so the father was referred to a provider in an adjoining county and offered financial assistance to get to and from the office. The father declined this offer. He remained on a waitlist for mental health services. The family was also referred for Triple P⁷ parent instruction and began that service in August 2019.

In mid-September 2019, the case was transferred to another CFWS caseworker following a staffing transfer which highlighted the current status of the case and outstanding service needs. Ongoing needs included the father completing a mental health evaluation, ongoing and consistent participation with Triple P and completion of the parenting plan.

On September 30, 2019, the recently assigned CFWS caseworker contacted the father to coordinate a health and safety visit for that day and was notified that H.H. burned 74.13.51 hand approximately one week before this CFWS caseworker's contact. The family was not able to meet on this day but the next day the CFWS caseworker did see H.H. and Ms. Dixon at the home. At that time, the worker learned the family did not seek medical attention for the burn. The CFWS caseworker asked how the burn occurred and was told that H.H. put 74.13.51 hand on a burner when the family was cooking. The CFWS caseworker directed the family to promptly seek medical attention. Ms. Dixon reported that she attempted to take H.H. to the doctor but because she is not a legal guardian, was not allowed to do so. The CFWS caseworker obtained permission from the father to allow Ms. Dixon to take H.H. to the doctor and sent notification to the doctor's office, but did not verify if Ms. Dixon had attempted to take H.H. to the doctor as reported. On October 3, 2019, H.H. was seen by 74.13.51 primary care physician, who then referred H.H. for follow-up at the 74.13.515 Clinic because there was the possibility 74.13.51 would need physical therapy due to the severity of the burn. An intake was also called in to CPS by RCW 13.50.100 due to a lack of parental response in seeking medical care for this injury, which generated a 24-hour CPS

⁷Triple P – Positive Parenting Program® is a parenting and family support system designed to prevent – “as we treat” – behavioral and emotional problems in children and teenagers. It aims to prevent problems in the family, school, and community before they arise and create family environments that encourage children to realize their potential.

response investigation. The CPS investigation was assigned to the CFWS caseworker. The CFWS caseworker completed an initial face-to-face and completed a one-on-one interview with the child. The CFWS caseworker also corresponded with medical professionals to ensure the family scheduled a follow-up appointment as directed. H.H.'s father confirmed that an appointment with the 74.13.515 Clinic was scheduled for October 14, 2019.

On October 15, 2019, the father called the CFWS caseworker to report that H.H. had sprayed something in 74.13.515 eye and needed to be taken to the doctor. The CFWS caseworker met the family at the emergency department. H.H.'s eye was flushed and 74.13.515 was discharged with a recommendation to follow-up with an ophthalmologist weekly due to possible permanent vision damage. No other concerns were noted by the physician at that time. The CFWS caseworker questioned the father about the incident and he reported that he believed 74.13.515 sprayed hair spray in 74.13.515 eye. He had a plan to move all dangerous products out of H.H.'s reach. The CFWS caseworker completed a health and safety visit in the home the following day and the father confirmed that he scheduled a follow-up eye appointment for October 23, 2019. The worker also verified that chemicals and beauty products had been stored out of H.H.'s reach. The CFWS caseworker asked about H.H.'s hand and H.H. reported that it felt okay. The worker observed H.H. still could not put full weight on 74.13.515 hand.

On November 13, 2019, a health and safety visit was completed with H.H. in the home. The father said he was using a new shampoo for H.H. due to 74.13.515 hair thinning, and reported the shampoo was helping with hair growth. He felt the hair loss was the result of the transition home and being in a new environment. No other injuries or medical concerns were noted. No additional information about the burn injury or eye injury was requested at this health and safety visit. The CFWS caseworker had a candid conversation with H.H.'s father regarding DCYF's position for the upcoming December court hearing and that DCYF would not be recommending case dismissal. This was due to the continued inconsistent participation with parenting instruction as well as the mental health evaluation not being completed. The father stated that H.H. would be back in full-time daycare as of November 27, 2019. He confirmed that his mental health evaluation was set for November 21, 2019 and that he had a scheduled appointment with the Triple P provider. The following day, the Triple P provider notified the family and Department that the referral was being returned due to the family missing another visit.

On November 27, 2019, DCYF was notified by law enforcement that H.H. had been taken to the hospital and was in critical care. This report generated a 24-hour CPS response investigation. H.H. was diagnosed with having a bilateral subdural hemorrhage and anoxic brain injury. 74.13.515 died on December 4, 2019.

Committee Discussion

The Committee had the opportunity to review the case through documented case history as well as interview many of the caseworkers and supervisors who had been involved with this case. The discussion focused on the following areas: ongoing child safety assessment and systemic barriers.

Through caseworker interviews, the Committee gathered information about the rationale to return the child to the father who had completed limited court-ordered services. The Committee questioned how DCYF evaluated the father's progress given that at the start of the trial return home he had only completed one RCW 13.50.100 treatment session and there was limited professional provider input. The RCW 13.50.100 history that led to DCYF becoming involved with this family was significant. The Committee speculated DCYF's inability to complete a RCW 13.50.100 assessment due to the father

denying this concern at the start of the case led to not being able to establish a baseline from which to evaluate progress. The supervisor reported to the Committee that the father was evaluated through the positive life changes he had made to include demonstrated sobriety, no criminal incidents and establishing and maintaining a means to provide for him and his family. It was reported that the father valued being a provider above all else and that this focus positively impacted his life.

A significant part of the Committee's discussion focused on DCYF's application of Sirita's Law⁸ and the assessment of a non-parental caregiver. Policy requires that DCYF not only complete background and CPS history checks, but also assess the service needs of individuals who will have frequent ongoing contact with the child. The Committee felt the evaluation of Ms. Dixon in her role as a non-parental caregiver for H.H. was not comprehensive or inclusive of her as a part of the family unit. Although this individual was examined under the background check process, DCYF did not further assess her current capacities and needs as a parent to her own child or as a co-parent to H.H. DCYF reported that it relied on the absence of new CPS history as evidence that she was an appropriate, safe support for the family.

The Committee also noted that the CFWS caseworkers receiving the case after the case transfer and once the trial return home began did not further assess Ms. Dixon or engage her with the dependency process. Before H.H.'s return home or at any point during the trial return home, it was not clear through department documentation or caseworker interviews if a needs assessment was completed to identify supports or services Ms. Dixon may have needed. The Committee also wondered if services could have been made available to Ms. Dixon under the Family First Prevention Services Act.⁹ Parent coaching services were offered to the father and child and DCYF included Ms. Dixon on that service referral, but it was not clear if DCYF informed Ms. Dixon of this opportunity or encouraged her to participate. The Committee speculated that if a provider had been working with the family who included Ms. Dixon, the provider may have completed an assessment of Ms. Dixon's bonding, discipline style and interactions with H.H.

Another area the Committee considered was the content gathered and documented in monthly health and safety notes throughout the life of the case. The Committee felt that child safety was not fully assessed during the health and safety visits through individual conversations with the child. The Committee asked the various caseworkers about the child's verbal abilities to respond to questions and the types of questions asked. The Committee expressed concerns related to inconsistent reports about H.H.'s language skills. It appears that H.H.'s language skills may have decreased in the months before 74.13.51 death. Taking into consideration that the case had been transferred to three CFWS caseworkers in a six-month period it may have been difficult for the newly assigned caseworkers to establish a baseline for H.H.'s language skills. The Committee understands that H.H. was a young child and that early in the case 74.13.51 language skills were developing. However, given 74.13.51 age and developmental status it was assumed

⁸Prior to the child returning home, DCYF must complete the following: (i) Identify all adults residing in the home and conduct background checks on those persons; (ii) Identify any persons who may act as a caregiver for the child in addition to the parent with whom the child is being placed and determine whether such persons are in need of any services in order to ensure the safety of the child, regardless of whether such persons are a party to the dependency. DCYF may recommend to the court and the court may order that placement of the child in the parent's home be contingent on or delayed based on the need for such persons to engage in or complete services to ensure the safety of the child prior to placement. If services are recommended for the caregiver, and the caregiver fails to engage in or follow through with the recommended services, DCYF must promptly notify the court. Source: RCW 13.34.130 <https://app.leg.wa.gov/RCW/default.aspx?cite=13.34.138>.

⁹See <https://www.dcyf.wa.gov/practice/practice-improvement/ffpsa>.

that [74.13.51] would be able to share information with the CFWS caseworker. DCYF did make attempts to gather basic information about [74.13.51] medical and dental care, but did not consistently complete collateral contacts to verify this information. The Committee also felt there was a gap in documentation because it was reported during the interview with the supervisor that the caseworker did observe extended visits of H.H. in the father's home before the transition home, but there was no written documentation of this occurring.

Another area identified as problematic in regards to assessing child safety, was the decision to assign a CPS 24-hour response investigation for the burn to an ongoing CFWS caseworker. The Committee felt this decision was a miscalculation and did not lead to a thorough investigation that considered all information gathered. The rationale provided by the office for this decision was that the CFWS caseworker had already gathered some of the information needed to complete the investigation through a regularly scheduled health and safety visit. Also, this CFWS caseworker was considered to be an unbiased evaluator of the family because they had only recently been assigned to the case. The office also noted that at the time there were staff vacancies in the CPS program with a higher than normal volume of CPS reports screening in for investigation. This also guided the decision to assign the burn investigation to a CFWS caseworker instead of a CPS caseworker. It was noted by the Committee that the investigative process that was completed for the intake was indicative of a more case management-based response versus an investigative response. For example, the CFWS caseworker did not interview all individuals in the home (Ms. Dixon's son) but did ensure that Ms. Dixon would be able to take the child to the doctor for follow-up. Also, a medical consultation was not completed to have a medical child abuse expert determine if this injury could have been considered non-accidental. The Committee speculated the burn investigation's outcome may have led to founded findings¹⁰ if the investigation had been conducted by a CPS caseworker. The investigative assessment was completed and submitted on December 2, 2019.

Systemic barriers faced in child welfare cases include factors that may delay permanency outcomes or hinder case progress. The Committee identified some notable factors that may have impacted the work done on this case. H.H. was placed in out-of-county relative care throughout the duration of [74.13.51] out-of-home placement. Although the relatives were accommodating and supported visitation for both parents, the distance between the parent's and the child's location created challenges. For example, the mother was offered visitation and provided with resources to travel to and from visits. However, she struggled to follow the plans which led to limited in-person contacts between her and H.H., which caused her to express frustration. A formerly assigned CFWS worker identified the distance as a challenge to service planning because parent coaching was not offered during visitation, and the assigned CFWS caseworker was unable to frequently observe the interaction between the parent(s) and child. For purposes of parent-child interactions during visitation DCYF relied on the reports provided by the relative caregivers and the visitation agency.

The Committee also discussed whether H.H.'s out-of-county placement may have led to an expedited trial return home. As mentioned above, the trial return home moved forward despite the father's limited engagement with court-ordered services. The supervisor did acknowledge this as problematic,

¹⁰"Founded" means the determination following an investigation by CPS that based on available information it is more likely than not that child abuse or neglect did occur." WAC 110-30-0020.

but expanded on how DCYF assessed the parent's readiness for return home outside of the standard compliance with court ordered services. The assessment identified no active safety threats¹¹ that would prevent the child from returning home. So that H.H. did not have to travel more than absolutely necessary, the supervisor shared that the child had been on an extended visit with the father prior to the court hearing authorizing the trial return home.

During discussions with the various caseworkers, concerns came to light regarding a CFWS caseworker feeling personally attacked by a defense attorney during court proceedings. This was described as having a negative impact on the entire CFWS program at this particular office, impacting overall morale and possibly contributing to turnover. This led to the Committee further discussing the relationship between the court system, legal parties and DCYF and what this particular community does to foster a positive, working relationship as well as how to address conflict between professionals when they occur.

CFWS caseload information was shared during this review and averaged 20 to 24 child assignments per caseworker. The CFWS caseworker last assigned to this case was identified as having the highest caseload within the CFWS program at 24 child assignments. Both she and her supervisor were able to share with the Committee the impacts from a high workload. The Committee noted that limited collateral contacts were made in the last few months of this case and critical information, such as the CPS investigation from October 2019, was not shared in a timely manner with the CASAs. The CFWS caseworker attributed this to the limited time available when required to manage 24 cases. In addition to high caseloads there was turnover within the CFWS program, which led to this case being assigned to three different CFWS caseworkers in a 6-month time period.

Findings

The Committee concluded there was no critical error. The Committee did however make the following findings.

- The assignment of the 24-Hour CPS investigation should have been assigned to a CPS caseworker and not the ongoing CFWS caseworker.
- DCYF did not call in an intake for either the burn or eye injury. The intake for the burn was called in by a medical professional and no intake was called in for the eye injury.
- The assessment of Ms. Dixon, who was also considered a member of the household, was not comprehensive, did not include an assessment of her current needs and did not offer services. DCYF neglected to document efforts to engage Ms. Dixon with the dependency process as a member of the household and a caregiver who would have unsupervised access to the child.

¹¹ 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. Retrieved from: <https://www.dcyf.wa.gov/sites/default/files/pdf/SafetyThresholdHandout.pdf>

- There was a lack of communication with the CASAs and a delay in sharing information about H.H.'s injuries and the CPS investigation in October 2019.

The Committee recognizes and acknowledges the supervisory support offered to staff from the current CFWS supervisor. The consistency with in-person transfer staffings facilitated by the supervisor demonstrates a promising practice, teamwork and the future provision of a continuity of care.

Recommendations

The Committee recommends a targeted training on global assessments and assessing safety throughout the life of the case be offered to CFWS caseworkers in this office, and should be considered statewide as well.

The Committee also recommends the office connect with the UW Alliance to review available training opportunities to address the above subject matter. One example of available training is the Child Protection Medical Consultation (MedCon) that provides training on child abuse injuries and the role of medical consultants.

The Committee further recommends a training to this particular office to increase caseworkers' understanding and application of Sirita's Law. The content should include assessing safety, risk and the needs of the family to include both the biological parent and the non-parental caregiver. The training should also focus on service delivery and engagement with the entire family unit. Available resources for this training may include the CFWS Program Manager (Statewide), Quality Practice Specialist and UW Alliance.

For purposes of caseworker retention the Committee recommends the following:

- Offer a training for workers, the court and other legal parties regarding roles, respect and civility with this office and the court system.
- To foster positive stakeholder working relationships, address barriers as they may arise and improve the outcomes in the court process for children and their families, the Committee recommends the continuation of DCYF leadership participation in the county's Tables of Ten¹² work group between the court, legal parties and DCYF.

Finally, it was suggested this DCYF office work with the Assistant Attorney General, Guardian ad Litem/CASA program and court to develop a memorandum of understanding to ensure appropriate and timely notification from DCYF to the GAL/CASA program for shared cases.

¹²Tables of Ten begin with the gathering of ten or more individuals in your child welfare legal community who want things to be better. Source: <https://www.wacita.org/improvements/tables-of-ten> /<https://www.wacita.org/improvements/tables-of-ten/whatcom-county/>.