Washington State Department of Social and Health Services

Transforming Lives

REPORT TO THE LEGISLATURE

Quarterly Child Fatality Report

RCW 74.13.640

April – June 2017

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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 April through June 2017 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 two (2) child fatalities and one (1) near fatality that occurred in the second quarter of 2017. 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 near fatalities from two of the three regions.

Region	Number of Reports
1	2
2	1
3	0
Total Fatalities and Near-Fatalities Reviewed During 2nd Quarter 2017	3

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 2017.

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 2017			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2017	12	6	6

Child Near-Fatality Reviews for Calendar Year 2017			
Year	Total Near-Fatalities Reported to Date Requiring a Review	Completed Near-Fatality Reviews	Pending Near-Fatality Reviews
2017	2	0	2

The child fatality review referenced in this Quarterly Child Fatality Report is 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 included in this report nor posted on the public website.

Notable Second Quarter Findings

Based on the data collected and analyzed from the two (2) fatalities and one (1) near fatality during the 2nd quarter, the following were notable findings:

- Two (2) of the three (3) cases referenced in this report were open at the time of the child's death or near fatal injury.
- Both of the fatality cases resulted from the infant dying in unsafe sleep environments.
- In both fatalities, a parent under the influence of alcohol co-slept with their infant children causing an unsafe sleep environment for the child.
- Safe sleep was discussed with the parents of one (1) of the infants who died in an unsafe sleep environment prior to the child's death. A safe sleeping environment was observed.
- In the other infant fatality case, the case was not open when the child died and safe sleep was not discussed with the child's parents.
- The near fatality case involved a toddler accessing an unsecured handgun and accidentally shooting himself.
- In all three (3) cases referenced in this report the children were two (2) years of age or younger when the fatality occurred.
- Two (2) of the three (3) cases referenced in this report were the result of abuse or neglect by the children's parents or caregivers.
- Two (2) children in this report were Native American and one (1) was African-American.
- Children's Administration received intake reports of abuse or neglect in the each of the cases in the report prior to the death of the child. In one (1) case, there were five (5) intakes reported to CA prior to the fatality; in the other fatality case, there were between six (6) intakes prior to the child's death. In one (1) fatality case, there were three (3) intakes on the family prior to the fatal incident.
- Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

Child Fatality Review

K.B.

RCW 74.13.515 **2016**
Date of Child's Birth

October 4, 2016
Date of Child's Death

February 23, 2017
Date of the Fatality Review

Committee Members
Patrick Dowd, Director, Office of the Family & Children's Ombuds
Jenna Kiser, Intake and Safety Program Manager, Children's Administration
Amy Person, M.D., Benton-Franklin Health District
Ryan Kelly, Sargent, Kennewick Police Department

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

Executive Summary

On February 23, 2017, the Department of Social and Health Services Children's Administration (CA) convened a Child Fatality Review (CFR)[1] to assess the department's practice and service delivery to a RCW 74.13.515 -old infant and RCW 74.13.515family.[2] The child is referenced by RCW 74.13.515initials, K.B., in this report. The incident initiating this review occurred on October 4, 2016, when K.B., who was residing with RCW 74.13.515mother and maternal grandfather, died while co-sleeping with RCW 74.13.515mother. Three weeks prior to the incident Child Protective Services (CPS) had initiated an investigation regarding the family.

The CFR Committee included CA and community professionals with relevant expertise in child advocacy, child abuse and child safety, law enforcement and pediatric medicine. None of the Committee members had any previous direct involvement with this family.

Prior to the review, the Committee was provided 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 at the time of the review. Supplemental sources of information and resource materials were also available to the Committee, including state laws and CA policies relevant to the review.

The Committee interviewed CA social workers and a supervisor who had previously been assigned to the case. Following the review of the case file documents, completion of staff interviews and discussion regarding CA activities and decisions, the Committee made recommendations that are presented at the end of this report.

Case Summary

Three reports, including two that were screened out, came to CA in 2014 concerning the mother and the father of RCW 13.50.100. The allegations concerned RCW 13.50.100, RCW 13.50.100, and the mother attempting to RCW 13.50.100. Due to significant

[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 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

[2] The parents are not identified by name in this report as no criminal charges were filed relating to the incident. [Source: RCW 74.13.500(1)(a)]

safety concerns identified by CPS, K.B.'s maternal grandmother pursued and was awarded third party custody[3] of K.B.'s older sibling in December of 2014.

CA received a report in April 2016 alleging RCW 13.50.100 by K. B.'s mother while she was RCW 13.50.100. The report screened out[4] as K.B. had not yet been born.[5] In RCW 13.50.100 2016, two reports screened in[6] for CPS investigation. At the hospital when K.B. was born, RCW 13.50.100 between K.B.'s mother and father was reported in conjunction with RCW 13.50.100 and RCW 13.50.100. On October 4, 2016, K.B.'s maternal grandfather called CA to inform that K.B. had died while sleeping with K.B.'s mother. Law enforcement later informed CA that a search warrant was implemented on the home and they took the mother to the police station for an interview and for bloodwork to assess for substances. CA was not able to access the bloodwork results taken by law enforcement and the cause of death was considered as undetermined according to the medical records. The result of CA's investigation of K.B.'s death was unfounded[7] for abuse and neglect.

Committee Discussion

Although believing that some aspects of the 2014 CPS involvement with the family was germane to the 2016 case involving K.B., the Committee discussed the screening decisions made for the December 2014 intake. This report came to CA after regular business hours and the state centralized call unit took the report. The intake was screened out and assigned for review to King County jurisdiction as the mother was residing in King County. The Committee surmised that the Richland office may have

[3] Third party custody, or nonparental custody, is a legal mechanism whereby an individual who is not a child's parent may obtain physical and legal custody of a child through a court order. An individual seeking a custody order must submit, along with his or her motion for custody, an affidavit declaring that the child is not in the physical custody of one of its parents or that neither parent is a suitable custodian and setting forth facts supporting the requested order. The party seeking custody shall give notice, along with a copy of the affidavit, to other parties to the proceedings, who may file opposing affidavits. [Source: RCW 26.10.032 (1)]

[4] 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 CA/N; 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.

[5] Washington state law does not authorize Children's Administration (CA) to screen in intakes for a CPS response or initiate court action on an unborn child. [Source: CA Practices and Procedures Build Chapter 2200]

[6] Intake social workers determine program response type and response times (emergent or non-emergent) for an investigation. CA intakes fall into three categories: CPS – Involves a child who is allegedly abused, neglected, or abandoned and includes child abuse allegations. CPS Risk Only – Involves a child whose circumstances places him or her at imminent risk of serious harm but does not include child abuse allegations. Non-CPS – Involves a request for services for a family or child.

[7] 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 child abuse did or did not occur. 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. [Source: RCW 26.44.020]

assessed the screening decision differently than the King County office based on historical information known locally that may not have been documented in FamLink, CA's case management system.

The Committee acknowledged the short time span between the assignment of the intake dated RCW 74.13.515 19, 2016 and K.B.'s death on October 4, 2016. A Family Team Decision Making meeting[8] (FTDM) was held on September 23, 2016 identifying that a safety plan[9] was needed. The Committee discussed the decision to postpone creating the formal safety plan. Although CA had a verbal agreement with the parents of K. B. and other family supports, the Committee discussed the importance of having a very specific and written safety plan upon determining there is a safety threat to a child. The Committee opined that a safety plan could have been constructed immediately at the FTDM. The Committee discussed the potential benefit of having all safety plan participants present and included in the creation of the safety plan, that they understand their expected roles therein and that they complete background checks if required.

The Committee pondered the local law enforcement agency withholding certain records from CA and the impact that action had on CA's inability to proceed with a substantiated finding of child abuse and neglect. The Committee discussed how local law enforcement protocols can impact CA's ability to gather sufficient information for safety assessments and findings of abuse or neglect.

The Committee discussed how CA's assessment of historical and possible current parental substance abuse may have impacted this case. The Committee recognized the challenges faced by CA social workers to fully assess clients for current chemical dependency issues, such as cases where clients may intentionally minimize their drug use or need for treatment and justify their use based on prescription

[8] 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. An 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: CA Practices and Procedures Guide Chapter 1720]

[9] The Safety Plan is a written agreement between a family and CA that identifies how safety threats to a child will be immediately controlled and managed. The Safely Plan is implemented and active as long as threats to child safety exist and caregiver protective capacities are insufficient to protect the child. A safety plan is required for all children where there is a safety threat(s) indicated on the safety assessment. Note: when creating an in-home safety plan, the following criteria must be met: 1) there is at least one parent/caregiver or adult in the home; 2) the home is calm enough to allow safety providers to function in the home; 3) the adults in the home agree to cooperate with and allow an in-home safety plan; 4) sufficient, appropriate and reliable resources are available and willing to provide safety services/tasks. [Source: CA Practices and Procedures Guide Chapter 1130]

authorization or legality of a substance. The Committee discussed possible disparities in response by CA workers across the state when considering a legal or prescribed drug versus an illegal drug. The Committee discussed the importance for CA staff to assess the impact that substance use or abuse has on a parent's ability to safely care for his/her children regardless of the legality of a substance, by considering observations, historical CA records and collateral information.

The Committee spent a considerable amount of time discussing the importance of CA staff receiving sufficient and ongoing training to inform social work practice. Emphasized in conversation were two areas of training - substance use and domestic violence. The Committee was concerned to learn that training on substance use and its impact on child safety and child welfare has not been available for to CA staff for a prolonged period of time. The Committee believed that assessing the parent's substance use and/or abuse in this case could have been more thorough, but recognized that without sufficient training on how to assess substances as it relates to child safety, any assessments may be limited.

The Committee heard from the supervisor and CA caseworker that domestic violence training has been offered and available in their local office; however, due to conflicts with schedules, neither the supervisor nor the CA caseworker were able to attend. The Committee discussed that during the 2016 investigations, had the assigned social worker and supervisor attended the domestic violence training, they would likely have received helpful information to assist them in sorting out who the victim and perpetrator were and been able to more fully assess the child's safety. Attending available training on substance use and domestic violence that include information on their impacts on child safety should be considered a priority for staff.

Findings

Given that the manner of the child's death remains undetermined, the Committee did not find critical errors or make correlating conclusions with regard to actions taken or decisions made by the CA.

Recommendations

- The Committee recommends that CA consider requiring a safety plan to be developed immediately at the time of an FTDM if a safety threat has been identified and the FTDM plan calls for a safety plan to be developed.
- The Committee recommends that the local DCFS office social worker and supervisory staff attend the two-day domestic violence training available in their region.
- The Committee recommends that CA provide yearly training to all CA staff on the assessment of legal and illegal substances and their impact on a person's ability to safely care for a child.

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

Child Fatality Review

A.M.

RCW 74.13.515 **2015**
Date of Child's Birth

November 2, 2016
Date of Child's Death

March 1, 2017
Date of the Fatality Review

Committee Members
Patrick Dowd, Director, Office of the Family & Children's Ombuds
Jenna Kiser, Intake and Safety Program Manager, Children's Administration
Shelley Little RN, BSN, CCM, Supervisor Safe Babies Safe Moms Tri-Cities
Ronna Washines, Tribal Prosecutor, Yakama Nation

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

Observer
Angie Keith, Supervisor, Children's Administration

Executive Summary

On March 01, 2017, the Department of Social and Health Services, Children's Administration (CA) convened a Child Fatality Review (CFR)[10] to assess the department's practice and service delivery to an infant child, A.M., and RCW 74.13.515 family. The child is referenced by RCW 74.13.515 initials, A.M., in this report. At the time of RCW 74.13.515 death, A.M. had been residing with RCW 74.13.515 parents and extended family.[11] The incident initiating this review occurred on November 2, 2016, when A.M. died while co-sleeping with RCW 74.13.515 father.

The CFR Committee included CA and community professionals with relevant expertise in child advocacy, child abuse and child safety, law enforcement and pediatric medicine. None of the Committee members had any previous direct involvement with this family. Prior to the review, each Committee member received a detailed case summary, a family genogram, un-redacted case documents including case notes, referrals for services, assessments and medical records. The hard copy of the file was available at the time of the review. Supplemental sources of information and resource materials were also available to the Committee, including state laws and CA policies relevant to the review.

The Committee interviewed the local CA area administrator. Previously assigned CA caseworkers and supervisors were not interviewed due to unavailability. Following the review of the case file documents, completion of staff interviews, and discussion regarding CA activities and decisions, the Committee made findings and recommendations that are presented at the end of this report.

Case Summary

CA received seven reports on A.M.'s family between February 10, 2012 and March 21, 2016, three of which resulted in investigations with unfounded[12] findings in 2014, 2015 and 2016. The allegations noted in the intakes were RCW 13.50.100, RCW 13.50.100, RCW 13.50.100. The March 2016 investigation was closed on April 19, 2016.

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[10] 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 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.

[11] The parents are not identified by name in this report as no criminal charges were filed relating to the incident. [Source: RCW 74.13.500(1)(a)].

[12] 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 child abuse did or did not occur 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. [Source: RCW 26.44.010]

On November 07, 2016, a federal law enforcement agent contacted the RCW 74.13.515 CA supervisor to notify her that A.M. died on November 2, 2016 while in the care of RCW 74.13.515 father. A.M.'s father was reported to have returned home between 4:00 a.m. and 6:00 a.m. on November 2, 2016. Once the father arrived home he removed A.M. from the paternal grandmother's bed and into his own bed. Local law enforcement was dispatched to the home on the same date at approximately 7:30 a.m. for a welfare check on an older child in the home due to RCW 13.50.100. While local law enforcement was at the home, A.M. was observed face up in the bed with RCW 74.13.515 father and appeared to be alive. Later that same day, the family called 911 at approximately 1:00 p.m. requesting assistance as A.M. was unresponsive. When local law enforcement responded to the home for the second time on November 2, 2016, A.M. was found face down on the father's bed. The father stated to law enforcement that he had been drinking alcohol until around 4:00 a.m. that morning. The cause of death was documented as Sudden Infant Death Syndrome (SIDS).

Additionally, the federal law enforcement agent informed CA that another child died a few years earlier in the family home. The CA investigator assigned discovered that RCW 13.50.100. CA found information about RCW 13.50.100death in law enforcement reports and medical records. SIDS was the documented cause of death. CA had not previously been aware of the birth or the death of RCW 13.50.100.

Discussion

For purposes of this review, the Committee primarily focused on case activity that occurred prior to A.M.'s death; however, the Committee did discuss the medical examiner and law enforcement activities related to A.M.'s death.

The Committee spent considerable time discussing the 2014 investigation of RCW 13.50.100. RCW 13.50.100. The Committee did not connect the 2014 investigation to A.M.'s death but believed discussion was important for the purpose of practice improvement. The Committee discussed the necessity of collateral contacts in conducting a comprehensive investigation and in assessing risk and safety. The Committee noted missed opportunities to gather additional clarifying information from the medical providers, from law enforcement, from the school, from DSHS databases and from other sources within the family's community, including the tribal members and neighbors. The Committee discussed the importance of teaming with tribal social and health services to gather information from the tribal community noting cultural intricacies that CA may not be aware of or understand.

Although the CA social worker identified that the children were "unsafe" on the safety assessment[13] and a safety plan[14] was developed, the Committee noted that the safety plan lacked specific safety tasks that would protect the children from the identified safety threat[15]. The tasks in the plan relied on the parents to keep their children safe from harm and included a task for a referral for an in-home service. The Committee acknowledged that had the department better understood the day-to-day functioning of the caregivers, their substance use, and when the safety threat became active, a more functional and successful safety plan could have been developed to manage the identified safety issues in the home. The Committee strongly believed that a CA medical consultation and a medical assessment should have occurred RCW 13.50.100 .

The Committee was concerned to learn that training on interviewing children with disabilities or developmental delays has not been available to staff outside of a brief session in Regional Core Training (RCT)[16]. The Committee discussed the importance of child interview training to include all levels of child development. The Committee discussed that CA's ability to effectively interview children with disabilities without training is limited and would likely vary by caseworker depending on previous education, training and practice.

The Committee discussed the death of RCW 13.50.100 . The Committee wondered why the medical examiner or law enforcement bypassed notifying CA of this child's death. Some Committee members

[13] Safety Assessment is used throughout the life of the case to identify impending danger and determine whether a child is safe or unsafe. It is based on comprehensive information gathered about the family at the time the safety assessment is completed. [Source: CA Practices and Procedures Guide, Chapter 1120]

[14] The Safety Plan is a written agreement between a family and CA that identifies how safety threats to a child will be immediately controlled and managed. The Safely Plan is implemented and active as long as threats to child safety exist and caregiver protective capacities are insufficient to protect the child. A Safety Plan is required for all children where there is a safety threat(s) indicated on the Safety Assessment. Note: when creating an in-home Safety Plan, the following criteria must be met: 1) there is at least one parent/caregiver or adult in the home; 2) the home is calm enough to allow safety providers to function in the home; 3) the adults in the home agree to cooperate with and allow an in-home safety plan; 4) sufficient, appropriate and reliable resources are available and willing to provide safety services/tasks. [Source: CA Practices and Procedures Guide, Chapter 1130

[15] 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]

[16] RCT is the initial, intensive, task-oriented training that prepares newly hired Social Service Specialists to assume job responsibilities. RCT starts on the first day of employment and lasts for 60 days, or the first two months of employment. Competencies are used to assess learning needs and to identify a developmental plan for the new workers.

discussed mandatory reporting[17] and that unlike law enforcement, medical examiners aren't required by law to report child deaths to CA even if there is concern for child abuse or neglect[18]. The statute requires medical examiners to make a report to law enforcement or CA if they feel the death is suspicious or criminal in nature. Other Committee members opined, understanding CA's inability to mandate or enforce reporting by community professionals, that they would have liked CA to have been notified of the death of RCW 13.50.100based the Committee's RCW 13.50.100 . The Committee heard from the local area administrator that CA usually receives information from the medical examiner or law enforcement in such instances of a child death and that this particular situation was unusual. The Committee noted that local law enforcement did not notify CPS of the death of RCW 13.50.100nor did they report A.M.'s death. The Committee further noted that a federal agent contacted CA about A.M.'s death almost a week past the death. Some Committee members questioned why the case workers that were assigned in subsequent investigations might not have come across the information of the birth and death of RCW 13.50.100in the Department of Health (DOH) records. Discussion centered on lack of training for staff on DOH programs as well as other state agency computer information systems. The Committee considered the importance of case consultation, multi-disciplinary team staffings and shared decision-making when dealing with complex cases like this one and that the consultation should include a medical consultation, connections with Developmental Disabilities Administration (DDA) services as well as program experts and CA staff at all levels in the chain of command.
The area administrator informed the Committee that a community multidisciplinary team meets monthly and has done so for over the last twenty years to discuss local protocols and information sharing among agencies on serious physical abuse and sexual abuse cases. Further, the area administrator informed the Committee that the local CA

[17] RCW 26.44.030(1)(a) defines mandated reporter as: "…any practitioner, county coroner or medical examiner, law enforcement officer, professional school personnel, registered or licensed nurse, social service counselor, psychologist, pharmacist, employee of the department of early learning, licensed or certified child care providers or their employees, employee of the department, juvenile probation officer, placement and liaison specialist, responsible living skills program staff, HOPE center staff, or state family and children's ombuds or any volunteer in the ombuds office has reasonable cause to believe that a child has suffered abuse or neglect, he or she shall report such incident, or cause a report to be made, to the proper law enforcement agency or to the department…"

[18] Any law enforcement agency receiving a report of an incident of alleged abuse or neglect pursuant to this chapter, involving a child who has died or has had physical injury or injuries inflicted upon him or her other than by accidental means, or who has been subjected to alleged sexual abuse, shall report such incident in writing as provided in RCW 26.44.040 to the proper county prosecutor or city attorney for appropriate action whenever the law enforcement agency's investigation reveals that a crime may have been committed. The law enforcement agency shall also notify the department of all reports received and the law enforcement agency's disposition of them. In emergency cases, where the child's welfare is endangered, the law enforcement agency shall notify the department within twenty-four hours. In all other cases, the law enforcement agency shall notify the department within seventy-two hours after a report is received by the law enforcement agency. [Source: RCW 26.44.030(5)]

staff use shared planning meetings[19] and the Local Indian Child Welfare Advisory Committee(LICWAC[20]) to gain information on families. The Committee recognized that the LICWAC committee may not provide much information to CA on a child that has passed away due to customary cultural traditions not to speak of those who have died. The Committee questioned whether there is a statewide lack of consensus about CA's role in the investigation of child deaths related to unsafe sleep and ongoing misunderstandings among staff and community agency's about the meaning of the terms "SIDS"[21] and "SUID."[22] The Committee expressed concern that what appears to be a lack of consensus may be a system-wide issue with the professional entities involved regarding the SIDS determination and the potential effect it can have on CA's ability to more fully assess child safety of other children in the home. Committee members questioned the possibility of some medical examiners using the SIDS determination to eliminate further intervention from agencies such as law enforcement or CA in order to protect the family from additional hardships post child death. The Committee expressed concern that an autopsy was not completed on A.M. The Committee discussed that A.M. was RCW 74.13.515 short of RCW 74.13.515 first birthday and wondered what the cause of death determination would have if A.M. had officially been one-year-old (the usually observed cut off for a SIDS determination). The Committee believed that education from the area administrator and/or a CA medical consultant[23] might assist the local community professionals including the local medical examiner in understanding that although not always mandated, the importance of information sharing in child death cases.

[19] All staffings engage parents in the shared planning process to develop family specific case plans focused on identified safety threats and child specific permanency goals. Working in partnership with families, natural supports and providers helps identify parents' strengths, threats to child safety, focus on everyday life events, and help parents build the skills necessary to support the safety and well-being of their children. The shared planning process integrates all CA staffings. [Source: CA Practices & Procedures Guide, Chapter 1700]

[20] A LICWAC is a body of volunteers, approved and appointed by CA who staff and consult with the department on cases of Indian children who: are members of a tribe, band or First Nations has not responded, or has chosen not to be involved, or is otherwise unavailable; or for whom the child's tribe, band, or First Nations has officially designated the LICWAC to staff the case; or are defined as a recognized Indian child.

[21] Sudden Infant Death Syndrome (SIDS) is defined as the sudden death of an infant less than one year of age that cannot be explained after a thorough investigation is conducted, including an autopsy, examination of the death scene and a review of the clinical history. SIDS is a type of SUID. [Source: Centers for Disease Control and Prevention]

[22] The Centers for Disease Control (CDC) defines SUID as "Deaths in infants less than 1 year of age that occur suddenly and unexpectedly, and whose cause of death are not immediately obvious prior to investigation." According to the CDC, the 3 most frequently reported causes of SUID are SIDS, unknown, and accidental suffocation and strangulation in bed.

[23] The tasks of the statewide Child Abuse Consultation 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.

Findings

After a review of the case chronology, interviews with staff and discussion, the Committee did not identify any critical errors linked to the death of A.M. The Committee reached consensus on the findings and recommendations below:

- The Committee found that the investigations related to the April 2014 and 2015 reports were incident-focused and lacked comprehensive information gathering from collateral sources; if the information had been gathered, it may have improved the CA's assessment of risk and safety or the current law.
- The Committee found that a CA medical consultation or emergency medical care did not occur for the 2014 investigation regarding the RCW 13.50.100.[24]

Recommendations

- In an attempt to reduce possible ambiguity in CA's role in child death investigations, the Committee recommends that the local DCFS area administrator and/or a CA medical consultant communicate with the local professionals who investigate child death and child abuse (including the local medical examiner and local law enforcement), possibly at a multidisciplinary meeting, how SIDS findings, autopsy reports, and information sharing impacts CA's ability to assess the safety of the surviving children in the home and complete investigations more accurately.
- The Committee recommends that CA make training available to all CA staff on interviewing children with disabilities, safety assessment of children with disabilities, and partnering with the community for assessment and services of children with disabilities to include working with Developmental Disabilities Administration.
- The Committee recommends that CA make training regularly available to all CA staff on navigating and using Department of Health records and the Community Service Office databases.

[24] Consultations, Evaluations and Referrals (i)Secure a prompt medical evaluation or treatment for a child:
A. If indicators of serious CA/N exist.
B. A child is three or younger with a physical abuse allegation.
C. The alleged CA/N cannot be reasonably attributed to the explanation and a diagnostic finding would clarify the assessment of risk or determine the need for medical treatment.
D. If the alleged neglect includes concerns that children are deprived of food, underweight, or are starved.
(ii.) Contact the Child Protection Medical Consultant in your region when identification or management of CA/N would be facilitated by expert medical consultation.
(iii.) Seek legal authority for the medical examination if the parent does not comply with the request.
(iv.) Contact the Washington Poison Control Center at 1-800-222-1222 if consultation is needed about prescribed or non-prescribed medications. [Source: CA Practice & Procedures Manual, Chapter 2331(4)(f)]