

## **Report to the Legislature**

### **Quarterly Child Fatality Report**

RCW 74.13.640

April - June 2016

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Washington State Department of Social & Health Services

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## Executive Summary

This is the Quarterly Child Fatality Report for April through June 2016 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 October 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 2016. 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 three regions.

| Region  | Number of Reports |
|---|-------------------|
| 1   | 1                 |
| 2   | 1                 |
| 3   | 1                 |
| Total Fatalities and Near-Fatalities Reviewed During 2nd Quarter 2016 | 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 2016. 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 2016 |  |                            |                          |
|---|--|----------------------------|--------------------------|
| Year  | Total Fatalities Reported to Date Requiring a Review | Completed Fatality Reviews | Pending Fatality Reviews |
| 2016  | 6  | 2                          | 4                        |

| Child Near-Fatality Reviews for Calendar Year 2016 |   |                                 |                               |
|--|---|---------------------------------|-------------------------------|
| Year   | Total Near-Fatalities Reported to Date Requiring a Review | Completed Near-Fatality Reviews | Pending Near-Fatality Reviews |
| 2016   | 8   | 3                               | 5                             |

The two (2) child fatality reviews referenced in this Quarterly Child Fatality Report are subject to public disclosure and are 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 nor included in this report.

#### ***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:

- All three (3) of the cases referenced in this report were open at the time of the child's death or near-fatal injury.

- Only one (1) of the child fatalities referenced in this report occurred when the children were under 2 years of age.
- One (1) fatality was the result of abuse or neglect.
- In one (1) of the fatalities the child died from pneumonia. The Child Protective Services (CPS) investigation into this child's death resulted in a founded finding of medical neglect against his parents.
- One (1) child fatality was coded as an accidental death by a medical examiner. This child died from an accidental overdose of medication following routine surgery. This child was four years old at the time of his death.
- The one (1) near-fatality is the result of a near drowning. The child was a dependent of the state and placed with a family friend as a Suitable Person Placement. The CPS investigation found the caregiver was negligent in her supervision of the child when he was in a swimming pool.
- Two (2) children were Caucasian and one (1) was Hispanic.
- Children's Administration received intake reports of abuse or neglect on two (2) of the three (3) cases prior to the death or near-fatal injury of the child. One case had two (2) prior intakes and another had only one (1) less intakes reported to CA prior to the critical incident.
- Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.



## **Child Fatality Review**

**RCW 13.50.100**

**August 2011**

Date of Child's Birth

**November 7, 2015**

Date of Fatality

**March 31, 2016**

Child Fatality Review Date

### **Committee Members**

Ryan Rechtenwald, Chief Criminal Deputy, Grant County Sheriff's Office  
Oscar Ochoa, Social Services Supervisor, Economic Services Administration  
Margo Amelong, Executive Director, Support Center of Okanogan County  
Gabriel Ortiz, Licensing Analyst, Division of Early Learning  
Julie Ellis, Family Assessment Response Program Manager, Children's Administration, Region One  
Kristopher Warren, Child Protective Services Supervisor, Children's Administration  
Patrick Dowd, Director, Office of the Family and Children's Ombuds

### **Observer**

Sharon Ostheimer, Child Protective Services Program Manager, Children's Administration, Region One North

### **Facilitator**

Susan Danielson, Critical Incident Case Review Specialist, Children's Administration

## ***Executive Summary***

On March 31, 2016, the Department of Social and Health Services (DSHS) Children's Administration (CA) convened a Child Fatality Review (CFR)<sup>1</sup> to assess the department's practice and service delivery to four-year-old<sup>2</sup> RCW 13.50.100 and his family. The incident precipitating this review occurred on November 7, 2015, when RCW 13.50.100 died in a relative's home after he had a scheduled operation to remove his RCW 70.02.020. The Grant County Coroner stated the cause of death was pneumonia with RCW 70.02.020 as a contributing factor. At the time of RCW 13.50.100.'s death, CA had an open Family Assessment Response (FAR)<sup>3</sup> case with the family.

The CFR Committee included CA staff with expertise in child welfare, law enforcement, domestic violence, child development and a representative from the Office of the Family and Children's Ombuds. No committee members had previous contact or involvement with the 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 medical records and the medical examiner's report. Supplemental sources of information and resource material regarding caseload data and CA policies were available to the committee at the time of the review. The Committee interviewed the FAR social worker and supervisor who were assigned to the case at the time of the fatality to gain an understanding of FAR practice expectations and decision-making on the case and local office guidelines for community collaboration and law enforcement investigative protocols.

## ***Case Summary***

On October 9, 2015, CA received an intake alleging neglect of RCW 13.50.100 six-year-old brother, identified RCW 13.50.100. This intake reported that RCW 13.50.100

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<sup>1</sup> 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.

<sup>2</sup> The parents are not identified by name in this report as no criminal charges were filed relating to the incident. The names of RCW 13.50.100 and his siblings are subject to privacy law. [Source: [RCW 74.13.500\(1\)\(a\)](#)].

<sup>3</sup> 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](#)]

experienced RCW 70.02.020 and RCW 70.02.020 at school and that his mother, RCW 13.50.100, was not responsive to the school's efforts to address the problem. The intake reported that RCW 13.50.100 resided with his mother, his two younger siblings RCW 13.50.100 and RCW 13.50.100 and RCW 13.50.100 father. This intake was assigned to CPS/FAR; the social worker met with the family on October 12, 2015 to discuss the allegations and review the FAR program guidelines. The mother agreed to work with CA voluntarily and consented to take F.R. to the doctor for evaluation which she did within the week.

On October 15, 2015, the mother took her second oldest child, RCW 13.50.100, for a consultation with an RCW 70.02.020 specialist to evaluate his persistent snoring and nasal congestion. The RCW 70.02.020 recommended that RCW 13.50.100 have both his RCW 70.02.020 removed and scheduled this surgery for November 6, 2015. RCW 13.50.100 was discharged the same day with a prescription for RCW 70.02.020 for pain.

On November 9, 2015, CA received an intake stating that RCW 13.50.100 had died on Saturday, November 7, 2015 at a relative's home. This intake reported RCW 13.50.100's death as accidental but a second intake received on November 10, 2015 provided additional information that alleged that RCW 13.50.100 may have died as a result of an overdose of oxycodone. The November 10<sup>th</sup> intake was accepted for investigation and the matter was referred to law enforcement. In her statements to investigators, RCW 13.50.100 reported that she had given RCW 13.50.100 his prescribed dose of oxycodone the night of November 6 and again on the following morning, November 7 at about 8:30 a.m. She reported she gave him another dose on November 7 and allowed him to spend time undisturbed in a bedroom. On the evening of November 7, the mother left RCW 13.50.100 at a relative's residence while she went to run errands. At about 7:00 pm that same night, one of the relatives found that RCW 13.50.100 had stopped breathing, initiated CPR and called 911. Emergency responders were unable to revive the child and he was pronounced deceased at about 8:25 p.m. The investigating officer noted that 30 ml of RCW 13.50.100's medication was missing from the bottle. The Grant County Coroner's report listed the cause of death as RCW 70.02.020 with RCW 70.02.020 as a risk factor.

### ***Committee Discussion***

After discussing case activities, case planning and services to this family from the initial intake on October 9, 2015 through the date of the fatality on November 7, 2015, the Committee found no critical oversights and further found that the social worker appeared to have complied with CA policies, procedures and practice guidelines. The Committee noted that both the social worker and

supervisor demonstrated a solid understanding of the case and ability to tell the story of the case in a clear and concise manner. The Committee also noted that the social worker provided much more information than had been recorded in the case notes and strongly encouraged her to ensure this information is documented.

Although the primary focus of the CFR is to review CA's actions and decision-making prior to the child's death, the Committee was concerned about the lack of information available to CA regarding the investigation of the fatality by law enforcement. As a general practice, CA staff should collaborate with law enforcement agencies to investigate allegations of child abuse and neglect. In cases where the allegations may be criminal in nature or result in criminal charges, law enforcement takes the lead on the investigation as was the case in the investigation of RCW 13.50.100's death. Local CA staff explained to the Committee that the law enforcement agency investigating RCW 13.50.100's death specifically requested that CA staff not interview RCW 13.50.100's mother and relatives regarding the circumstances of the fatality until the investigation had been completed. CA staff informed the Committee that as of the time of this review, four months after RCW 13.50.100's death, this information was still not available to the social worker. The Committee believed that the lack of information significantly impacts the worker's ability to assess safety and risk in this home. Noting that there are two surviving children who may be at risk, the Committee made several recommendations about strategies to address this problem.

### ***Findings***

None

### ***Recommendations***

1. The Committee believed that the medical examiner's report raised the possibility of risk of neglect by the parent and that further evaluation is needed to assess the safety of the surviving children. The Committee made the following suggestions as possible strategies for the local CA office to consider in order to obtain needed investigative reports.
  - Contact the prosecuting attorney to obtain an updated copy of the investigative protocol, and ensure that law enforcement agencies who are within this office's catchment area have a copy.<sup>4</sup>

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<sup>4</sup> In 1999, the Washington state legislature amended [RCW 26.44.180](#) to require prosecuting attorneys in each county to develop a written protocol for handling criminal child sexual abuse investigations. In 2007, the legislature added [RCW 26.44.185](#) which required prosecuting attorneys in each county to revise and expand their child abuse investigation protocols to include investigations of child fatalities, child physical abuse and criminal child neglect cases.

- Consider consultation with the Attorney General's Office to elicit its advocacy to obtain reports needed to assess child safety.
- Consider working with local law enforcement agencies within the office's catchment area to develop a memorandum of understanding regarding the exchange of information.

The Committee recommended that the assigned social worker consult with CA's Regional Medical Consultant in order to better understand the terminology and findings in the medical examiner's report.



## **Child Fatality Review**

**RCW 13.50.100**

**July 2015**

Date of Child's Birth

**December 3, 2015**

Date of Fatality

**March 3, 2016**

Child Fatality Review Date

### **Committee Members**

Mary Moskowitz, J.D., Ombuds, Office of the Family and Children's Ombuds

Oleg Pynda, Executive Director, **RCW 13.50.100** Community Center of Washington

Stephanie Frazier, Child Protective Services Program Manager, Children's Administration

Janell Berger, Child Protective Services Supervisor, Children's Administration

### **Consultant**

Francine Chalmers, MD, Regional Medical Consultant, Children's Administration

### **Observer**

J. Christopher Graham, Ph.D., Senior Reports and Data Developer/Designer,  
Children's Administration Data Management and Reporting Section

Shawn Matthews, Adult Protective Services Fatality Review Program Manager,  
Home and Community Services

### **Facilitator**

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

## ***Executive Summary***

On March 3, 2016, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)<sup>5</sup> to assess the department's practice and service delivery to four-month-old [REDACTED] and his family.<sup>6</sup> The child will be referenced by his initials, [REDACTED] in this report.

On November 4, 2015, CA was notified that [REDACTED] had been admitted to [REDACTED] Hospital. [REDACTED] was diagnosed with [REDACTED] related to [REDACTED] medical condition. [REDACTED] remained inpatient until [REDACTED] death on December 3, 2015. Prior to [REDACTED] hospital admission [REDACTED] lived with [REDACTED] father, mother and 13-year-old [REDACTED]. The King County Medical Examiners Officer declined to conduct an autopsy stating [REDACTED] death was considered to be due to natural causes [REDACTED].

The review Committee included members selected from the community with relevant expertise including the Office of the Family and Children's Ombuds and an executive director of a social service agency supporting the [REDACTED] community within Washington state. The Committee also included a child protective services supervisor and child protective services program manager with CA. A contracted medical consultant with CA was consulted by telephone. There were two DSHS employees who observed the review. Neither DSHS/CA staff nor any other Committee members had previous involvement with this family.

Prior to the review, each Committee member received a case chronology, a summary of CA involvement with the family and 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 the [REDACTED] Hospital autopsy report, medical records, relevant state laws and CA policies.

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<sup>5</sup> Given its limited purpose, a 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.

<sup>6</sup> [REDACTED]'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: [RCW 74.13.500\(1\)\(a\)](#)]

The Committee interviewed the assigned CPS worker and her supervisor, the family team decision meeting facilitator and the area administrator.

### ***Family Case Summary***

On July 31, 2015, CA received a call from a physician treating [REDACTED] RCW 13.50.100. Also present with the physician during the call was a public health nurse assigned to work with the family. At the time of the intake [REDACTED] RCW 13.50.100 was one week old. The physician alleged [REDACTED] RCW 13.50.100 of [REDACTED] RCW 13.50.100 by [REDACTED] RCW 13.50.100 parents. The physician stated [REDACTED] RCW 13.50.100 has an [REDACTED] RCW 13.50.100. [REDACTED] RCW 13.50.100 during the [REDACTED] RCW 13.50.100. The mother refused to follow medical advice. [REDACTED] RCW 13.50.100 mother and father refused the [REDACTED] RCW 13.50.100 for [REDACTED] RCW 13.50.100 until they were informed Child Protective Services would be contacted. Another reported concern was the parents' failure to attend two follow-up [REDACTED] RCW 13.50.100. The physician was concerned that the parents may not be adequately medicating [REDACTED] RCW 13.50.100 to prevent [REDACTED] RCW 13.50.100. This intake was assigned for a 24-hour CPS investigation.

The CPS investigation included interviews with both parents and collateral contacts. On September 29, 2015, the investigative assessment was completed as unfounded for negligent treatment or maltreatment. Before the closure of the investigation, CA had been informed that [REDACTED] RCW 13.50.100 tested positive for the [REDACTED] RCW 13.50.100 as his mother.

On November 4, 2015, a second intake was received from a local hospital. The hospital social worker reported medical neglect of three-month-old [REDACTED] RCW 13.50.100. It was reported that [REDACTED] RCW 13.50.100 needed to have [REDACTED] RCW 13.50.100 within two days or [REDACTED] RCW 13.50.100 would [REDACTED] RCW 13.50.100, but the parents were not cooperating with the hospital. [REDACTED] RCW 13.50.100 presented at the hospital with [REDACTED] RCW 13.50.100 and was diagnosed with [REDACTED] RCW 13.50.100. The type of [REDACTED] RCW 13.50.100 is directly related to [REDACTED] RCW 13.50.100. The social worker stated the family does not believe in the [REDACTED] RCW 13.50.100 and that the [REDACTED] RCW 13.50.100 are too [REDACTED] RCW 13.50.100. According to the caller, the parents appear to be bonded and providing for their [REDACTED] RCW 13.50.100 other than related to this [REDACTED] RCW 13.50.100 issue. The social worker reported that the hospital has provided all of its recommendations in a [REDACTED] RCW 13.50.100 and [REDACTED] RCW 13.50.100 appropriate manner; however, the parents continue to refuse the recommended [REDACTED] RCW 13.50.100. This intake was assigned as a 24-hour CPS investigation.

On November 4, 2015, the investigation was assigned to the CPS worker who had conducted the prior CPS investigation. She contacted the public health nurse and the hospital. The CPS supervisor contacted the Child Protection Team at [REDACTED] RCW 13.50.100 Children's Hospital to discuss the case. On November 5, 2015, [REDACTED] RCW 13.50.100 was placed on life support.

On November 5, 2015, an FTDM<sup>7</sup> occurred. The parents, [RCW 13.50.100], familial support and medical professionals were present. This meeting occurred at the hospital. A dependency petition was filed on November 6, 2015 as to [RCW 13.50.100]. The petition did not include [RCW 13.50.100] older half-sister. [RCW 13.50.100] remained inpatient until [RCW 13.50.100] death on December 3, 2015.

Based on two suspected child abuse and neglect consultations by two differing CA medical consultants, the investigative assessment was [RCW 13.50.100] for [RCW 13.50.100] as to both parents regarding their failure to meet [RCW 13.50.100]'s medical needs resulting in [RCW 13.50.100] death.

### ***Committee Discussion***

For purposes of this review, the Committee focused on case activity prior to the fatality. The CPS investigation regarding the fatality was briefly discussed.

There was a suggestion that inclusion of a person from the [RCW 13.50.100] culture/community, who was not identified by the family, may have assisted CA with an unbiased education regarding the culture and interactions with the family. This contact may have aided CA staff with a better understanding of how this infectious disease is viewed within the [RCW 13.50.100] culture, the lack of trust of the medical field within the community and overall interactions between Child Protective Services and the [RCW 13.50.100] community. There has been recent communication between the Everett area administrator and the [RCW 13.50.100] representative on the Committee to discuss collaboration between the office and local community.

The Committee also discussed that once the actual [RCW 13.50.100] of the communicable disease of [RCW 13.50.100] was made known to us, and knowing that the father had not yet been made aware, the investigation could have been extended. This extension would have allowed for CA to assess the family's willingness to maintain medically recommended care and connect with natural or community supports in light of this new information.

An overarching area identified as a challenge was the stress faced by the field offices. Those areas include turnover, increased caseloads, inability to obtain and/or provide timely and comprehensive training to new staff and the inception of [SB 5888](#) also known as Aidan's Act.

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<sup>7</sup>Family Team Decision Making (FTDM) meetings bring people together who are involved with the family to make critical decisions regarding the removal of child(ren) from their home, changes in out-of-home placement, and reunification or placement into a permanent home. [Source: [CA Practices and Procedures Guide 1720](#)]

The issue of staff retention was included in the Committee's discussion regarding stress. While a litany of reasons were suggested related to staff turnover, the Committee primarily discussed the fact that staff feel overwhelmed immediately upon starting in child welfare. The CPS investigator on this case was new when she received the first intake. Within three months of that initial intake, the subsequent intake qualified for the first Aidan's Act review and a near-fatality review. Understanding that the work of child welfare will be open to scrutiny, it can have a chilling impact on staff's willingness to remain in this field unless they feel they have received adequate training and have a supporting supervisor and area administrator.

### ***Findings***

The Committee did not identify any critical errors that contributed the fatality. However, there were areas where the Committee identified possible improvements in case practice.

At the conclusion of the first investigation, the worker's last case note was regarding contact with the public health nurse. During that conversation, the public health nurse noted concerns about the parents' unwillingness to follow through with recommended [RCW 13.50.100], the child had [RCW 13.50.100] for the [RCW 13.50.100] and there was a comment made that [RCW 13.50.100] Children's Hospital wanted to admit the child to the hospital. The investigator did not follow up on the identified concerns.

The Committee believed it would have been appropriate to have had a shared planning meeting or FTDM with the parents, identified familial supports and the medical professionals. The meeting would have allowed for all parties to have the same information regarding [RCW 13.50.100] medical needs, [RCW 13.50.100] positive test result ([RCW 13.50.100] father was not aware of the [RCW 13.50.100] result at the closure of the case) and a plan for notification to CA if the parents failed to maintain the recommended [RCW 13.50.100].

The Committee noted that it may have been beneficial for the CPS investigator to have requested the prenatal records and [RCW 13.50.100] birth records. Those documents may have assisted CA in identifying and verifying what conversations occurred with the parents regarding recommended [RCW 13.50.100] for the birth of [RCW 13.50.100] and for [RCW 13.50.100] care post birth.

The Committee also identified positive actions as evidence of good decision making and [RCW 13.50.100] competence related to this case. When the CPS investigator contacted [RCW 13.50.100] older [RCW 13.50.100] school, [RCW 13.50.100] requested the contact list from the child's file. The investigator utilized this as a collateral

resource. The Committee noted this was good practice and a way to attempt to help verify information provided by the parents.

During the second investigation, an FTDM occurred. The FTDM occurred at the hospital where RCW 13.50.100 was admitted. The attendees included a pastor from the family's religion who shared their RCW 13.50.100 background. This pastor was utilized as a support to the family and as a RCW 13.50.100 advisor to the department regarding this family specifically. This was not only a respectful inclusion but also was a positive way to build trust with the family and to follow the department's expectation for RCW 13.50.100 competence.

The Committee did not make any recommendations during this review.