# CHILD FATALITY REVIEW

Washington State Department of
CHILDREN, YOUTH & FAMILIES

October 2021

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October 2021

# Full Report

## Child

- R.C.

## Date of Child's Birth

- RCW 74.13.515 2021

## Date of Fatality

- April 1, 2021

## Child Fatality Review Date

- June 22, 2021

## Committee Members

- Cristina Limpens, MSW, Ombuds, Office of the Family and Children's Ombuds
- Tara Camp, Statewide CFWS Program Manager, DCYF
- Lisa Sinnett, MAC, Alliance Coach, University of Washington
- Robert Welch, MSW, Human Services/Chemical Dependency, Clover Park Technical College

## Facilitator

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

## Executive Summary

On June 22, 2021, the Washington State Department of Children, Youth, and Families (DCYF) convened a Child Fatality Review (CFR)[1] to examine DCYF's practice and service delivery to R.C. and RCW 74 family. R.C. will be referenced by RCW 74 initials throughout this report.[2]

On April 1, 2021, DCYF received a notification from the medical examiner's office with preliminary findings about the death of RCW 74.13.515-old R.C. The parents reported co-sleeping with R.C. and believed RCW 7 suffocated as R.C. was partially underneath blankets, in between the parents on the bed. It was reported there was evidence of a possible injury to R.C.'s neck, but no additional information was known at the time of the report. The family had an open Child and Family Welfare Services (CFWS)[3] case with DCYF.

A diverse Committee was assembled to review DCYF's involvement and service provision to the family. The Committee included members with relevant expertise selected from diverse disciplines within DCYF and community partnerships. Committee members had no prior direct involvement with R.C. or RCW 74 family. The Committee received relevant case history from DCYF prior to the review. On the day of the review, the Committee had the opportunity to interview the DCYF caseworkers, supervisors, and the area administrator.

## Case Overview

The family first came to DCYF's attention in 2006. From 2006 to 2020, DCYF received 26 calls reporting concerns of abuse and neglect in the home. Throughout the reports, the family make-up changed as the mother gave birth to five children, RCW 74.1, RCW 74.13, RCW 74.13, RCW 74.13, and R.C., with four fathers. RCW 74.13.51 father died in 2020, RCW 74.13 and RCW 74.13.515 father resides out of state, and RCW 74.13.515 and R.C.'s fathers are in-state. The reported concerns related primarily to substance use in the home, but also lack of age-appropriate supervision, domestic violence (DV), and unmet mental health needs. DCYF responded to 17 allegations that met the criteria for Family Assessment Response (FAR)[4] and Child Protective Services (CPS) investigations. The other nine allegations did not meet the criteria to open a case. Through the investigative process, the mother received founded findings of neglect in three investigations and findings of physical abuse in two investigations.

In 2014, DCYF received allegations that the mother left the children unsupervised with vulnerable adults for whom she was responsible as a caregiver. DCYF assigned a CPS investigation. The CPS caseworker attempted to locate the family. The mother did not respond to the attempts, and the caseworker was unable to locate the family. The case closed.

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[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 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 DCYF or its contracted service providers.
The Committee has no subpoena power or authority to compel attendance and generally hears only from Agency 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 CFR 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 CFR to recommend personnel action against DCYF employees or other individuals.

[2]The names of R.C.'s parents are not used in this report because neither parent has been charged with a crime in connection with the fatality. R.C.'s name is also not used in this report because RCW name is subject to privacy laws. See RCW 74.13.500.

[3]Child and Family Welfare Services caseworkers assume responsibility of a child welfare case after the children have been removed from their caregivers and a dependency petition has been filed.

[4]"Family Assessment Response (FAR) is a Child Protective Services (CPS) alternative response to an investigation of a screened-in allegation of child abuse or neglect. FAR focuses on child safety along with the integrity and preservation of the family when lower risk allegations of child maltreatment have been screened in for intervention." See: **https://www.dcyf.wa.gov/practices-and-procedures/2332-child-protective-services-family-assessment-response**.

In 2017, there was an allegation that RCW 13.50.100. This information screened out due to no allegation of abuse or neglect. A FAR case was opened when, later in the year, there were concerns related to RCW 13.50.100. A caseworker responded RCW 13.50.100. The case closed with no further intervention.

In 2018, DCYF received two reports alleging the mother drank to the point of passing out, leaving the children unattended. The youngest child was 14 months old at the time. DCYF opened a FAR case. The mother and her family developed a plan for the mother to participate in SUD treatment and for the fathers and extended family members to provide for the children's care. The family participated with Triple P (Positive Parenting Program),[5] and DCYF verified the mother's compliance and progress in SUD treatment. The case closed.

In 2019, DCYF received seven calls alleging the mother used substances, including alcohol, RCW 13.5, and RCW 13.50.100. It was reported that the mother was decompensating, becoming increasingly paranoid, not providing age-appropriate supervision for her children, and was verbally abusive toward the children. The mother also reportedly left the children with the vulnerable adults she was employed to support. DCYF opened a FAR case, which continued into 2020 due to additional allegations.

In 2020, there were a total of 15 reports made to DCYF, leading to six CPS investigations, which led to Family Voluntary Services (FVS)[6] case being opened twice, and a CFWS case being opened as well. The FAR case, which carried over from 2019, converted to a CPS investigation. The reports alleged: ongoing concerns about the care of the children; allegations of physical abuse of RCW 74.13 and RCW 74.13; DV in the home, including use of a weapon by the mother; and ongoing substance use by the mother, including alcohol and illicit drugs leading to neglect of the children. Multiple contacts occurred with law enforcement due to the DV and physical abuse concerns.

In early 2020, DCYF attempted to engage the family with services and supports to prevent further penetration into the child welfare system. A CPS investigation in January 2020 alleging DV between the mother and RCW 74.13.515 father led to law enforcement involvement. The mother's weapons were confiscated, and RCW 74.13.515 father was arrested, resulting in a no-contact order prohibiting the father from having contact with the mother. This case led to continued monitoring through the FVS program. DCYF held a Family Team Decision Meeting (FTDM)[7] to discuss and address the concerns and develop a plan of support. Services included a drug and alcohol assessment, random urinalysis, participation with HOMEBUILDERS® intensive family preservation services,[8] and identification of daycare resources for the three youngest children. DCYF recommended the children remain in the home with the mother. In March 2020, the case closed as the mother reported sobriety, attended counseling, and completed the HOMEBUILDERS® program, which reported the mother did not present as a risk and made no recommendations for additional parenting services.

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[5]For information about Triple P Positive Parenting Program, see: Triple P Positive Parenting Program **https://www.triplep.net/glo-en/home/**. Accessed on July 30, 2021.

[6]"Family Voluntary Services (FVS) allows parents to voluntarily engage in services to increase their protective capacities and meet the child's safety, health, and well-being needs." See: **https://www.dcyf.wa.gov/practices-and-procedures/3000-family-voluntary-services-fvs**.

[7]"Family Team Decision Making (FTDM) meetings follow the Shared Planning Meeting model of engaging the family and others who are involved with the family to participate in critical decisions regarding the removal of child(ren) from their home, placement stabilization and prevention, and reunification or placement into a permanent home." See: **https://www.dcyf.wa.gov/1700-case-staffings/1720-family-team-decision-making-meetings**.

[8]For information about HOMEBUILDERS®, see: **https://www.dcyf.wa.gov/sites/default/files/pdf/ebp-hbHandout.pdf**. Accessed on August 2, 2021.

In May 2020, DCYF received two separate reports that led to CPS investigations. The allegations included: physical abuse of RCW 74.13, who had deep scratches in his head from his mother's fingernails, the mother using a belt to spank RCW 74.13, who could not sit down afterward, RCW 74.13 being forced to drink alcohol, and the children feeling uncomfortable with their mother's current partner. The report also alleged the mother lost her job and continued to drink alcohol. During face-to-face interviews with the children, the children disclosed additional details, including that RCW 74.13 was forced to vape. The mother and her current partner denied the allegations and the mother reported she experienced a medical issue that led to hospitalization and medications. The CPS caseworker collaborated with law enforcement to assess the safety of the children. DCYF held an FTDM and developed a plan for RCW 74.13, RCW 74.13, and RCW 74.13 to remain in the care of RCW 74.13.515 father while the mother's sobriety was assessed. It was reported that RCW 74.13.51 father passed away RCW 74.13.520. DCYF referred the mother to random urinalysis testing.

In June 2020, the CPS case transferred to FVS for continued monitoring and assessment. DCYF suggested an updated drug and alcohol evaluation, but the mother reported not having insurance due to losing her job. DCYF provided the mother with information on accessing state insurance. The FVS caseworker provided RCW 74.13.515 father with information about completing a parenting plan through family court. After RCW 74. and RCW 74.13 returned to their mother's care, a relative called the CPS caseworker to report that the mother admitted herself to an inpatient SUD treatment facility. DCYF also received a new report alleging the mother "choked" RCW 74.13 while she was angry at her former partner, RCW 74.13.515 father. This generated a new CPS investigation. An FTDM was held and the mother confirmed entering a treatment program. RCW 74.13 and RCW 74.13 were in the care of their maternal grandparents, and RCW 74.13 remained with her father. RCW 74.1 resided with her boyfriend's family.

In July 2020, DCYF received a report that the mother was to be discharged from inpatient treatment in two days, and the mother's home was filthy with dog feces and possible mold. The referrer reported the grandparents planned to have RCW 74.13 and RCW 74.13 return to their mother's care upon her discharge. RCW 74.13 disclosed the mother spanked her when the mother got mad. DCYF added this information to the ongoing CPS investigation. Two additional reports were called in following the children's return to the mother's care alleging DV in the home. These reports alleged that the mother screamed at the children, the mother was drinking again, and that three-year-old RCW 74.13 swam in the pool without supervision. Both of these reports were added to the ongoing CPS investigation.

In August 2020, three of the CPS investigations concluded. The following day, DCYF received a report alleging the mother was intoxicated and passed out in her room while three-year-old RCW 74.13.5 was outside unattended. The referrer watched RCW 74.13 and told DCYF they would also call law enforcement. This report generated a new CPS investigation. Another FTDM was held, and the mother did not participate. The fathers participated and agreed with the plan. It was reported that the mother completed 30 days of treatment but relapsed. The placement decision was for DCYF to file a dependency action for RCW 74.13 and RCW 74.13 with a recommendation for placement with the maternal grandparents. DCYF decided not to file a dependency petition for RCW 74.1 because she remained in her boyfriend's parents' home. The court granted DCYF's request for shelter care and placed RCW 74.13 and RCW 74.13 with the maternal grandparents. The case transferred to an ongoing CFWS caseworker. The FVS case remained open supporting RCW 74.13.515 father, but DCYF did not file a dependency. DCYF received an additional report in August alleging the mother was RCW 74.13.515 pregnant and went to the hospital with a blood-alcohol level of RCW 74.1. This report did not screen in for investigation due to the alleged victim being unborn.

In September 2020, the parenting plan proposing RCW 74.13 remain in her father's custody was developed and was anticipated to be finalized in October. The CFWS caseworker scheduled shared planning meetings (SPM) to

discuss the mother's progress and next steps. At the SPM in September, the mother reported participation with SUD treatment, urinalysis testing, parenting classes, and a DV class. [RCW 74.13] and [RCW 74.13] had updated medical appointments and began school online.

In October 2020, the CFWS caseworker and supervisor explored the option of returning to unsupervised visitation of [RCW 74.] and [RCW 74.13] with their mother. At the SPM, it was noted the mother made progress in her services. The mother completed a SUD evaluation, attended virtual intensive outpatient treatment, and provided urinalysis testing. The mother was also involved with the Parent-Child Assistance Program (PCAP)[9] and attended a support group for parents involved with DCYF. [RCW 74.13] and [RCW 74.13.515] father was provided with information for services, including a DV assessment and instructions on how to complete a background check.

The FVS case for [RCW 74.13.515] father closed in November 2020, with a court date set to finalize the parenting plan for [RCW 74.]. DCYF also established dependency for [RCW 74.13] and [RCW 74.]. Visitation was expanded to included unsupervised, liberal contact with their mother. At the SPM, it was noted the mother demonstrated progress and continued sobriety, addressing the safety concerns. The mother's parent ally described her as "engaged, motivated, and cooperative." The mother's partner was in the process of completing a background check and had not been approved to have unsupervised access to the children.

An SPM did not occur in December 2020. The supervisory review indicated the mother made progress with services and was allowed to have unsupervised visits. The visitation was not expanded to overnights in the home due to a pending background clearance review for the mother's partner. There was criminal history that included a DV incident with the mother. DCYF made it clear to the mother's attorney that [RCW 74.13.] and [RCW 74.13] could not have an overnight visit in the mother's home if her partner was there. [RCW 74.13] and [RCW 74.13] remained in the care of the maternal grandparents, where their needs were identified as being met. DCYF received a report late in the month alleging concerns related to the mother's visitation time with [RCW 74.13]. It was reported that the mother attempted to take [RCW 74.13] home with her when it was time for [RCW 74.13] to return to her father's care, and the maternal grandfather intervened. A CPS Risk-Only investigation[10] was assigned.

In January 2021, the court held the first dependency review hearing for [RCW 74.13] and [RCW 74.1]. Both the mother and father were noted as in compliance with the dependency order and making progress toward reunification with the children. At the SPM, the mother reported completing the Intensive Outpatient (IOP) treatment, relapse prevention, parenting classes, a DV class, and had a plan to become employed. DCYF completed the mother's partner's background check review and requested that he complete a SUD evaluation and DV assessment. The partner reported completing a SUD evaluation in the past, so DCYF requested he sign a release of information and asked that he complete 30 days of urinalysis testing to verify his sobriety. DCYF planned to refer the mother's partner for a DV assessment but did not believe this would delay a trial return home as long as there were no new incidents of DV between the mother and her partner. During the health and safety visit conducted in the mother's home by the CFWS caseworker, the caseworker observed the interactions between [RCW 74.13], [RCW 74.13], and their mother and saw their bedrooms. The mother shared [RCW 74.13.520].

In February 2021, an FTDM was held to discuss moving forward with a trial return home for [RCW 74.13] and [RCW 74.1]. The mother's partner provided urinalysis testing, all of which were free from substances. He also participated in

[9]For information about the Parent-Child Assistance Program (PCAP), see: **https://depts.washington.edu/pcapuw/**. Accessed on August 2, 2021.

[10]"Screen in CPS Risk Only reports when a child is at imminent risk of serious harm and there are no CA/N allegations". See: **https://www.dcyf.wa.gov/practices-and-procedures/2200-intake-process-and-response**.

parenting classes with the mother. It was noted there were no active safety threats and a plan for reunification of RCW 74.13 and RCW 74.13 was discussed. The CPS Risk-Only investigation did not identify a safety threat, and the parents moved forward with the parenting plan for RCW 74. . R.C. RCW 74.13.520 . The court granted approval for a trial return home for RCW 74. and RCW 74. .

In March 2021, the CFWS caseworker completed a health and safety visit in the home with RCW 74.1 , RCW 74.13. , RCW 74.13 , R.C., and the mother. R.C.'s father was not present during the visit. The caseworker discussed Safe Sleep[11] and Period of Purple Crying[12] with the mother. The caseworker observed R.C. sleeping in a swing. The mother shared that she and R.C.'s father continued to participate in the Incredible Years parenting program but recently missed a few sessions. The caseworker's observation was that the children were doing well, and the mother remained motivated. The caseworker left a message checking in with RCW 74.13 and RCW 74.13.515 father, ensuring his visitation occurred as scheduled.

On April 1, 2021, DCYF received a notification from the medical examiner's office with preliminary findings about the death of RCW 74.13.515 -old R.C. The cause of death was asphyxia due to overlay. On April 9, 2021, law enforcement contacted DCYF and reported they responded to the home the previous night because the mother was highly intoxicated RCW 13.50.100 . The mother RCW 13.50.100 . The mother was taken to the hospital RCW 74.13.520 . Following this, RCW 74.13 and RCW 74.13 were removed from the home, and DCYF filed a dependency petition for RCW 74 .

## Committee Discussion

The Committee had the opportunity to speak with caseworkers from all program areas, supervisors, and the area administrator regarding their involvement with the family. The Committee commented about all they learned during these interviews and wished the caseworkers' documentation reflected the efforts that were verbally reported to the Committee.

The Committee identified areas of positive practice through their conversations with the caseworkers. One area was related to DCYF's efforts to contact and engage with the children's fathers. It was noted during the CPS investigations that began in May 2020 that all of the fathers were contacted. In addition to the efforts to communicate with the fathers, there was evidence of ongoing engagement, specifically in the FVS case involving RCW 74.13 and her father. The Committee pointed out the extensive efforts the FVS caseworker made to assist the father in moving forward with a parenting plan.

Another positive area highlighted was the CFWS caseworker's request for the mother to complete additional urinalysis testing above and beyond the testing completed through her treatment program. The Committee understood it was not always DCYF's practice to request additional urinalysis for parents participating in treatment. The Committee believed this action demonstrated good insight on the importance of gathering accurate information related to the mother's sobriety given her long history of substance use.

The Committee identified the cross-collaboration between the caseworkers who were involved with the family as beneficial. The Committee was pleased to see the teamwork and ongoing efforts by the caseworkers to collaborate with one another, even during a time when caseworkers were primarily working from home due

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[11] For information about Safe Sleep, see: **https://safetosleep.nichd.nih.gov/safesleepbasics/about**; **https://www.nichd.nih.gov/sites/default/files/2019-04/Safe_to_Sleep_brochure.pdf**; **https://www.dcyf.wa.gov/safety/safe-sleep**. For information about crib safety, see **http://www.cpsc.gov**.
[12] For information about Period of Purple Crying, see: **http://www.purplecrying.info/what-is-the-period-of-purple-crying.php**.

to the COVID-19 pandemic. The Committee believed these efforts were important given the complexities of this particular case.

The Committee also discussed areas where they believed there was room for improvement. The Committee focused on the following topics: service provision, DV assessment, collateral contacts, and child safety.

The Committee discussed the tools used for assessment, including the Structured Decision Making Risk Assessment (SDMRA)[13] and the Child Safety Framework.[14] The Committee identified inaccuracies in the review of the SDMRA and questioned if the tool was used in the manner it was designed, which is to assess risk and guide service provision. The Committee wondered if there was more emphasis placed on safety over risk in the assessment process, which may have impacted the services offered to the family. The Committee discerned there was a heavy reliance on service providers to assess safety in the home.

The Committee noted the extensive array of services offered to the family throughout DCYF's involvement. However, the Committee wondered if DCYF could have done more to address barriers related to service provision. For instance, at one point, the mother reported not having insurance and, therefore, no access to SUD treatment. The Committee wondered if DCYF could have been creative in strategizing how to meet this need.

The Committee had a robust conversation related to DV assessment and the mother's pattern of DV behaviors. The Committee wondered if DCYF misidentified a safety threat during the investigation of physical abuse allegations related to RCW 74.13 being choked. The Committee understood the mother said the incident occurred due to her anger at a former partner and speculated about whether this should have been considered an act of DV in addition to child abuse.

The Committee had the sense the mother was system savvy with an ability to control her narrative to demonstrate that she was in compliance and making rapid progress. The Committee's observation was that the mother's engagement with DCYF and the services offered was solely on her terms. The Committee thought DCYF did little in the way of challenging the mother. For example, the mother was offered DV services in the FVS case, which she refused. DCYF did not attempt to further engage her with this service despite the case being opened due to a DV incident. The Committee understood that prior to an established dependency, no services can be court-ordered, but they questioned why DV services were not court-ordered for the mother following the establishment of dependency given her DV history and the caseworkers' identification that the mother was the DV perpetrator.

Another area of focus for the Committee related to collateral contacts and information gathering. The Committee learned from the caseworkers that multiple service providers questioned DCYF's involvement with the family, indicating they did not observe the reported concerns. The Committee wondered what collateral information, if any, had been given to the service providers to help inform them about the identified concerns and needs of the family.

The Committee emphasized collateral contacts they believed could have been beneficial in completing a thorough assessment and may have provided opportunities to corroborate the mother's self-reports. The

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[13]For information about Structured Decision Making Risk Assessment (SDMRA), see: **https://www.dcyf.wa.gov/practices-and-procedures/2541-structured-decision-making-risk-assessmentrsdmra**. Accessed on August 2, 2021.

[14]For information about Child Safety Framework, see: **https://www.dcyf.wa.gov/sites/default/files/pdf/ChildSafetyFramework.pdf**. Accessed on August 2, 2021.

Committee felt it would have been beneficial to include the mental health provider and SUD provider in the monthly treatment team meetings to have a dialogue about the mother's progress and any unmet needs. The caseworkers reported learning after the fact that the mother's urinalysis had not been observed by the SUD provider due to the COVID-19 pandemic. The Committee wondered if this information would have come to light had there been verbal communication with the SUD provider. The mother connected with a variety of other service providers and programs within the community. The Committee felt it may have been helpful to learn more about these service providers' roles, expertise, and focus of service provision. Overall, the Committee believed additional dialogue with the service providers may have led to additional details regarding the mother's progress, treatment, and any outstanding needs.

The Committee discussed the assessment of child safety for all of the children but specifically focused on the efforts made for the oldest child, RCW 74.1, and the youngest, R.C. The Committee discussed DCYF's decision not to file a dependency action on behalf of RCW 74.1 when court action was taken for the younger children. The Committee understood RCW 74.1 often communicated her concerns about her mother's ability to care for her and the younger children, which led to RCW 74.1 residing out of the home as approved by the mother. The Committee discussed if more could have been done to assess and support any needs RCW 74.1 may have had. For example, the caseworkers did not assess the home environments in which RCW 74.1 resided, and the Committee concluded that this may have been helpful. The Committee hypothesized that RCW 74.13.51 age and her strong ability to articulate her concerns to the caseworkers may have led to a belief that she could self-protect, thus the decision not to file a dependency petition for RCW 74.1 earlier in the case.

The Committee discussed the planning prior to R.C.'s birth and the post-birth assessment. The Committee did not observe that significant planning took place prior to R.C.'s birth. The Committee questioned the delay in completion of a health and safety visit with the family after R.C.'s birth. The Committee also pointed out the health and safety visits occurring with RCW 74.13 and RCW 74.13 did not include one-on-one conversations with the children. The caseworker reported to the Committee that their observation of the family was that they were functioning well with no identifiable safety concerns during the home visit after R.C.'s birth. The Committee wondered if this observation was based on what the caseworker may have wanted to see versus truly seeking any potential concerns or red flags.

The Committee learned the caseworker communicated with the mother about Safe Sleep and the Period of Purple Crying but did not have the opportunity to share this information with the father. The caseworker acknowledged they did not see R.C.'s sleep environment, which is required by policy. The Committee wondered if DCYF should have proactively offered a safe sleep environment for R.C. prior to RCW 74 birth. The Committee recognized that even if DCYF communicated with both parents about Safe Sleep practice and offered a safe sleep environment, the parents may have still chosen to co-sleep with R.C

## Findings

The Committee believed additional collateral contacts should have been made in order to thoroughly assess safety, including the following:

- Verbal communication with the SUD provider to discuss any additional relevant details related to the parents' progress or unaddressed concerns.
- The treatment providers, including the mental health provider and SUD therapist, should have been invited to attend the monthly team meetings.

- Further inquiries regarding the additional treatment providers who were involved with the parent to learn about their expertise, treatment focus, and learn any information they may have shared regarding the parents' progress.

The Committee identified the following areas where DCYF missed opportunities to share and gather information related to safety:

- Communication regarding Safe Sleep and Period of Purple Crying was communicated with the mother, but not the father. The Committee believed DCYF should have made efforts to have this conversation with the father prior to R.C.'s birth.
- R.C.'s sleep environment was not viewed during the health and safety visit.
- There was no communication regarding R.C.'s medical care or assessment of any additional supports the family may have needed to care for R.C.
- Prior to R.C.'s birth, the health and safety visits with RCW 74.13 and RCW 74.13 did not include one-on-one conversations with the children.

The Committee believed DV services should have been court-ordered for the mother based on the pattern of her behaviors related to DV and the caseworker's identification that the mother was the perpetrator.

## Recommendations

The Committee recommended DCYF Policy 4420 (Health and Safety visits with Children and Youth and Monthly Visits with Parents and Caregivers)[15] clearly articulate DCYF's responsibility to assess the safety of all children in the home to better align with RCW 74.13.031.[16] The Committee also recommended that training related to this policy and statute be included in the Supervisory Core Training (SCT).

[15]See: **https://www.dcyf.wa.gov/4400-concurrent-tanf-benefits/4420-health-and-safety-visits-children-and-youth-and-monthly-visits**.

[16]**https://app.leg.wa.gov/rcw/default.aspx?cite=74.13.031**