STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
CHILDREN'S ADMINISTRATION
PO Box 45040 Olympia WA 98504-5040

August 22, 2011

Mary Meinig
Director Ombudsman
Office of the Family and Children's Ombudsman
6720 Fort Dent Way, Suite 240
Tukwila, WA 98188

Dear Ms. Meinig:

Thank you for your July 2011 report, Implementation Status of Child Fatality Recommendations. I appreciate the information your office compiled working with our regional and headquarters' staff and in identifying some patterns or trends in the recommendations from these reviews.

The Office of the Family and Children's Ombudsman made four final recommendations to the department in the Conclusion section of this report. They include:

1. Establish a centralized process for all child fatality reviews.
2. Have child fatality review findings and recommendations be tailored in a way to identify and address specific issues.
3. Consider developing a protocol for timely and consistent transfer of knowledge learned from fatality reviews so that information is shared between regions and regions are informed about the implementation status of recommendations.
4. Convene a workgroup to further examine CPS intake issues identified through child fatality reviews, review national best practices and identify steps to improve the quality and consistency of CPS intake decisions.

Children's Administration supports all of the recommendations and is already taking action on all four of the recommendations. Child Fatality Reviews are one component of the quality assurance activities conducted by the Children's Administration. We continue to refine our ongoing efforts to improve practice while being mindful of decreasing but more focused resources. With the passage of SHB1105 we will focus our resources on child fatalities, near fatalities or other critical incidents that are related to child abuse or neglect.

Children's Administration is planning to centralize the responsibility for conducting and writing reviews for child fatality and critical incidents from the regions to headquarters. As you know our headquarters' staff have, for the most part, been responsible for the Executive Child Fatality Reviews (ECFR) and with SHB1105, all reviews will be conducted similar to these ECFRs. We believe that centralizing the review process will provide greater consistency and focus on tailored recommendations that address the immediate practice or system issues. Specifically, when a review finds that the social work practice was not consistent with existing policy, we will take deliberate steps to identify any underlying reasons why a policy was not followed.

Children's Administration recognizes the importance of assessing and analyzing trends to determine if a policy, practice or system issue applies to a local office, region or statewide, and we agree that sharing lessons learned from critical incidents is an important component to improving practice. The CA Lessons Learned curriculum that addresses the practice issues identified through our reviews is being continually updated. Although this training has previously not been mandatory, it is now required training for new and seasoned social workers, supervisors and management. We are also exploring ways to provide this training, as well as other case review findings, through regular feedback and online resources.

We are also convening a small work group to further develop a consistent protocol for timely and consistent transfer of knowledge learned from our case reviews of critical incidents. This work group will address implementation of the following work plan:

- Recommendations from reviews will be tailored to identify and address specific practice, policy or system issues
- Recommendations from reviews will be applied to local, regional or statewide based upon the analysis of information
- Critical incident, office case reviews and case staffing information and recommendations will be shared at statewide extended Children's Administration (CA) leadership meetings and will be made available to all CA staff electronically
- Staff will be informed about the implementation status of recommendations.

In January 2011, CA's Central Case Review Team, Intake staff and managers from across the state conducted a statewide review of CPS intakes. The team reviewed 380 CPS intakes from a total of 37,081 CPS intakes received statewide from June 2010 to November 2010.[1] There were many specific recommendations, some of which mirror OFCO's recommendations, made to improve the CPS intake process and intake reports.

[1] The sample size met the statewide 95% confidence level with a confidence interval of +/-5%. A stratified sampling methodology was developed so that the number of intakes reviewed from each of the five CA regions and Central Intake closely approximated their percentage in the total number of CPS intakes received for the identified time period.

A work group will be convened to further examine CPS intake issues identified through child fatality and other critical incident reviews, address the recommendations in the January 2011 CPS intake review, and identify steps to improve the quality, consistency and timeliness of CPS intake decisions. The workgroup will also examine the most efficient strategies to receive and process intake calls statewide.

The Children's Administration has clearly learned and recognized both from our own reviews and from national research that children three years old and younger are the most vulnerable, and we have made policy changes in our intake program that prioritize the safety needs of these children.

We also recognize the critical role of supervisors in child welfare practice and we are partnering with the University of Washington School of Social Work, Eastern Washington University and Partners for Our Children to strengthen our current training system. This collaboration includes designing a professional development curriculum that provides greater focus on clinical supervision and practice.

Thank you again for OFCO's detailed report. We will continue to work closely with you and your staff on addressing the patterns, trends and recommendations that are identified in our reviews. We have a strong ongoing commitment to continuous improvement in our work and in system reforms focused on providing quality services to children and families.

Sincerely,

Denise Revels Robinson, Assistant Secretary
Children's Administration

cc: Susan Dreyfus, Secretary, DSHS
Becky Smith, Director, Field Operations Division
Sharon Gilbert, Deputy Director, Field Operations Division