WASHINGTON STATE
Department of
Children, Youth, and Families

QUARTERLY CHILD FATALITY REVIEW
RCW 74.13.640
JULY – SEPTEMBER 2018

December 2018

www.dcyf.wa.gov

CONTENTS

EXECUTIVE SUMMARY

This is the Quarterly Child Fatality Report for July through September 2018, provided by the Department of Children, Youth, and Families (DCYF) to the Washington State Legislature. RCW 74.13.640 requires DCYF 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 receiving services described in this chapter or who has been in the care of the department 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.

On July 1, 2018, DSHS Children's Administration transitioned from DSHS to the Department of Children, Youth, and Families (DCYF). The reviews included in this report were completed before July 1, 2018, therefore, references to DSHS/Children's Administration (CA) will be cited throughout this report.

This report summarizes information from the reviews of three (3) child fatalities and three (3) near fatalities that occurred in the third quarter of 2018. All child fatality review reports can be found on the DCYF website: https://www.dcyf.wa.gov/practice/oiaa/reports/child-fatality.

The reviews in this quarterly report include child fatalities and near fatalities from five of the six regions (DCYF divides Washington state into six regions). Previous quarterly fatality reports reflect three regions when child welfare was administered within DSHS under CA.

Region	Number of Reports
1	1
2	
3	1
4	1
5	1
6	2
Total Fatalities and Near-Fatalities Reviewed During 3rd Quarter 2018	6

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 DCYF within the 12 months prior to the child's 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 DCYF and the number of reviews completed and those that are pending for calendar year 2018. The number of pending reviews is subject to change if DCYF discovers new information through reviewing the case. For example, DCYF may discover that the fatality or near-fatality was anticipated rather than unexpected, or there is additional DCYF history regarding the family under a different name or spelling.

Child Fatality Reviews for Calendar Year 2018			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2018	18	8	10

Child Near-Fatality Reviews for Calendar Year 2018			
Year	Total Near-Fatalities Reported to Date Requiring a Review	Completed Near-Fatality Reviews	Pending Near-Fatality Reviews
2018	3	0	3

The child fatality reviews referenced in this Quarterly Child Fatality Report are subject to public disclosure and posted on the DCYF website:
https://www.dcyf.wa.gov/practice/oiaa/reports/child-fatality.
Near-fatality reports are not subject to public disclosure and are not posted on the public website.

Notable Third Quarter Findings

Based on the data collected and analyzed from the three (3) fatalities and three (3) near fatalities during the 3rd quarter, the following were notable findings:

- Five (5) of the six (6) cases referenced in this report were open at the time of the child's death or near-fatal injury.
- Two (2) of the incidents occurred with children in out-of-home placements.
- Only one (1) child died in an unsafe sleep environment.
    - Safe sleep was discussed with the caregivers prior to the death of the child in their care.
- In another fatality case, a child died from untreated medical issues.
- One of the fatality review reports in this quarterly report documents the death of a sibling group of five (5) children who perished in a single car motor vehicle accident.
- In two (2) near fatality cases, both children suffered near-drowning. Both cases were open when the near drowning occurred. In one case a 10-month-old child was left unsupervised in a bathtub, in the other case a 3-year-old child was not properly supervised in a swimming pool.
- Four (4) children referenced in this report were 12 months old or younger when the fatality or near fatal incident occurred.
- Two (2) of the six (6) cases referenced in this report were the result of abuse or neglect by the children's parents or caregivers. One case occurred in California where the child was placed with relatives, the finding related to the near fatal incident is not known.
- Four (4) children referenced in this report were Caucasian, five were (5) African American, and one (1) child was Native American.
- Domestic violence, substance abuse, and prior allegations of physical abuse were significant risk factors identified in several of the cases in this report.
- DCYF received intake reports of abuse or neglect in each of the cases in this report prior to the death or near fatal injury of the child. In two (2) of the fatality cases and one (1) near fatality case, there was only one (1) prior report made regarding the family. In the other two (2) near fatality cases, there were two (2) prior reports to the department. In another fatality case, the department received 12 intake reports prior to the child's death.
- Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

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

Child Near-Fatality Review
C.A.

December 2016
Date of Child's Birth

June 1, 2017
Date of Near-Fatality

September 28, 2017
Child Near-Fatality Review Date

Committee Members

Mary Moskowitz, JD, Ombuds, Office of the Family & Children's Ombuds
Jenna Kiser, MSW, Safety/Intake/Domestic Violence Program Manager, Children's Administration
Judy Ziels, MPH, CPH, RN, Public Health Nurse Supervisor, Whatcom County Health Department
Susie Terrell, CDP, Chemical Dependency Professional, Evergreen Recovery Center

Observer

Janice Banning, Central Intake Supervisor, Children's Administration
Judy Bunkleman, Licensing Monitor and Risk Management Coordinator, Department of Early Learning

Facilitator

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

Executive Summary

On September 28, 2017, the Department of Social and Health Services (DSHS or Department), Children's Administration, convened a Child Near-Fatality Review (CFR) to assess the Department's practice and service delivery to C.A. and her family.[1] The child will be referenced by her initials, C.A., in this report.[2]

On June 1, 2017, Children's Administration received a report form a local hospital stating five-month old C.A. was brought in by her mother. The mother reported that C.A. had fallen out of her arms and down the stairs approximately 25 feet. C.A. sustained significant head trauma and was in process of transferring to a trauma center. The referent stated the mother had a strong odor of marijuana and alcohol.

At the time of the critical incident, C.A. was living with her mother and older brother. The children's father lived out of state. C.A.'s maternal aunt may have also been residing with the mother and children at the time. The family did not have an open case with the Department at the time of the critical incident.

The Review Committee (Committee) included members selected from diverse disciplines within the community with relevant expertise including public health of children, chemical dependency, child welfare and a representative from the Office of the Family and Children's Ombuds. There were also two observers who attended the review. Neither Children's Administration staff nor any other Committee member or observer, had previous involvement with this family.

Prior to the review, each Committee member received a case chronology, a summary of Children's Administration involvement with the family and un-redacted Children's Administration 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 including Children's Administration policies, medical reports and state statutes.

During the course of this review, the Committee interviewed the child protective services (CPS) investigative social worker, the CPS supervisor and the area administrator.

Family Case Summary

The Department became aware of this family on December 8, 2016, after an intake was received regarding the birth of C.A. Information noted by the hospital included a positive urinalysis for marijuana from the mother, the mother gave birth at home and then went to the hospital, the mother and her son had moved to Washington state a month prior and that the mother stated she smoked marijuana throughout her pregnancy but denied any other drug use. That intake was screened in for a Risk Only CPS assessment.[3]

The CPS investigator made contact with the mother that same day at the hospital. The CPS investigator did not identify any concerns for this family and did not have contact again until April 24, 2017. The contact on April 24, 2017 was by telephone.

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[1] Given its limited purpose, a Child Near-Fatality Review (CNFR) should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The CNFR 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 Near-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 near-fatal injury. Nor is it the function or purpose of a Child Near-Fatality Review to recommend personnel action against DSHS employees or other individuals.

[2] C.A.'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)]

[3] B. Screen in CPS Risk Only reports when a child is at imminent risk of serious harm and there are no CA/N allegations. https://www.dshs.wa.gov/ca/2000-child-protective-services/2200-intake-process-and-response

Between December 8, 2016, and April 24, 2017, the assigned worker sent a letter to the father of the children who resides in North Carolina. There were two in-person, attempted home visits in an attempt to conduct a health and safety visit with the mother and children. However, no one answered the door. The CPS investigator requested information from the pediatrician's office regarding C.A., which indicated the mother failed to show for three out of four appointments. C.A. had not been seen by her pediatrician since the beginning of January. On April 24, 2017, the CPS worker requested records from a previous health care provider for the mother in North Carolina, North Carolina's CPS records and Charlotte police records.

On May 4, 2017, a courtesy health and safety visit by another worker was conducted. A courtesy worker was requested because the family had moved out of the county. The courtesy worker saw both children and observed C.A.'s sleeping environment. The case was approved for closure on May 5, 2017.

On June 1, 2017, CA received the intake stating C.A. had fallen while being held by her mother. The fall resulted in life threatening head trauma. A CPS investigation was completed and was unfounded for child abuse and/or neglect.

Committee Discussion

The Committee discussed many areas pertaining to this case. This section details some of those discussions while other areas may be briefly referenced in the findings or recommendations sections.
The Committee was informed that this particular office struggled with worker retention. This retention issue presented struggles for staff to complete their tasks in a timely and, at times, thorough manner. This particular case was not assessed in a timely manner. The assigned investigator states she had a high number of cases assigned to her and a large portion of those cases were at higher levels of risk than this particular case. The supervisors in this particular office were also asked to stretch their supervision to staff beyond their assigned units which may have led to less than ideal clinical supervision of the case work by line-staff.

The Committee discussed that staff retention is known to be an issue in many offices throughout CA. Retention of staff may also lead to an increased morale, lower and more consistent case load numbers as well as many other positive outcomes. There was discussion that CA should consider assessing how the agency as a whole, should improve staff retention.

Based on the staff interviews, the Committee noted that bias played a large role in the lack of corroborating of statements made by the mother. The Committee members acknowledged that bias is present in every person regardless of their work. However, having an understanding and awareness of personal bias is critical.

The Committee believed there was bias, on the part of the CPS investigator, regarding the validity of the December 8, 2016 intake which appeared to play an immediate role in the investigator's limited collateral contacts and corroboration of the mother's statements. The mother stated she had a medical condition that caused her significant pain. The mother treated her pain with marijuana. This condition was not assessed by the assigned investigator as to how it may or may not have impacted her ability to parent. The investigator did not believe there was a need to research the condition based on knowing someone who had the same diagnosis. It may have been beneficial for the Department to have verified the diagnosis and recommended treatment as well as to assess for any impacts it may have had to the mother's ability to safely provide care.

The mother denied abusing marijuana. The Committee agreed it would have been appropriate to request a urinalysis of the mother. This tool would have allowed the Department to see, at

that moment, if the mother's statements were accurate. Urinalysis would also have possibly given the Department a clearer picture as to the amount of marijuana the mother was using to treat her pain. The Committee discussed that utilizing consultation with medical and chemical dependency providers for their expert opinions on issues surrounding medical conditions and treatment options may have been beneficial.

The Committee discussed how the legalization of marijuana in Washington state has impacted how professionals within child welfare and beyond view it's use and how it interacts with child safety. This piece of the discussion is reflected in the recommendation below.

Understanding that child welfare workers may have preferences in the types of cases they handle, the Committee also noted that having a varied caseload may assist workers to not have tunnel vision and aid in more thorough critical thinking while assessing child safety.

Findings

The Committee found no critical error made by Department staff during the assessment prior to the critical incident. However, they did identify areas where practice could be improved and opportunities were missed to fully assess the family's situation.

Based upon the interview with the CPS investigator, the Committee concluded that bias played a role in investigator's corroboration of statements made by the mother. This bias also appeared to impact the investigator's critical thinking when assessing the safety of the children.

The investigator took the majority of the mother's statements regarding substance use, mental health and history at face value and did not seek out collateral sources to corroborate her statements. This led to an incomplete assessment of the family situation. Other collaterals could have included the maternal aunt, physicians treating the mother's medical condition prior to her move to Washington, the father of the children, and pediatrician for the older child. The oldest child was not assessed until almost five months into the case.

The Committee agreed that the case should not have been approved for closure by the supervisor, even though the case had exceeded the 60 day policy guideline for completing an Investigative Assessment.[4] The Committee agreed that there should have been a much more comprehensive assessment of the family and child safety to include more collateral contacts, more corroboration of the mother's statements, reviewing the mother's medical records that were requested, and urinalysis of the mother.

Recommendations

CA should provide training to staff on how marijuana impacts a fetus in utero (to better understand possible impacts post birth), what to expect when mothers who are using marijuana are also breast feeding and how the use of marijuana may influence parents while they provide care for their children.

[4] iv. Complete the Investigative Assessment (IA) on all investigations within 60 calendar days of date and time CA receives the intake. [https://www.dshs.wa.gov/ca/practices-and-procedures-guide/2331child-protective-services-cps-investigation]

WASHINGTON STATE
Department of
Children, Youth, and Families

Child Near-Fatality Review
D.S-J.

Date of Child's Birth
December 2016

Date of Near-Fatality
November 01, 2017

Child Near-Fatality Review Date
April 27, 2018

Committee Members

Lorraine Van Brunt, Indian Child Welfare Department, Nisqually Tribe of Indians

Bruce Hall, Indian Child Welfare Caseworker, Nisqually Tribe of Indians

Stephanie Frazier, former Children's Administration Child Protective Services Program Manager (currently Region 6 Acting Safety Lead and CPS Program Manager, Department of Children, Youth, and Families)

Patrick Dowd, JD, Director, Office of Family and Children's Ombuds

Robert C. Smith, former Children's Administration Indian Child Welfare Program Supervisor [currently Indian Child Welfare Program Manager, Office of Tribal Relations, Department of Children, Youth, and Families)

Facilitator

Bob Palmer, Critical Incident Review Specialist, Department of Children, Youth, and Families

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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 74.13.649(4).

Executive Summary

On April 27, 2018, the Department of Social and Health Services (DSHS or Department), Children's Administration (CA)[5] convened a Child Near-Fatality Review (CNFR)[6] to examine the Department's practice and service delivery to the family of D.S-J. The incident initiating this review occurred on November 1, 2017, when D.S-J. nearly drowned in a bathtub at the family residence. Only minimal resuscitation efforts were required, and, following transport to a local hospital, D.S-J. was quickly discharged. At the time of the incident, Child Protective Services (CPS) had an open case with the family.[7]

The CNFR Committee included CA staff, the Director of the Office of Family and Children's Ombuds, and two representatives from the Nisqually Tribe of Indians. With the exception of the tribal representatives, none of the participating Committee members had any prior knowledge of D.S-J.'s family.

Prior to the review, each Committee member received a chronology summarizing the CPS involvement with the family. Committee members were also provided un-redacted CPS case notes and various assessments regarding risk and safety and the law enforcement field response report from the near-drowning incident. Supplemental information and reference materials were available to the Committee at the time of the review.

During the course of the review, the Committee interviewed the CPS worker and supervisor who were involved. Following review of the case file documents, completion of the interviews, and discussion regarding Department activities and decisions, the Committee made several findings that are presented at the end of this report. There were no recommendations.

Case Overview

CA initially became involved with the family in late March of 2017, in response to reported facial injuries to a 6-year old family member who had not been properly restrained in the family vehicle that had abruptly stopped. All other children in the vehicle were unharmed and reportedly properly restrained. The injuries were consistent with the explanation of events. The child was medically treated and released with the recommendation of a follow-up with medical and dental providers. Information provided at the time of the intake indicated family affiliation with the Nisqually Indian Tribe.

Nisqually Tribal Police and Nisqually Tribal Children and Family Services were notified per the Indian Child Welfare Act (ICWA)8 and CA protocols. A Tribal police officer accompanied a CPS After Hours worker to the home on the Nisqually Reservation where the worker made initial contact with the mother, the alleged victim, and 2 other children. No significant safety issues were assessed at that time.

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[5] As of July 1, 2018, the work of CA transferred to the Department of Children, Youth, and Families (DCYF). However, because this review was completed before July 1, 2018, CA is referenced throughout this report.

[6] Given its limited purpose, a CNFR should not be construed to be a final or comprehensive review of all of the circumstances surrounding the near death of a child. The CNFR Committee's review is generally limited to documents in the possession of or obtained by the Department or its contracted service providers. A CNFR Committee has no subpoena power or authority to compel attendance and generally only hears from Department 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 CNFR is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies or other entities with legal responsibility to investigate or review some or all of the circumstances of a child death. Nor is it the function or purpose of a CNFR to recommend personnel action against Department employees or other individuals.

[7] As there are no known criminal charges filed relating to the incident, none of the caregivers are identified by name in this report. *See* RCW 74.13.500.

[8] See: Bureau of Indian Affairs ICWA Regulations 25 CFR Part 23

On April 12, 2017, CPS received second-hand information sourced from an anonymous person that an infant (D.S-J.) and a sibling toddler may have been left briefly in the care of a 12-year-old half-sibling. The Department determined that the information provided did not meet the definition of child abuse or neglect as described in WAC 388-15-009, and thus the second intake screened out.

After the second intake screened out, the CPS supervisor made the decision to close the investigation of the allegations made during the first intake in March 2017 based, in part, on RCW 46.61.687.[9] The case then transferred to another supervisor who disagreed with the decision to close the investigation until confirmation that the 6-year old had medical follow-up. During the subsequent 6 months, the investigation remained open, and despite numerous attempts, the CPS investigator reportedly was unsuccessful in contacting the family, obtaining medical records, and meeting with tribal caseworkers.

In late September 2017 CPS was notified that the tribe declined to take over the investigation. Also at that time, the CPS investigator completed a follow-up interview with the 6-year-old family member at school. There were no disclosures of child maltreatment or safety issues.
On November 1, 2017, CA was notified that D.S-J. had been admitted to the hospital following brief resuscitation during a bathtub near-drowning incident at the family home. Reportedly, on Halloween night, the mother got distracted after putting D.S.-J and a sibling in the bathtub and returned to the bathroom to find D. S-J. underwater and unconscious. The father, who had training in CPR, revived the child while 911 was called. The child was transported to a local hospital by first responders. D.S-J. was then transferred to another hospital for observation and was soon discharged back into the care of the family.

A CPS investigation was initiated for the near-drowning incident. Soon after, CPS completed the investigation from March 2017 regarding the older child and determined the allegation of negligent treatment to be unfounded.[10] The family agreed to services with both the tribe and CA, and the case was moved to Family Voluntary Services (FVS).[11] The CPS investigation of the near-drowning incident was completed in January 2018, with an unfounded for negligent treatment.

CNFR Committee Discussion

The Committee briefly reviewed and discussed basic CA policies and protocols regarding delivery of child welfare services to tribal-affiliated families. This included brief consideration of the protocols for intake notification to tribes, for CPS intervention with on-reservation families, and regarding tribal jurisdiction. Discussion as to tribal jurisdiction focused on what appeared to

[9] RCW 46.61.687 **Child passenger restraint required—Conditions—Exceptions—Penalty for violation—Dismissal—Noncompliance not negligence—Immunity. Section (4)**: Failure to comply with the requirements of this section shall not constitute negligence by a parent or legal guardian. Failure to use a child restraint system shall not be admissible as evidence of negligence in any civil action.

[10] Findings are determined when the investigation is complete and are based on a preponderance of the evidence standard. **Unfounded** means the determination that, following an investigation by CPS, based on available information: it is more likely than not that child abuse or neglect did not occur, or there is insufficient evidence for the Department to determine whether the alleged child abuse did or did not occur. **Founded** means the determination that, following an investigation by CPS, based on available information: it is more likely than not that child abuse or neglect did occur. [Source: RCW 26.44.020]

[11] FVS is a child welfare services program for families not involved in dependency matters. FVS social workers offer the parent(s) services designed to reduce the safety threats while the children remain in the care and custody of their parent(s).

be an unrealistic but hopeful assumption by the CA supervisor in September 2017 that the Nisqually Tribe would consider taking investigative jurisdiction 6 months into the investigation.

While not relevant to this case, the Committee also reflected on the use of tribe-specific Memorandums of Understanding (MOUs) which seek to clarify roles and responsibilities and to enhance coordination and cooperation between the tribal governments and CA in providing appropriate child welfare services to Indian Children. The Committee noted that the Nisqually Indian Tribe is not currently among the 13 Washington Tribes with an MOU. The Committee considered information from a variety of sources about the positive quality of the relationships between the involved CA office and the tribes in the area – particularly with the Nisqually Tribe.

The Committee discussed the Department's decision to screen in the March 2017 intake, and in light of RCW 46.61.687(4), the Committee agreed that a decision to screen out the intake would have been supportable. Given the likelihood that many CA staff (including intake workers) may be unaware of this RCW, the Committee pondered how awareness might be strengthened to prevent unnecessarily screening in similar intakes going forward.[12]

The Committee looked at the excessive length of time the March 2017 CPS investigation was open, with long periods of no significant investigative activities. The Committee reviewed the worker's efforts to connect with the family, the significant delays in completing a safety assessment, the accuracy of the Structured Decision Making Risk Assessment (SDMRA)[13] and the investigative assessment and finding. While appreciating the supervisor's position of keeping the case open for verification of medical follow-up on the alleged victim, the Committee debated the decision to keep the investigation open for over 5 months without substantive indications of present or imminent danger or significant safety issues.

The Committee discussed the CPS worker's caseload, which did not appear to be a barrier to completion of work. However, the worker's lack of experience (less than 1 year), having multiple supervisors over that time, and possible ineffectual supervision were discussed as potential reasons why the March 2017 investigation languished for some many months.

Given that the task of the Committee members is to review and evaluate Department service delivery prior to a critical incident, the Committee only had limited discussion about the post-critical incident activities. The Committee did note that medical follow-up information regarding the older sibling's injuries from March 2017, obtained shortly after D.S-J.'s the near-drowning in September 2017, indicated the sibling's injuries did not require significant follow-up medical intervention.

Findings

The Committee found no critical errors by the Department. However, the Committee did identify several issues that, while not directly connecting to the circumstances of the near drowning incident, were sufficiently noteworthy to be included in this report.

The worker did identify D.S-J.'s father as a secondary caretaker in the SDMRA, which is consistent with the concept that the SDMRA is a household assessment. However, the worker

[12] **Note Action Taken:** Based on the suggestion from the Committee, the state CA Intake Leads Meeting on May 1, 2018 included discussion on RCW 46.61.687.

[13] The Structured Decision Making Risk Assessment (SDMRA)® is a household-based assessment focused on the characteristics of the caregivers and children living in that household. By completing the SDM following the Safety Assessment, the worker obtains an objective appraisal of the risk to a child. The SDM informs when services may or must be offered.

admitted a lack of awareness of the father's CPS history with other partners, which a search of CA's data base would have revealed. Not accounting for this history may have underestimated the calculated risk level in the SDMRA.

Efforts to connect with the family over the 5 months before the critical incident, appeared to be limited, sporadic, and not strategic for timely completion of work. There were extended periods with no documented investigative activities. The limited activities that were documented were primarily telephonic and electronic efforts seeking assistance from the tribe to locate the family. There were missed opportunities for "boots on the ground" efforts such as going in person to the Nisqually Tribe Indian Child Welfare office and to medical providers' offices.

While the inability to contact the family may have been the stated main reason for keeping the initial investigation open for so many months, the Committee speculated that the investigation could have been closed according to the timeline prescribed in policy. An earlier resolution might have occurred through more direct supervisory instruction or suggestions to the worker on completing work, or considering a determination of "unable to complete the investigation."

Recommendation

No recommendations emerged from this review.

WASHINGTON STATE
Department of
Children, Youth, and Families

Child Near-Fatality Review
N.R.

Date of Child's Birth
December 2014

Date of Near-Fatality
August 13, 2017

Child Near-Fatality Review Date
January 25, 2018

Committee Members

Rebecca Via, Adoption Coordinator, Pierce County Superior Court Juvenile Division
Cristina Limpens, MSW, Senior Ombuds, Office of Family and Children's Ombuds
Alyssa Valentine, Social Services Specialist 3 – Adoptions, Department of Children, Youth, and Families

Consultant to the Committee

Maya Brown, MSW, Washington State Deputy Interstate Compact Administrator, Department of Children, Youth, and Families

Facilitator

Bob Palmer, Critical Incident Review Specialist, Department of Children, Youth, and Families

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Executive Summary

On January 25, 2018, the Department of Social and Health Services (DSHS or Department) Children's Administration(CA)[14] convened a Child Near-Fatality Review (CNFR)[15] to examine the department's practice and service delivery to N.R., a Washington State legally free child[16] placed with relatives in California. The incident initiating this review occurred on August 13, 2017, when it was reported N.R. nearly drowned while attending a swimming pool party. Only minimal resuscitation efforts were required, and N.R. was quickly discharged following transport to a local hospital. At the time of the incident, concerns were raised about possible lack of adequate supervision by N.R.'s caregivers.[17]

The CNFR Committee included CA staff and community members selected from disciplines with relevant expertise in child and family advocacy, public child welfare, and general child safety. Efforts to secure participation by an injury prevention expert were unsuccessful. None of the participating Committee members had any prior knowledge of N.R. The Deputy Administrator of Children's Administration Interstate Compact Unit provided consultation to the Committee regarding the Interstate Compact on the Placement of Children (ICPC).[18] Committee members were aware that the consultant had significant knowledge of the case per her supervisory and oversight responsibilities for the state ICPC unit. The consultant did not participate in the Committee interviews of the adoption staff due to potential conflict of interest.

Prior to the review, each Committee member received a chronology summarizing CA activities and decisions relating to the relative placement in California. Committee members were also provided un-redacted case notes from June 2015 through August 2017 and a copy of the Interstate Compact Home Evaluation Report completed by California's equivalent of CA in San Diego County. Supplemental information and reference materials were available to the Committee at the time of the review. This included some court-related and ICPC documents, and information regarding childhood drowning/near drowning rates in California.[19]

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[14] As of July 1, 2018, the work of CA transferred to the Department of Children, Youth, and Families (DCYF). However, because this review was completed before July 1, 2018, CA is referenced throughout this report.

[15] Given its limited purpose, a CNFR should not be construed to be a final or comprehensive review of all of the circumstances surrounding the near death of a child. The CNFR Committee's review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers. A 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 CNFR is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies or other entities with legal responsibility to investigate or review some or all of the circumstances of a child death. Nor is it the function or purpose of a CNFR to recommend personnel action against DSHS employees or other individuals.

[16] When a child's parents or guardians have relinquished their parental rights or have had them terminated in a court of law, the child is then "legally free" to be adopted by another person or family member. [*See* RCW 13.34]

[17] As there are no known criminal charges filed relating to the incident, none of the relative caregivers are identified by name in this report. [*See* RCW 74.13.500].

[18] ICPC is a compact with joining jurisdictions that governs the interstate placement of foster children. The Compact prohibits states from sending a dependent child to live with an out-of-state caregiver without first obtaining approval from the receiving state's child welfare agency following a home study and other assessments of the prospective caregiver. Chapter 26.34 RCW.

[19] About 1,500 children drown every year in the United States. Drowning is the second leading cause of injury-related deaths in children ages one month to 14 years of age in the United States as a whole, and the first leading cause of injury-related deaths in California, Arizona, and Florida. The rate of **near drowning** is much higher, as not all near drownings are reported. It is estimated that for every drowning, there are four additional hospitalizations and 14 additional emergency room visits due to near drowning. [Source: Encyclopedia of Children's Health]

During the course of the review, the Committee interviewed two adoption workers and their supervisors who were involved in N.R.'s case prior to the critical incident. The adoption worker assigned to the case from June 2016 to May 2017 currently works for a different DSHS administration, but agreed to be interviewed by the Committee. The other adoption worker had the case only for a brief time (May-August 2017). Following review of the case file documents, completion of the interviews, and discussion regarding Department activities and decisions, the Committee made several findings and one recommendation as presented at the end of this report.

Case Overview

CA initially became involved with N.R. shortly after the child's birth. Dependency was established and N.R. was placed into licensed foster care. The permanent plan was adoption by the maternal grandparents who had previously adopted a half-sibling and lived in California. An Interstate Compact Home Evaluation was completed and N.R. was placed with the maternal grandparents in June 2015. Monthly visits to the home by a San Diego County courtesy supervision worker indicated N.R. was doing well in relative care. Relinquishment of parental rights occurred in early February 2016, and the case was transferred to an adoption worker once N.R. was declared legally free.

The Adoptive Home Study (AHS) process was initiated in San Diego County as required for adoption. However, efforts by a California AHS worker to meet with the grandparents were unsuccessful. The unsuccessful efforts to meet were communicated to the Washington State adoption worker and supervisor in October 2016. California reported concerns about the grandparents after a continued decline in communication and follow through, as well as to minor deterioration of the home environment (e.g., untidiness, potential health hazards). In December 2016, the Department learned that the grandmother had an emerging medical condition. Later it was reported that the grandfather might also be suffering from escalating health issues.
In late February 2017, the Washington adoption worker was notified by the San Diego County courtesy worker that N.R. had apparently been staying with an aunt 4 to 5 days a week (sometimes overnight) due to the grandmother being ill. No requests had been made, nor permissions granted, for such caretaking, which would have required background checks for members of the aunt's household. Efforts were made by both Washington State and California workers to be clear with N.R.'s caretakers as to N.R.'s placement, including the requirements and procedures for the ICPC process to continue. California discontinued the AHS process when the grandparents continued to be unavailable to the California AHS worker. The decision was made to seek legal placement for N.R. with the aunt through a new ICPC request.
N.R. continued to intermittently stay with the aunt who passed a background check and was cleared to care for the child. June and July monthly visits with N.R. by the California courtesy supervision worker occurred in the home of the aunt. Observations by the worker suggested that N.R. was adjusting very well to moving between caregivers.

On August 14, 2017, CA was notified that N.R. required resuscitation during an incident at a community pool. Reportedly, a 20-year old relative entrusted with taking N.R. to the pool, asked an 11-year old relative to watch N.R. for a while. At some point, a bystander noticed N.R. was face down in the pool, pulled the child out, and initiated resuscitation. Only minimal resuscitation efforts were required, and, following transport to a local hospital and brief observation, N.R. was quickly discharged back into the care of the aunt.

Due to concerns by California CPS regarding neglect (lack of adequate supervision), San Diego County rescinded the ICPC request as to the aunt and requested that N.R. be returned to Washington immediately. On August 17, 2017, an adoption worker traveled to California and retrieved the child, who then was placed in the home of her previous foster caregiver in Washington State.

CNFR Committee Discussion

Very limited discussion occurred about N.R. while in the care of her biological parent before parental rights were terminated. The major focus of the review was the activities and decisions involving N.R.'s out-of-state placement with relative caregivers initiated in mid-2015.Given that the task of CNFR Committee members is to review and evaluate department service delivery prior to the critical incident under review, the Committee pursued only limited discussion about post-incident activities and decisions, including N.R.'s return to Washington State in August 2017 following revocation of the ICPC by California.

The consultant to the Committee presented a brief overview on ICPC procedures for placing Washington children out-of-state. This included the general responsibilities (and time frames) for the requesting and receiving states, such as effecting a home study, conducting criminal background and fingerprint checks, arranging for services for the child and caretakers, and completing and reporting monthly in-home health and safety checks. Noted was the fact that a sending state may have different policies, practices, and timeframes for such tasks that can significantly conflict with the receiving state's practices, to which the sending state must accede. Additional challenges can emerge when the receiving state has a county administered rather than state centralized child welfare system.[20] Consideration was also given to the fact that county based child welfare systems, such as found in California, can provide additional challenges in terms of variance in organization, funding, and workforce size.[21]

The Committee also looked at the roles and responsibilities of the Washington ICPC Unit and field social services staff in the case management of ICPC cases, per CA policy and practice standards. This includes responsibilities for initiating the ICPC referral, notifications and case tracking, follow-up contacts with courtesy supervision workers, and securing monthly/quarterly reports. The Committee noted the extensive child welfare experience and knowledge of the supervisors and the adoption workers involved with this case. The Committee also acknowledged and was mindful during the review that while the caseloads of the assigned adoption workers (in Washington state) appeared higher than recommended by the Child Welfare League of America, they were consistent with current rates in CA.[22]

The Committee also discussed the uniqueness of ICPC cases and how they sometimes receive less focus and involvement than non-ICPC cases from both the sending and receiving states. In looking at the specifics of the case under review, the Committee reflected on several instances of delays in case management activities and in relaying documentation of important information about the child and caregivers between the states. The Committee noted a few instances where San Diego County courtesy workers did not urgently follow up on concerns that surfaced as to the grandparents. And there were occasions where adoption workers in Washington appeared to have relaxed attention to the need to pursue more details from the California courtesy workers. In review of case documentation, and in consideration of verbal responses by adoption staff when interviewed, it was not always clear to the Committee which state was most responsible for information sharing not occurring quickly between the states.

[20] According to the U.S. Department of Health and Human Services Children's Bureau, there are twelve states with complete or partial county administered child welfare systems.

[21] California's child welfare services programs are administered by the 58 individual counties. This means that each county organizes and operates its own program of child protection based on local needs while complying with state and federal regulations. The California Department of Social Services (CDSS) monitors and provides support in the counties efforts to best serve children and families. [Source: CDSS]

[22] CWLA recommends workers providing on-going services have no more than 17 active families. [Source: CWLA]

Findings

The Committee did not identify any critical errors made by CA that contributed to the critical incident involving N.R. The Committee reached full consensus that there were no indicators that N.R. was in any obvious peril in the care of the grandparents or other relatives prior to the swimming pool incident. However, the Committee did identify three areas that, while not directly connecting to the circumstances of the near-drowning incident, were notable opportunities for improved practice.

Ongoing efforts to gather information regarding the child and the relative caregivers:
While the information gathered on the grandparents initially was sufficient, ongoing updates were not adequately provided to CA by California. There were missed opportunities for the CA adoption staff to press San Diego County workers to provide timely updated and detailed information.

There appeared to be a growing reliance on unverified information provided by N.R.'s grandmother (and later the aunt), particularly regarding significant health issues of the grandparents and of the child. It is believed there were indications of intentional minimizing by the relatives of their diminishing caretaking abilities, that went unrecognized by both Washington workers and the California courtesy workers. The Committee believed that eventually the issues were realized, resulting in the adoption home study being discontinued and consideration made for placement of N.R. with the aunt.

There appeared to be a significant delay by both CA and California workers in gathering information on the aunt and her family after it became evident that they had assumed significant caretaking responsibilities without any permission from California or Washington State authorities. This resulted in N.R.'s placement being in violation of the ICPC agreement.

Information Sharing/Communication/Documentation
Initially there appeared to be good communication and collaboration on the case by the two states involved, the Guardian ad Litem (GAL),[23] and the court. Timely information sharing started to deteriorate just prior to transfer of the courtesy supervision case to a different San Diego County worker in December 2016.While adoption staff may have received brief notifications by phone and email communications from the courtesy workers, the Department did not receive another formal report until June 2017, which included 5 months of courtesy supervision information. Again, The Committee believed there were missed opportunities for the CA adoption staff to press San Diego County workers to provide timely updated and detailed information.

Some of the documentation from the San Diego County courtesy worker lacked sufficient detail and/or was entered by CA adoption workers into the electronic case file after a significant delay. This may account for why some supervisory monthly reviews by the adoption supervisor had insufficient information or included information from several months prior.
CA adoption workers stated that some conversations, email communications, and case consultations, including intra-agency and interstate, had inadvertently not been documented in case notes or uploaded.

The case transfer process from one adoption unit to another in May 2017 appeared cursory, and significant information may have not been shared. For example, the new adoption worker and supervisor may not have been aware that the original ICPC placement approval with the

[23] A Guardian ad Litem (GAL) is appointed by the court to represent the best interests of a child involved in a dependency case. See RCW 13.34.100.

grandparents had been withdrawn by California, as information from the ICPC was directed to the previous adoption worker and not to the new worker.

Placement/Shared Planning
The Committee believes a Family Team Decision Making (FTDM) meeting[24] should have been considered in February 2017 when it became clear that the grandparents needed significant and frequent help from other relatives to care for N.R.

There is no evidence that the ICPC unit was asked to consult or otherwise give input on any considerations of changes with N.R.'s placement until after a new ICPC placement request was formally made regarding the aunt. Given that the focus of the FTDMs in March and April was to discuss seeking a new interstate placement with the aunt (which was subsequently made in May 2017), input from the ICPC Unit would have been reasonably expected and beneficial. Due to lack of documentation and lack of recall by adoption staff, it is not clear how much involvement or input the GAL provided to Children's Administration, or if the court was notified when the Department learned that the grandparents had placed N.R. with the aunt without prior authorization. The Committee had significant concern that neither the GAL nor the court were fully involved in the permanency planning process.

Recommendation

The Committee encourages the Department to provide the regional adoption units with an annual half-day refresher training on ICPC. This would require direct collaboration with the state ICPC unit in facilitating discussions with adoption workers about communicating with the ICPC unit, strategies for communicating with workers in other states (e.g., courtesy supervision and home study workers), and consulting with ICPC staff particularly at case transfer and shared planning meetings. Furthermore, the Committee encourages the Department to share previous ICPC cases that involved child fatalities or near-fatalities with field staff as opportunities to learn.

[24] Family Team Decision-Making (FTDM) meeting 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 an emergent removal of child(ren) from their home, changes in out-of-home placement and reunification or placement into a permanent home. An FTDM will take place in all placement decisions to achieve the least restrictive, safest placement in the best interests of the child. [Source: Family Team Decision-Making Meeting Practice Guide]

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

Child Fatality Review
E.R.

April 2017
Date of Child's Birth

January 10, 2018
Date of Child's Death

May 11, 2018
Date of the Fatality Review

Committee Members

Patrick Dowd, Director, Office of the Family & Children's Ombuds
Annabelle Payne, Director, Pend Oreille County Counseling Services
FaLeisha Wright, Supervisor, Children's Administration
Sharon Ostheimer, CPS Program Consultant, Children's Administration

Facilitator

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

Executive Summary

On May 11, 2018, the Department of Social and Health Services (DSHS), Children's Administration (CA), convened a Child Fatality Review (CFR)[25] to assess the department's practice and service delivery to E.R. and her family.[26] The incident initiating this review occurred on January 10, 2017 when E.R. was found by her parents not breathing around 6:00 p.m. The mother called 911 when E.R. was found not breathing; the father reportedly began chest compressions. At the hospital, the child was pronounced dead. E.R. reportedly had been napping since 2:00 p.m. that day and was checked on by her parents around 5:15 p.m. The parents reported E.R. to have been breathing at 5:15 p.m. but not at 6:00 p.m. At the time of the CFR, the local coroner had not made a ruling regarding the cause of E.R.'s death. E.R. was residing with her mother, her father and sibling.

The Review Committee included members selected from diverse disciplines within the community with relevant expertise including the Office of the Family and Children's Ombuds, a CA program manager, a Child Family Welfare Services (CFWS) supervisor and mental health/chemical dependency specialist. Neither CA staff nor any other Committee members had previous direct involvement with this family.

Prior to the review, each committee member received a family genogram, 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 medical reports, relevant state laws and CA policies.

During the course of this review, the Committee interviewed the CPS supervisors for the 2013 and 2015 investigations regarding E.R.'s siblings, an intake area administrator and the Family Assessment Response[27] (FAR) CPS worker who was assigned in 2018. The CA investigator who was previously assigned to the case is no longer employed with CA and was not present during the review. Following the review of the case file documents, completion of interviews and discussion regarding department activities and decisions, the Committee discussed possible areas for practice improvement, while recognizing the limited time CA was involved prior to the incident. The Committee did not make any findings or recommendations related to CA's response or CA systems.

Family Case Summary

CA had opened a CPS/FAR case on Friday January 5, 2018, five days before E.R.'s death. A FAR worker was assigned when the case was opened, however, the case was transferred to a

[25]Given its limited purpose, a 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 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 DSHS employees or other individuals.

[26] 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)]

[27] Family Assessment Response (FAR) is a 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 reported. [Source: CA Practices and Procedures Guide 2332. Family Assessment Response]

different FAR unit and worker on January 8, 2018 due to the location of the family's residence and an internal jurisdiction policy. The newly assigned FAR worker responded within 72 hours, per policy requirements,[28] making the initial home visit on January 8, 2018. The FAR worker did not observe any obvious signs of neglect (based on the physical observation of the children, parents and household) or household hazards (accessible drug paraphernalia) during the home visit.

Prior reports involving this family include 11 intake[29] reports, nine of which screened out and two that screened in[30] for investigation. Of the two that screened in for investigation in December 2013 and December 2015, the allegations included domestic violence, substance abuse, neglect and supervision concerns, custodial issues, criminal issues and physical abuse as to both of E.R.'s parents and/or E.R.'s siblings' fathers. The allegations were determined to be unfounded[31] and no safety threats were identified by the CA social worker in both circumstances.

Committee Discussion

The Committee briefly discussed the investigations that occurred prior to the 2018 FAR response involving E.R.'s sibling. The Committee wondered if the assigned CA worker assessed all of the allegations prior to closure as documentation was limited in the case file. The Committee noted the importance of CA staff and supervisors addressing each allegation in documentation, providing written and photographic evidence if warranted. The Committee recognized that it is difficult to know what the CA worker assessed if it is not documented and, as with this case, the worker is no longer working for CA to clarify what occurred.

Understanding CA's inability to remedy or oversee outside agencies' protocols, the Committee discussed the potential benefits of care coordination between community agencies and CA. The Committee discussed the barriers surrounding communication between mental health and chemical dependency providers with CA due to confidentiality laws. The Committee added that CA might have been able to respond to the family much earlier had CA received information regarding the mothers drug use from a local chemical dependency provider in December, 2017. CA was not aware of the December chemical dependency assessment concerns and services until after E.R. had passed away. The Committee recognized that it is not regular practice for a chemical dependency provider to share assessments with CA when CA does not have an open

[28] Initial Face-to-face (IFF): When conducting an IFF contact with the child, the DCFS caseworker, afterhours worker and the DLR/CPS investigator must: Meet in-person with the victim or identified child in the following timeframes from the date and time CA receives the intake: 24-hours for an emergent response and 72-hours for a non-emergent response. [Source CA Practice and Procedures Guide 2310. Child Protection Services Initial Face-to-Face Response]

[29] An "intake" is a report received by CA in which a person or persons have reasonable cause to believe or suspect that a child has been abused or neglected. A decision to screen out an intake is based on the absence of allegations of child abuse or neglect as defined by WAC 388-15-009.

[30] 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.

[31] CA findings are based on a preponderance of the evidence. "Child abuse or neglect" is defined in Chapter 26.44 RCW, WAC 388-15-009 and WAC 388-15-011. Findings are determined when the investigation is complete. Founded means the determination, following an investigation by CPS and based on available information, that it is more likely than not child abuse or neglect did occur. Unfounded means the determination, following an investigation by CPS and based on available information that it is more likely than not child abuse or neglect did not occur, or there is insufficient evidence for DSHS to determine whether the alleged child abuse did or did not occur.

case and there is not a signed consent to share information. The Committee wondered whether legislation could be passed to address the privacy laws and incorporate necessary communication between agencies so that CA is better able to promptly assess child safety. The Committee wondered about the possibility of a shared electronic information system for CA in accessing mental health and chemical dependency records.

The Committee noted that the newly assigned FAR worker in January 2018 responded to the home as required. However, the Committee noticed that there was a systemic delay in assignment which prevented the worker from having time to review the case history prior to responding to the family home. The Committee recognized that the worker completed the tasks in the required timeframes, however noted that global assessment of a situation and family is enhanced when workers have an opportunity to prepare prior to responding. Further, the Committee noted that the FAR worker's documentation was above standard practice.

Safe sleep[32] policy and practice was discussed. Some committee members wondered if CA staff assigned to this case or in statewide practice discuss secondary, third or fourth risks to infants associated with second hand smoke or exposure to various chemicals on clothing or in a household. The CA supervisor, program consultant as well as the staff interviewed, discussed the policy for safe sleep and that based on individual staff's experience or training, it varies as to what information is provided beyond the required information CA staff already provides families. The Committee noted that the FAR worker assigned in January 2018 covered safe sleep as required by CA policy.

Based on a review of the case documents and interviews with staff, the Committee did not find any critical errors made by department staff directly linked to child's death. The Committee did not have any findings or recommendations.

[32] Safe Sleep is a nationwide campaign to promote safe sleeping habits for children. Safe sleep practice can reduce the risk of SIDS. According to the National Institute of Child Health and Human Development the top 10 safe sleep guidelines are: 1) always place your baby on his or her back to sleep, for naps and at night; 2) place your baby on a firm sleep surface, such as on a safety-approved crib mattress, covered by a fitted sheet; 3) keep soft objects, toys, and loose bedding out of your baby's sleep area; 4) do not allow smoking around your baby; 5) keep your baby's sleep area close to, but separate from, where you and others sleep; 6) think about using a clean, dry pacifier when placing the infant down to sleep; 7) do not let your baby overheat during sleep; 8) avoid products that claim to reduce the risk of SIDS because most have not been tested for effectiveness or safety; 9) do not use home monitors to reduce the risk of SIDS; and 10) reduce the chance that flat spots will develop on your baby's head, provide "Tummy Time" when your baby is awake and someone is watching, change the direction that your baby lies in the crib from one week to the next and avoid too much time in car seats, carriers and bouncers.

WASHINGTON STATE
Department of
Children, Youth, and Families

Child Fatality Review
Child's Initials
A.F.

Date of Child's Birth
July 2017

Date of Fatality
January 2018

Child Fatality Review Date
May 31, 2018

Committee Members

Cristina Limpens, Senior Ombuds, Office of the Family and Children's Ombuds
Ashley Robillard, Sexual Assault Unit Detective, Tacoma Police Department
Erin Summa, MPH, Health Promotion Coordinator, Mary Bridge Children's Hospital and Health Network
Tarassa Froberg, Family Voluntary Services and Child Family Welfare Services Program Manager, Children's Administration
Jennifer Gaddis, MSW, Region 3 Safety Administrator, Children's Administration

Observer

Lori Gianetto Bare, Incident Management and Communications Program Manager, Developmental Disabilities Administration

Facilitator

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

Executive Summary

On May 31, 2018, the Department of Social and Health Services (DSHS or Department), Children's Administration (CA)[33] convened a Child Fatality Review (CFR)[34] to assess the Department's practice and service delivery to A.F., her family and out-of-home placement.[35] The child will be referenced by her initials in this report.

On January 12, 2018, the CA received a call from King County Sheriff's Office stating that A.F. had passed away. A.F. was placed in out-of-home care by CA at the time of her death and her case was open to Child Family Welfare Services (CFWS).

A.F. was sleeping in a Fisher Price Rock 'n Play Sleeper in front of the main floor fireplace. A.F. had been wrapped in an afghan and her bottle had been propped when she was put down to sleep at approximately 8:00 p.m. She was found unresponsive at 11:40 a.m. the following morning. The Medical Examiner's office ruled A.F.'s cause of death as Sudden Infant Death Syndrome (SIDS) and the manner of death was natural.

The CFR Committee (Committee) included members selected from diverse disciplines within the community with relevant expertise including individuals from the Office of the Family and Children's Ombuds, law enforcement, prevention specialist and child welfare. There was an observer from the DSHS Developmental Disabilities Administration, as well. The Committee members and observer did not have any involvement or contact with this family.

Prior to the CFR, each Committee member received a summary of the CA involvement with the family, including 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 CFR. These included the Medical Examiner's report, relevant state laws and the CA policies and procedures.

The Committee interviewed the CFWS supervisor and case worker as well as the area administrator. The Child Protective Services (CPS) case workers and supervisor assigned to the A.F. case no longer worked for the CA and could not be interviewed.

Family Case Summary

On June 13, 2017, the CA received an intake stating concerns for an unborn child (who was named A.F. after birth). The caller stated the mother did not obtain prenatal care until 36 weeks' gestation. The mother told the caller she had six other children but would not provide information about them. The caller did an internet search and found a news article stating the parents were criminally charged with child abuse in Michigan. The intake worker did an internet search and found that the mother and alleged father of this unborn child had absconded with the six children. The intake worker further discovered that the National Center for Missing and Exploited Children had been involved in attempting to locate the family. This intake was closed at screening because the mother had not yet given birth.

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33 Effective July 1, 2018, the Department of Children, Youth, and Families (DCYF) replaced the Department of Social and Health Services (DSHS) Children's Administration (CA) as the state agency responsible for child welfare (and early learning programs). The fatality happened prior to July 1, 2018, therefore CA or department is used throughout the report.

34 Given its limited purpose, a 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 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 DSHS employees or other individuals.

35 A.F.'s parents and the placement 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-Revised Code of Washington 74.13.500(1)(a)]

A second intake was received on July 10, 2017, by the same caller whom called the CA June 13, 2017. The intake stated that A.F. was born at home. The caller stated the mother and child are bonding well and the mother's drug screen at delivery was negative. Based on the historical information out of Michigan regarding the mother's six other children, this intake was assigned for a 24 hour CPS Risk Only.[36]

The case was assigned to a CPS worker who attempted to contact the family at their home that same day. No one answered the door, yet the CPS worker saw blinds moving in the window. The CPS worker left her business card in the door-jam of the front door and on the fence gate. The next day the CPS worker contacted Cheboygan Police Department and Michigan Department of Health and Human Services. The CPS worker obtained police reports and CPS investigative information regarding significant trauma and abuse to the mother's six other children by A.F.'s father. The mother's parental rights had been terminated as to the six children. The father also had a warrant for his arrest for a probation violation but the law enforcement agency indicated they would not extradite him. The CPS worker then requested assistance from the Des Moines Police Department to be present with her while attempting to make contact with the family again. When the social worker went back once again, no one answered the door. The neighbor living next door denied seeing anyone at the home for several months. The CPS worker then called the referent who provided a phone number for the mother. The CPS worker left a voice mail message requesting a call back.

On July 14, 2017, the CPS worker again attempted to make contact with the family at their residence. She left another business card in the door-jam. On July 17, 2017, the CPS worker contacted law enforcement to once again accompany her to the home. The CPS worker first contacted a neighbor who stated she had just met the father and verified the recent birth of a baby girl, A.F. The CPS worker saw a mailman delivering mail, and that one piece of mail was addressed to A.F. When law enforcement arrived, the CPS worker discussed the historical familial child abuse, the father's current warrant for a probation violation, and current concerns for A.F.'s welfare based on the child abuse incidents out of Michigan.

The mother answered the door and was holding a cell phone in her hand recording the interaction. The mother was holding a baby girl. The CPS worker requested that A.F. be placed in protective custody (PC). Law enforcement did not feel they had adequate cause to PC the child. There was considerable documentation by the CPS worker in case notes regarding the disagreement between the CA and law enforcement with how to proceed.

The CPS worker asked the mother to provide a urinalysis. The worker observed the home, a bassinet in the front of the home and a crib in a bedroom. The mother was requested to take A.F. to the hospital for a well-child exam and then to make an appointment with a pediatrician and provide all of this information by the following morning to the CPS worker.

The mother called the CPS worker the next morning. The mother stated she took A.F. to the hospital and was provided with discharge paperwork indicating the child was healthy. She had a pediatrician's appointment set for July 24th. The CPS worker reiterated the need for a urinalysis from both parents and the mother agreed. A home visit was set for the following day to review safe sleep and Period of Purple Crying. There was a discussion regarding services that were not completed in Michigan, and the mother did not agree with the information obtained from Michigan. CA obtained a pick-up order for A.F. the following day, July 18, 2017. The assigned CPS worker requested law enforcement to accompany her to the home to remove A.F., but no one answered the door when the CPS worker and law enforcement arrived.

[36] CPS Risk Only is when a child is at imminent risk of serious harm and there are no child abuse or neglect allegations. https://www.dshs.wa.gov/ca/practices-and-procedures-guide/2200-intake-process-and-response

The next day, July 19, 2017, CPS workers and law enforcement again attempted contact with the mother and A.F. The mother answered the door and was video recording the interactions. The mother was served with the paperwork to place A.F. in protective custody as well as a schedule of hearings regarding the child's dependency action. The mother was later notified of a Family Team Decision Meeting (FTDM) to discuss placement of A.F. The parents failed to show for the meeting. The CA received a call from the referent of the initial intakes who indicated the mother wanted A.F. to be placed with her. This was later confirmed by the mother.

On July 28, 2017, A.F.'s placement was changed from foster care to suitable other, the referent on both intakes, who is the midwife that delivered A.F. This decision was made by the CFWS supervisor in consultation with an area administrator and after an FTDM occurred. The CFWS supervisor took A.F. to her new placement. The CFWS supervisor stated to the Committee that she did a walk-through of the placement and observed as well as discussed safe sleep and Period of Purple Crying with the placement, though this was not documented in a case note.

The Department continued to work towards reunification with the parents to include supervised visitations, health and safety visits and communication regarding recommended services. On January 12, 2018, the CA was notified of A.F.'s death. At that time, the mother was the only parent actively involved in the case. The father had left Washington State. The CFWS worker spoke with the investigating detective who provided the following details surrounding the event precipitating A.F.'s death. There were three adults living in the home, the placement (husband and wife) and a male adult relative. The husband put A.F. to sleep in the Rock 'n Play Sleeper around 8:00 p.m. He had wrapped A.F. in a knitted afghan blanked that was about five and a half feet long. It wrapped around A.F.'s body about three and a half to four times. A.F. was placed in the rock n' play and the husband put another quilt on top of her and then propped a bottle for her to eat. The husband indicated she was too long for the rock n' play chair and her bottom was not in the correct spot. He then watched a movie with his children and then they went to bed. At 8:00 the next morning, A.F. appeared to still be asleep so the wife asked the other male adult (her brother) in the home to keep an eye on the child. At 9:45 a.m. when she returned home, the wife noticed A.F. was still in the chair but assumed she had woken up and was already down for her morning nap. The wife herself laid down for a nap. Around 11:00 a.m. she texted her brother to check on A.F., and he noticed there was a bubble coming out of her nose. The family then contacted emergency services and started cardiopulmonary resuscitation which was continued by responding emergency personnel. They were not able to revive A.F.

Committee Discussion

The Committee noted concerns about lack of mandatory, ongoing trainings for the CA staff regarding safe sleep. The Committee was aware of some trainings that are offered (Safety Boot Camp) as well as Regional Core Trainings for new staff through the University of Washington Alliance for Child Welfare Excellence. However, the Committee discussed how unsafe sleep-related deaths remain a significant percentage of fatality review cases. The Committee believed that the CA's Infant Safety Education and Intervention policy provides clear guidance regarding the sleeping environment and guidelines to follow but that some of the language could be more consistent. There was also some discussion that safe sleep may be more strongly emphasized in early service areas (CPS and Family Voluntary Services) in CA's involvement with a family and not as emphasized in CFWS.

When the CA staff were interviewed, they were asked if they believed they had a bias regarding the placement provider's employment as a midwife and how that may have impacted their belief that she would know what safe sleep is. The staff agreed that they may have been biased in believing this. This may also have led to a less thorough discussion regarding what safe sleep looked like. However, the CFWS supervisor did state she believed it was safe for A.F. to sleep

in the rock n' play based on her own parenting experience. There was discussion regarding how this is not congruent with the CA's safe sleep policy.[37]

The Committee was also concerned by some of the details surrounding the relationship between A.F.'s parents and the placement. The Committee was aware that the placement was cautioned regarding the father's history of violence when discussing interactions and the placement facilitating visits between A.F. and her parents. The placement told the CA that they were allowing the father to build or rebuild a deck at their residence to pay back the placement for the delivery fees related to A.F.'s birth as well as allowing the parents in their home for supervised visitation. The placement also indicated they wanted to adopt a baby. The placement had attempted to adopt a baby through a private agency on two previous occasions but for unknown reasons those adoptions did not take place. This, coupled with the fact that the placement was also the referent on both intakes, was noted by the Committee as concerning for a possible conflict of interest.

There was some discussion by the Committee regarding systemic barriers to CA staff completing all of the expectations on all cases, the turnover of staff throughout the state, and the lack of seasoned staff to mentor newer staff. Another Committee member discussed how challenging the work is and the difficult circumstances staff are expected to navigate on a daily basis.

The Committee discussed the documented frustrations of CA staff regarding law enforcement's refusal to place A.F. in protective custody. The CA asked law enforcement to place A.F. in protective custody seven days after the intake was screened in. However, at that time, the baby appeared to be well cared for by the parents, the home did not present any imminent danger and CA had been aware of the risks presented to A.F. for an entire week. A Committee member who is a law enforcement officer provided the Committee with education surrounding the restrictions law enforcement face for what constitutes imminent danger in order to place children in protective custody. The Committee discussed that if there was such concern from the onset of the intake assignment regarding the risk to A.F., that it would have been appropriate for CA to staff the case with an Assistant Attorney General and request a pick up order as opposed to relying on law enforcement to place her in protective custody.

The Committee did note how the persistence by the CPS worker to make contact with the family and gather information from Michigan was very well done. There were three attempts to locate the family at their home, three calls to the referent and information gathered from law enforcement and child welfare in Michigan within a short period of time.

Findings

The Committee was informed that the CFWS supervisor had given approval for the out-of-home placement provider to use the rock n' play for A.F. to sleep in. Based on that information coupled with the Infant Safety Education and Intervention policy, the Committee identified that a critical error had occurred. A critical error is something the Committee identifies as a factor that may have contributed to a fatality or near-fatality. Below are the areas the Committee identified as findings related to this case, which unlike critical errors are not identified as factors that may have contributed to the fatality or near-fatality.

The Committee noted that including strong, descriptive language in case notes regarding the CA's frustration with law enforcement was not appropriate. It would have been more appropriate to have the AA or supervisor meet with law enforcement to discuss this issue rather than document the frustration.

[37] https://www.dshs.wa.gov/ca/1100-child-safety/1135-infant-safety-education-and-intervention

The Committee also noted that the CA did not document a review of the infant safe sleep guidelines at either of the two placements for A.F. nor at each health and safety visit, per policy 1135.

The Committee members were impressed with the CFWS worker. Her presentation was professional. The CFWS social worker was able to create a positive relationship and engaged well with the biological mother. She also did a very good job of gathering information from the placement provider regarding A.F. and documenting this in her health and safety visit case notes.

Recommendations

The CA should remove the term "pack-n-play or bedside co-sleeper" from Infant Safety Education and Intervention policy 1135, procedures 2.b. It should be replaced with "crib, bassinet, or play-yard that meets current federal safety standards. Car seats, swings and sleepers/nappers do not qualify as a safe sleep environment." Also within this policy, the safe sleep guidelines should be listed and not just on the attachment/link. A definition of safe sleep assessment should be included within the policy. This assessment should include observing and assessing all of the places that baby sleeps as well as a discussion regarding how often they sleep in those environments.

CA should remove the link to the Department of Health brochure on safe sleep in Policy 1135. The brochure link is currently not working and the brochure is not utilized by hospitals that are certified as National Safe Sleep hospitals and has been somewhat controversial in the SIDS/Safe Sleep community.

CA should discuss how to provide ongoing training for all CA staff regarding infant safety on a yearly basis. This recommendation is based on the Committee's assessment that there continue to be consistent reviews of infant deaths related to unsafe sleep.

CA should add language and a check box to the Placement Agreement form 15-281 to include discussion of policy 1135 including providing the handout Infant Safe Sleep Guidelines 22-1577. The CA Child and Family Welfare Family Voluntary Services (CFWS/FVS) Program Manager has started working on this process.

CA should include a link to policy 1135 on the Child Information and Placement Referral 15-300. This would allow placements to access the policy and Infant Safe Sleep Guideline form at their convenience.

CA should include language in the Health and Safety Visits with Children and Monthly Visits with Caregivers and Parents policy 4420 to align with the Infant Safety Education and Intervention policy 1135 stating, "DCFS caseworkers must also review the Infant Safe Sleep Guidelines DSHS 22-1577 at each health and safety visit." The CFWS/FVS Program Manager has started working on this process.

The CFWS/FVS Program Manager also added instruction in the new placement policy rolling out on July 1, 2018, for staff to give the Infant Safe Sleep Guidelines to the caregiver at the time of placement. A link on the online CFWS Tools and Guide for "Safe Sleep for Your Baby Every Time" was removed and replaced with a link to the 22-1577 Infant Safe Sleep Guidelines. The CFWS/FVS Program Manager also added the Infant Safe Sleep Guidelines to the online placement packet.

The King Southwest and King Southeast offices should receive training regarding the Practices and Procedures policy 1135 Infant Safety Education and Intervention. This training should include (but not be limited to) a virtual walkthrough of assessing infant sleep, discussing developmentally appropriate care such as when to stop swaddling an infant/when to drop the crib's mattress level, intervening in unsafe sleep environments and the expectation of ongoing assessment during health and safety visits throughout the life of a case. This training should be provided to all staff.

The Committee noted the frustration by the CPS staff, as well as law enforcement, when asking law enforcement to place A.F. in protective custody. The relationship between law enforcement and the CA is integral. The King Southwest area administrator should meet with the Chief of the Des Moines Police Department to address the challenges faced by each agency during this case and to better understand each agency's responsibilities and roles in hopes to not repeat this same situation in the future.

WASHINGTON STATE
Department of
Children, Youth, and Families

Child Fatality Review

D.H.
H.H.
A.H.
S.H.
J.H.

Date of Fatalities

March 26, 2018

Child Fatality Review Date

August 24, 2018

Committee Members

Brad Graham, Senior Investigator/Analyst, Office of the Attorney General, Criminal Justice Division
Jennifer King, MSW, LICSW, Clinical Supervisor Child and Family Therapist, Connections Counseling Services NW
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Ly Dinh, MSW, Region 5 Quality Practice Specialist, Department of Children, Youth, and Families

Facilitator

Bob Palmer, Critical Incident Review Specialist, Department of Children, Youth, and Families

Executive Summary

On August 24, 2018, the Department of Children, Youth, and Families (DCYF or the Department)[38] convened a Child Fatality Review (CFR)[39] to examine the Department's practice and service delivery to a family henceforth referred to as the H. family.[40] The incident initiating this review occurred on March 26, 2018, when the H. family's vehicle was found at the bottom of a 100-foot cliff in Mendocino County, California. The parents and their six adopted children (including five minors) all presumably perished. Crash site investigators believe the crash may have been intentional, and the incident garnered national media attention. Three days earlier, Washington Child Protective Services (CPS) conducted an unannounced visit to the family home in response to reported allegations of neglect. No one answered the door and, as unknown to the Department at the time but later reported by news media, the family had left Washington State for California that same evening.

The CFR Committee included DCYF staff, a representative from the Office of Family and Children's Ombuds, a senior investigator and analyst with the Criminal Justice Division of the Washington State Office of the Attorney General, and a clinical therapist who currently works with adoptive families and previously worked in public child welfare. None of the participating CFR Committee members had any direct knowledge of the family prior to the well-publicized deaths.

Prior to the review, each CFR Committee member received un-redacted Washington CPS records related to the family. Additionally, the CFR Committee received a chronology summarizing child welfare involvement with the family in three states, including Washington. Supplemental information and reference materials were available to the CFR Committee at the time of the review. This included case file materials obtained from Minnesota and Oregon child welfare services, applicable portions of the Cowlitz County Child Abuse and Neglect Investigation Protocol,[41] and Department policies relevant to CPS investigations.
Due to the brevity of the Washington CPS involvement, neither the CPS worker nor the supervisor was asked to appear in person for interview by the CFR Committee. However, in advance of the CFR, the CFR Committee approved the CFR facilitator to present the CPS worker and supervisor with a specific set of questions to help supplement and clarify case note documents. Responses to the questions were provided to, and discussed by, CFR Committee

[38]Effective July 1, 2018, the Department of Children, Youth, and Families (DCYF) replaced the Department of Social and Health Services (DSHS) Children's Administration (CA) as the state agency responsible for child welfare. The fatality here happened prior to July 1, 2018, and therefore CA and DSHS are occasionally referenced in this report.
[39] Given its limited purpose, a 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 is generally limited to documents in the possession of or obtained by DCYF or its contracted service providers. A CFR Committee has no subpoena power or authority to compel attendance and generally only hears from DCYF 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 death. Nor is it the function or purpose of a CFR to recommend personnel action against DCYF employees or other individuals.
[40] As there are no known criminal charges filed relating to the incident, the parents involved are not identified by name in this report. The names of the children are also subject to privacy laws.*See* RCW 74.13.500.
[41] In 2007, SHB 1333 became law (RCW 26.44.185). It required the Prosecuting Attorney in each county in Washington to revise and expand their current investigative protocols to include investigations of child fatality, child physical abuse, and criminal child neglect cases. The purpose was to establish a working agreement between Law Enforcement, the Prosecuting Attorney's Office, CPS, and First Responders in order to ensure and accomplish a high degree of coordination, cooperation and interaction.

members during the review. Following review of the case file documents, the interview responses, and discussion regarding Department activities and decisions, the CFR Committee concluded the Department made no critical errors.

Summary of Family History

State of Minnesota: According to a number of records obtained after the fatalities occurred, including Minnesota child welfare records, three of the H. children were an African American sibling group from Texas adopted and placed with the H. parents, a same-sex Caucasian couple living in Minnesota in 2006. In 2009, the couple adopted another group of three African American siblings from a different county in Texas. During the 6 years the family lived in Minnesota, that state's CPS and law enforcement responded to numerous reports of neglect and physical abuse. These included repeated allegations of withholding food as a form of punishment, and corporal discipline and physical abuse by both parents. In 2010, Minnesota CPS determined, by a preponderance of evidence, that both parents had committed child maltreatment. One of the mothers also pled guilty to a misdemeanor domestic assault of a child charge in 2011. According to Minnesota records, the family worked with child welfare services to remedy the concerns that brought the family to Minnesota CPS's attention, though records show that several more CPS intakes relating to food deprivation were subsequently made but screened out. Records indicate the Minnesota CPS case closed in March 2011. Subsequently, the H. children were unenrolled from public school and became homeschooled. The family continued to receive monthly adoption support funds from Texas while they lived in Minnesota.

State of Oregon: According to records obtained post-fatality, the H. family moved to Oregon in February 2013. In July 2013, Oregon CPS took a report from an anonymous source that the parents were depriving the children of food and water and carrying out inappropriate, excessive, and cruel discipline. Oregon CPS and law enforcement subsequently conducted an unannounced home visit. Reports indicate vehicles were seen at the home, but no movement was detected in the home. The Oregon CPS worker left a business card with a request that the parents contact the worker. One of the parents contacted the CPS worker, indicating the family would not be immediately available to meet with the Oregon CPS worker due to summer travel plans. During a home visit the following month in late August 2013, one Oregon CPS worker interviewed the children away from the parents while a second worker spoke with the parents. While there were no disclosures of maltreatment, the Oregon CPS reports indicate the children's answers to questions were nearly identical. The parents denied any abusive parenting and defended the family's lifestyle choices (homeschooling, following a strict vegetarian diet, incorporating meditation and yoga into discipline). In September 2013, records from the primary care physician showed all the kids, except one, were below normal ranges in height and weight, but the doctor cited no substantive concerns. Oregon CPS did not identify any imminent threat to safety, but did note elevated risk for child maltreatment due to the children being homeschooled and not seen regularly by mandated reporters. The Oregon CPS case soon closed with an investigative finding of "unable to determine if child abuse or neglect is occurring due to insufficient evidence." The family reportedly moved to Washington sometime in mid-2017.

State of Washington: The H. family first came to the Department's attention in Washington on Friday, March 23, 2018. A neighbor reported that one of the H. children, D.H., had come over several times a day for the past week to beg for food. According to the intake, D.H. stated he and his siblings were hungry because their parents were withholding food as punishment. The child also allegedly disclosed to the neighbor physical abuse at home, but was vague in details. The neighbor also reported that another child, H.H., six months earlier came over at 1:30 in the morning stating her parents were physically abusive and asked the neighbor to hide her. The neighbor had not previously reported that incident to CPS.

The intake cleared around 3 pm on Friday, March 23, 2018, and was designated for emergent field response. The assigned CPS worker had difficulty locating the family residence, and contacted the neighbor/referrer for detailed directions. When the CPS worker drove up to the area at around 5:30 pm, the referrer pointed to the H. family driveway. Moments before the worker noticed a vehicle turn into the gravel driveway. The CPS worker rang the doorbell and knocked, but received no response. The CPS worker walked around to the back of the house and knocked on a sliding glass door. The CPS worker did not detect any human movement or sounds and observed no signs that would indicate the presence of children. The CPS worker contacted her supervisor who advised the worker to resume efforts to contact the family on Monday. The CPS worker left after leaving her business card on the front door.
On Monday, March 26, 2018, the Department continued its efforts to contact the H. family. Inquiries made with two local school districts indicated none of the H. children were enrolled. Two CPS workers also made a second attempt to contact the H. Family at the home but again received no response and saw no indication that anyone was there. Local law enforcement also made a child welfare check and similarly reported that no one appeared to be at the home.
On Tuesday, March 27, 2018, the case transferred to a Department office in a different county because the Department realized the family residence was just over the county line. Efforts to locate the family continued by the second Department office that same day. A CPS worker and a regional practice specialist went to the home and reported that the residence looked vacant. Law enforcement conducted a second child welfare check with similar results. Requests for records were made to other states allegedly having prior child welfare involvement with the family. Around midday on March 27, 2018, the Department was notified that the H. family had been involved in a fatal motor vehicle crash in California a day earlier.

Details from California law enforcement indicated the H. family left Washington State on Friday evening, March 23, 2018, possibly for a spring break trip. The family arrived in Mendocino County, California, late Saturday evening, and remained in the area on Sunday. On Monday, March 26, 2018, the H. family's vehicle was discovered upside down on the rocky coastal shoreline below a 100-foot cliff in a remote area of Mendocino County. California crash site investigators believed the vehicle had been in the water for several hours. Eventually law enforcement reported circumstantial evidence that all eight family members died in the crash, noting the bodies of two of the children were not found at the crash site and presumably were carried out to sea. Post-mortem toxicology on the parent who was driving showed a blood alcohol level of .10, slightly over California's legal limit of .08. Based on crash site analysis, California investigators reported they believe the crash may have been intentional. At the time of the CFR, California law enforcement had not concluded their investigation.

Due to the death of all family members, Washington CPS was unable to complete an investigation of the allegations made on March 23, 2018. The Department's case closed in early May 2018.

CFR Committee Discussion

Aware that the purpose and scope of a CFR is to examine the Department's service delivery to a family prior to a fatality incident, the CFR Committee primarily focused on the actions and decisions made over the three days from the date of the initial intake to the day the Department was notified of the suspicious fatal motor vehicle crash in California. The CFR Committee recognized that the Department had very limited information about the family at the time of the intake and field response. The CFR Committee believed it was unreasonable to hold the Department accountable for information not available until after the fatality incident, i.e., prior public child welfare history from other states received after the fatalities). While the historical information provided a valuable accounting of recurring concerns for inappropriate parenting and child maltreatment in other states, the CFR Committee viewed evaluation of child welfare

services delivered by other states as both problematic and outside the intended scope of the CFR.

Abiding by the intended limited scope of the CFR, the CFR Committee primarily looked at Washington's CPS efforts to contact and gather information about the family after the Department received the intake on March 23, 2018. A major area of CFR Committee discussion involved the unannounced home visit the same afternoon the Department received the intake and the decision to leave a business card at the residence informing the family of CPS involvement. The CFR Committee understood that leaving a card on a door is routine practice for workers when there is no response at a family residence, unless there is a reasonable concern that such action may place children at significant risk of harm. The CFR Committee saw no concrete indicators that would have led to the CPS worker to believe leaving a card placed the children at significant risk of harm. The CFR Committee deliberated about the possibility that the card left on the door served as an alarm to the parents and precipitated a flight to California over the weekend. However, the CFR Committee could only speculate about whether the H. family leaving for California was pre-planned or spontaneous since there was no evidence to indicate the family's intent one way or the other, and the CFR Committee therefor drew no conclusions about the family's reason and timing for leaving Washington.

Another area of discussion was whether the lack of response at the home on March 23, 2018, would have been sufficient reason for the CPS worker to request assistance from local law enforcement at that time. However, the CFR Committee again found no fault with the Department's actions and no substantive information regarding immediate danger that would have justified the CPS worker calling law enforcement to intervene[42] or to meet the requirements for law enforcement responses to CPS cases as prescribed in local county protocols where CPS involvement with this family occurred.[43] Similarly, the CFR Committee explored the options available for requesting CPS after-hours workers to contact families after business hours and on weekends. In review of the after-hours response policy,[44] the CFR Committee determined that the circumstances of this case did not support a reasonable basis for such a request to be made. The plan for the CPS worker to return to the home on Monday, March 26, 2018, appeared supportable to the CFR Committee.

Several ancillary topics emerged during the CFR that prompted brief discussion. While these areas had only marginal applicability to the specifics of this case, the CFR Committee believed such inquiry to be valuable to understanding important system issues. The CFR Committee examined how the Department views homeschooling for CPS assessment of risk and safety, since there is an increased risk of maltreatment going undetected due to isolation from mandated reporters. The CFR Committee was also interested in Department policies relating to the homeschooling of children in out-of-home placements[45] and for adopted children receiving adoption support. The CFR Committee was aware that Washington State home-based instruction laws and the authority to enforce compliance rests with local school districts, not the

[42] RCW 26.44.050: "A law enforcement officer may take, or cause to be taken, a child into custody without a court order if there is probable cause to believe that the child is abused or neglected and that the child would be injured or could not be taken into custody if it were necessary to first obtain a court order pursuant to RCW **13.34.050**."

[43] The Cowlitz County Protocol states that CPS should obtain assistance from law enforcement when there is evidence of criminal activity, when threatening, assaultive, or otherwise high-risk individuals need to be contacted, and where evidence is uncovered suggesting the need for children to be placed in temporary custody. The Clark County Child Physical and Sexual Abuse Coordinated Response Protocol and Guidelines state that CPS should seek assistance and coordinate with law enforcement for removal and placement of a child in serious physical abuse cases and sexual abuse cases.

[44] *See* Practices and Procedures Guide 2310: Child Protection Services (CPS) Initial Face-To-Face (IFF) Response.

[45] *See* Practices and Procedures Guide 4302A: DCYF Education Services and Planning Policy. *See also* WAC 110-148-1525 prohibiting homeschooling for children in the Department's care and custody.

Department, as outlined in 28A.200 RCW.[46] The CFR Committee also briefly discussed system and process barriers for obtaining up-to-date child welfare records from other states in a timely manner, including the lack of a national registry for individuals found to have committed child abuse or neglect.[47]

Findings

The CFR Committee found no critical errors by the Department. The Committee noted the excellent intake report produced by the intake worker, and that the CPS response to the emergent intake was timely. The CFR Committee determined the actions and decisions made by CPS appeared reasonable and consistent with CA policy and practice expectations. The limited information known at the time of the CPS response on Friday afternoon, March 23, 2018, was insufficient to give CPS reason to believe the H. children were in immediate danger. The CFR Committee reached full consensus that nothing the Department did or did not do had any impact on what later occurred – that the circumstances of the fatality event did not appear to be reasonably foreseeable to the Department.

Recommendation

The CFR Committee encourages Washington State and DCYF to advocate for a national central registry for child abuse and neglect information. The CFR Committee also recommended that DCYF consider working with Washington's border states (Oregon and Idaho) on developing agreements for rapid processing of requests for child welfare services history information.

[46] An overview from the Office of Superintendent of Public Instruction is available on line.

[47] Currently there is no national registry or clearinghouse for child abuse cases. Most states maintain a state-based central registry, which is a centralized database of child abuse and neglect investigation records. States vary as to what kinds of records are retained and for how long. State-based central registry reports typically are used to aid social services agencies in the investigation, treatment, and prevention of child abuse cases and to maintain statistical information for staffing and funding purposes.[Source: Establishment and Maintenance of Central Registries for Child Abuse Reports published at www.childwelfare.gov]