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 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)[1] to assess the department's practice and service delivery to E.R. and RCW 74.15.515 family.[2] The incident initiating this review occurred on January 10, 2017 when E.R. was found by RCW 74.15.515 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 RCW 74.15.515 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 RCW 74.15.515 mother, RCW 74.15.515 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[3] (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.

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[1] 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.

[2] 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] 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]

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 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,[4] 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[5] reports, nine of which screened out and two that screened in[6] for investigation. Of the two that screened in for investigation in December 2013 and December 2015, the allegations included RCW 13.50.100, RCW 13.50.100, RCW 13.50.100and RCW 13.50.100, RCW 13.50.100, RCW 13.50.100and RCW 13.50.100as to both of E.R.'s parents and/or E.R.'s siblings' fathers. The allegations were determined to be unfounded[7] 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

[4] 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]

[5] 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.

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

[7] 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.

CA might have been able to respond to the family much earlier had CA received information regarding the mother's RCW 13.50.100 from a local RCW 13.50.100 provider in December, 2017. CA was not aware of the December RCW 13.50.100 assessment concerns and services until after E.R. had passed away. The Committee recognized that it is not regular practice for a RCW 13.50.100 provider to share assessments with CA when CA does not have an open 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[8] 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.

[8] 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)[9] convened a Child Fatality Review (CFR)[10] to assess the Department's practice and service delivery to A.F., RCW 74.13.515 family and out-of-home placement.[11] The child will be referenced by RCW 74.13.515 initials in this report.

On January 12, 2018, the CA received a call from RCW 74.13.515 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 RCW 74.13.515 death and RCW 74.13.515 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 RCW 74.13.515 bottle had been propped when RCW 74.13.515 was put down to sleep at approximately 8:00 p.m. RCW 74.13.515 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 RCW 74.13.515 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 RCW 74.13.515. The mother told the caller she had RCW 13.50.100 but would not provide information about

9 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.

10 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.

11 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)]

them. The caller did an internet search and found a news article stating the parents were RCW 13.50.100 The intake worker did an internet search and found that the mother and alleged father of this unborn child had RCW 13.50.100. 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.

A second intake was received on RCW 74.13.515 10, 2017, by the same caller whom called the CA RCW 74.13.515 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 RCW 74.13.515 regarding the mother's RCW 13.50.100, this intake was assigned for a 24 hour CPS Risk Only.[12]

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 RCW 74.13.515 Police Department and RCW 74.13.515 Department of Health and Human Services. The CPS worker obtained police reports and CPS investigative information regarding significant RCW 13.50.100 and RCW 13.50.100 to the RCW 13.50.100 by A.F.'s father. The mother's RCW 13.50.100. 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 RCW 74.13.515 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 RCW 74.13.515 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 RCW 74.13.515 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 RCW 74.13.515, 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 RCW 13.50.100, the father's current warrant for a probation violation, and current concerns for A.F.'s welfare based on the RCW 13.50.100 incidents out of RCW 74.13.515.

The mother answered the door and was holding a cell phone in her hand recording the interaction. The mother was holding a baby RCW 74.13.515. 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 RCW 74.13.515 24th. The CPS worker reiterated the need for

[12] 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

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 RCW 74.13.515, and the mother did not agree with the information obtained from RCW 74.13.515. CA obtained a pick-up order for A.F. the following day, RCW 74.13.51518, 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.

The next day, RCW 74.13.51519, 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 RCW 13.50.100 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 RCW 13.50.100, 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 RCW 74.13.515new 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. RCW 74.13.515had 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 RCW 74.13.515was too long for the rock n' play chair and RCW 74.13.515bottom 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 RCW 74.13.515had woken up and was already down for RCW 74.13.515morning 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 RCW 74.13.515 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.[13]

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 RCW 13.50.100 when discussing interactions and the placement facilitating visits between A.F. and RCW 74.13.515 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 RCW 13.50.100, 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 RCW 74.13.515 in protective custody.

The Committee did note how the persistence by the CPS worker to make contact with the family and gather information from RCW 74.13.515 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 RCW 74.13.515 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

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

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.

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 RCW 74.13.515 Southwest and RCW 74.13.515 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 RCW 74.13.515 Southwest area administrator should meet with the Chief of the RCW 74.13.515 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
Patrick Dowd, JD, Director, Office of Family and Children's Ombuds
Colette McCully, M.Ed., Administrative Services Division Program Manager, Department of Children, Youth, and Families
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)[14] convened a Child Fatality Review (CFR)[15] to examine the Department's practice and service delivery to a family henceforth referred to as the H. family.[16] 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,[17] and Department policies relevant to CPS investigations.

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[14] 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.

[15] 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.

[16] 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.

[17] 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

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 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 RCW 74.15.515: According to a number of records obtained after the fatalities occurred, including RCW 74.15.515child welfare records, three of the H. children were an African American sibling group from RCW 74.15.515 adopted and placed with the H. parents, a same-sex Caucasian couple living in RCW 74.15.515in 2006. In 2009, the couple adopted another group of three African American siblings from a different county in RCW 74.15.515. During the six years the family lived in RCW 74.15.515, 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 of the mothers. In 2010, RCW 74.15.515CPS determined, by a preponderance of evidence, that both parents had committed child maltreatment. One of the mothers also pled guilty to a charge of misdemeanor domestic assault of a child in 2011. According to RCW 74.15.515records, the family worked with child welfare services to remedy the concerns that brought the family to RCW 74.15.515CPS's attention, though records show that several more CPS intakes relating to food deprivation were subsequently made but screened out. Records indicate the RCW 74.15.515CPS case closed in March 2011. Subsequently, the H. children were unenrolled from public school and became homeschooled. The family continued to receive RCW 13.50.100 from RCW 74.15.515 while they lived in RCW 74.15.515.

State of RCW 74.15.515: According to records obtained post-fatality, the H. family moved to RCW 74.15.515 in February 2013. In July 2013, RCW 74.15.515 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. RCW 74.15.515 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 RCW 74.15.515 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 RCW 74.15.515 CPS worker due to summer travel plans. During a home visit the following month in late August 2013, one RCW 74.15.515 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 RCW 74.15.515 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. RCW 74.15.515 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 RCW 74.15.515 CPS case soon closed with an

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.

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 RCW 13.50.100reported 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 RCW 74.15.515 and RCW 74.15.515 siblings were hungry because their parents were withholding food as punishment. The child also allegedly disclosed to RCW 13.50.100 physical abuse at home, but was vague in details. The RCW 13.50.100 also reported that another child, H.H., six months earlier came over at 1:30 in the morning stating RCW 74.15.515 parents were physically abusive and asked RCW 13.50.100 to hide RCW 74.15.515. The RCW 13.50.100 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 RCW 13.50.100 /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 RCW 74.15.515a day earlier.

Details from RCW 74.15.515law enforcement indicated the H. family left Washington State on Friday evening, March 23, 2018, possibly for a spring break trip. The family arrived in RCW 74.15.515County, RCW 74.15.515, 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 RCW 74.15.515County. RCW 74.15.515crash 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 RCW 74.15.515legal limit of .08. Based on crash site analysis, RCW 74.15.515 investigators reported they believe the crash may have been intentional. At the time of the CFR, RCW 74.15.515law 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

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 RCW 74.15.515 over the weekend. However, the CFR Committee could only speculate about whether the H. family leaving for RCW 74.15.515 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 therefore drew no conclusions about the family's reason and timing for leaving Washington. 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 RCW 74.15.515 over the weekend. However, the CFR Committee could only speculate about whether the H. family leaving for RCW 74.15.515 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 therefore 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[18] 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.[19] Similarly, the CFR Committee

[18] 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**."

[19] The RCW 74.15.515County 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 RCW 74.15.515County 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.

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,[20] 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[21] and for RCW 13.50.100 children receiving RCW 13.50.100.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 Department, as outlined in 28A.200 RCW.[22] 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.[23]

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.

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

[21] *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.

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

[23] 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]