WASHINGTON STATE
Department of
Children, Youth, and Families

CHILD FATALITY REVIEW

December 2018

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EXECUTIVE SUMMARY

On August 24, 2018, the Department of Children, Youth, and Families (DCYF or the Department)[1] convened a Child Fatality Review (CFR)[2] to examine the Department's practice and service delivery to a family henceforth referred to as the H. family.[3] 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 RCW 74.15.515 County, RCW 74.15.515 The parents and their six RCW 13.50.100 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 RCW 74.15.515 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.

[1]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.

[2] 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.

[3] 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.

FULL REPORT

FAMILY MEMBERS

- 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

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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 74.13.640(4).

SUMMARY OF FAMILY HISTORY

State of RCW 74.15.515: According to a number of records obtained after the fatalities occurred, including RCW 74.15.515 child welfare records, three of the H. children were an African American sibling group from RCW 74.15.515 RCW 13 50.100 and placed with the H. parents, a same-sex Caucasian couple living in RCW 74.15.515 in 2006. In 2009, the couple RCW 13.50.100 another group of three African American siblings from a different county in RCW 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 74.15.515 CPS 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 74.15.515 records, the family worked with child welfare services to remedy the concerns that brought the family to RCW 74.15.515 CPS's attention, though records show that several more CPS intakes relating to food deprivation were subsequently made but screened out. Records indicate the RCW 74.15.515 CPS 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 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 13.50.100 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 RCW 74.1 and RCW 74.1 siblings were hungry because their parents were withholding food as punishment. The child also allegedly disclosed to the 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 parents were physically abusive and asked the RCW 13 50.100 to hide RCW 74.15.5 The RCW 13.50.100 had not previously reported that incident to CPS.

The intake cleared around 3 p.m. 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 p.m., 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 74.15.515 a day earlier.

Details from RCW 74.15.515 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 RCW 74.15.515 County, 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 74.15.515 County. RCW 74.15.515 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 RCW 74.15.515 legal 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 74.15.515 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 RCW 74.15.515 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[4] 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.[5] 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,[6] 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, was seen as a reasonable action by 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[7] 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.[8] 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.[9]

[4] 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**."

[5] The RCW 74.15.515 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 RCW 74.15.5 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.

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

[7] *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.

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

[9] 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]

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.

RECOMMENDATIONS

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.