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August 30, 2019

To: Supervisor Janice Hahn, Chair
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From: Judge Michael Nash (Ret.)
Executive Director, Office of Child Protection

OFFICE OF CHILD PROTECTION (OCP) RESPONSE TO THE NOAH C. MOTION

On July 16, 2019, following the death of four-year-old Noah C., the Board of Supervisors directed County Counsel to oversee a review of the investigation into Noah C.'s death by the Office of Child Protection (OCP) and report back on the following:

1. An assessment of the various interactions that any agencies may have had with the family of Noah C., identifying any potential systemic issues or recommendations for modifying and/or strengthening services to optimally protect the health and well-being of children

2. An update on the new pilot program in Palmdale and Lancaster that co-locates social workers with law-enforcement agencies to increase cross-training and coordination of joint responses and investigations of child-abuse reports

3. An update on the ongoing collaboration between law enforcement, the Department of Children and Family Services (DCFS), and the District Attorney's Office, to enhance and improve the utility of the Electronic Suspected Child Abuse Reporting System (eSCARS), with recommendations as appropriate

4. An update on the assessment of the existing use of the Medical Hubs County-wide, including efficacy of services and effective collaboration between and among the departments of Health, Mental Health, Public Health, and Children and Family Services to support the needs of children and families involved in child protective services

5. In collaboration with DCFS, the Department of Health Services (DHS), and the Department of Mental Health (DMH), an update on staffing and resources available in the Antelope Valley, understanding the unique nature of the region and previous barriers experienced

The Board further directed the Chief Executive Officer (CEO) to collaborate with DCFS to identify positions that are experiencing recruitment and retention challenges in the department's Antelope Valley regional offices and provide recommendations to address them, including financial incentives such as a pay differential and bonuses.

The Board further directed the OCP and DCFS to report back comprehensive data that details the progress and improvements that have been made since the adoption of the recommendations of the Blue Ribbon Commission on Child Protection (BRC), such as proposed systemic and structural changes including, but not limited to, Medical Hubs; impediments to the department's progress, including workload ratios; the number of fatalities that existed prior to the BRC versus now; and the overall efficacy of the OCP, particularly towards prevention and including its accomplishments.

The Board further directed the CEO and the directors of DCFS, DHS, and DMH to report back on the number of vacancies versus the total allocated positions, including vacancies in the Antelope Valley.

In this report, the OCP will report on items 1 through 4 and on the comprehensive data detailing the progress and improvements made since the adoption of the recommendations of the BRC. The other items requested by the Board will be reported on separately by the CEO, DCFS, and other agencies.

1. History of Contacts and Systemic Issues Identified

The family of Noah C. consisted of mother Ursula, father José, and four children—Noah and three siblings. Contact with DCFS fell into three different contexts.[1]

- First, in August 2014, petitions for Noah and his older sibling were filed alleging that Mother had physically abused her own infant sibling, resulting in a skull fracture, and that Father was an abuser of marijuana. The petitions resulted in the detention of Noah's sibling and Noah, shortly after Noah's birth.

- Second, petitions were filed in November 2016 alleging that Noah had been diagnosed with "failure to thrive," developmental delay, and congenital hypertonia, and that he was medically neglected by Mother and Father, who failed to take the child to eight scheduled medical appointments. These petitions again resulted in the detention of Noah and his sibling.

- Third, following the return home of Noah in November 2018, reports were made to the DCFS Child Protection Hotline regarding Noah that contributed to the issuance of a removal order on May 15, 2019, that was not executed.

[1] When she was a child, the family of Mother was the subject of three DCFS referrals—one in 2001 and two in 2011. The third referral resulted in a Voluntary Family Maintenance (VFM) case that closed as the family stabilized. When Father was a child, his family was also the subject of three DCFS referrals, in 1999, 2001, and 2008. The 2008 referral was promoted to a VFM case that closed in 2009 as the family stabilized.

2014 Petitions

After the filing of the petitions in August 2014, Noah and his older sibling were placed in foster care and then with their maternal great-grandmother (MGGM).

On May 21, 2015, just prior to the adjudication hearing, the petitions were dismissed. The allegations against Mother were dismissed after a forensic evaluation requested by DCFS was received from Dr. Janet Arnold-Clark, M.D., Board Certified Child Abuse Pediatrician from the LAC+USC Violence Intervention Program. DCFS requested the dismissal after indicating that it did not have sufficient evidence to meet its burden of proof, "as it is more likely than not that the mother did not cause the injuries."

The allegations in the petitions against Father were dismissed because there was "no evidence to suggest that the . . . father is an abuser of marijuana."

Following the dismissal of the petitions, Noah and his sibling were returned to Mother and Father.

2016 Petitions

After the filing of these petitions, both Noah and his older sibling were placed in foster care. At the initial hearing on November 21, 2016, Noah's sibling was released by the court to Mother and Father over the objection of County Counsel.

On March 9, 2017, Mother and Father pled no contest to the petitions. The disposition hearing was held on June 1, 2017. Family maintenance services were ordered for Noah's sibling, and family reunification services were ordered for Noah. On August 14, 2017, Noah was placed with his MGGM and maternal great-grandfather (MGGF).

At the Welfare and Institutions Code (WIC) section 366.21(e) judicial review hearing on November 28, 2017, the court found by a preponderance of the evidence that the return of Noah to his parents would create a substantial risk of detriment to the child, thereby necessitating continued placement.

The court further found that the parents' compliance with the case plan had been substantial. Both had completed parenting programs and had provided proper care for Noah's sibling. Mother had not completed individual counseling, in part because she had seen a counselor who was not a DCFS-approved licensed therapist. The court liberalized visits for the parents with Noah after finding that previous visits had been consistent and of high quality. The DCFS report on the November 28, 2017, hearing indicated that both children were doing well. Overnight visits with Noah were set to begin. The report noted that Mother and Father "have made tremendous progress" in participating in and completing the court-ordered case plan. DCFS stated that the family would be referred to family preservation services upon reunification with Noah.[2]

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[2] There is no indication that this ever occurred after Noah was returned to his parents.

The court continued reunification services and found a substantial probability that Noah would be returned to his parents within 18 months of his removal. The case was continued for the next review pursuant to WIC section 366.21(f) on May 29, 2018. (At the November 28, 2017, hearing, court jurisdiction was terminated over Noah's sibling.)

At the May 29 hearing, Mother and Father contested the department's recommendation to continue family reunification services. The DCFS report noted that Mother and Father were both compliant with their case plan and were taking good care of Noah's siblings, which included a new baby born on January 25, 2018. A return home for Noah was not recommended because of the lack of consistency of overnight visits and difficulties in transitioning Noah from the home of MGGM to parents when visits did occur. The hearing was continued to August 27, 2018. The court also ordered Noah to be referred for mental health services and for conjoint counseling with his parents.

As transition difficulties continued, the court ordered on July 11, 2018, a bonding study to assess the bond between Noah and his parents and between Noah and the maternal great-grandparents.

The August 27, 2018, hearing was continued until November 1, 2018. In the interim, visits remained inconsistent and transition issues continued. Conjoint counseling did not occur. A new continuing-services children's social worker (CS-CSW) was assigned to the case on September 7, 2018. The evaluation for the bonding study was completed on September 21, 2018. The psychologist recommended that Noah be transitioned to his parents with the assistance of Parent Child Interactive Therapy (PCIT).

On November 1, 2018, DCFS indicated its disagreement with the bonding study and recommended that family reunification services be terminated and the case be set for a permanency hearing pursuant to WIC section 366.26. At the November 1 hearing, the court ordered Noah on an extended visit with his parents, over DCFS objections. The hearing was continued to November 9.

On November 2, 2018, the CS-CSW visited Noah at the family home and he appeared to be comfortable. Subsequent attempts to visit before the November 9 hearing were unsuccessful.

On November 9, 2018, the court found that return to the parents would not create a substantial risk of detriment to Noah. The suitable-placement order was terminated and Noah was ordered to Home of Parents, over the objection of DCFS. The court further ordered DCFS to make unannounced visits and to set up a visitation schedule for the maternal great-grandparents, and for the parents and Noah to participate in PCIT. The case was continued to May 9, 2019, for a judicial review pursuant to WIC section 364.

<u>2019 Activities</u>

Subsequent to the November 9, 2018, hearing, the CS-CSW had in-person visits with Noah on November 16 and December 17 of 2018, and on January 24, January 25, February 28, March 7, March 22, and April 17 of 2019. Noah was also seen by an

emergency-response children's social worker (ER-CSW) and Human Services Aide (HSA) on May 20, 2019, and by the ER-CSW again on June 28, 2019. The CS-CSW also made four unannounced visits, for three of which she could not see Noah and was told via telephone by the parents they were not at home.

In her report to the court for the May 9, 2019, hearing, the CS-CSW reported, "During this period of supervision, Noah appeared to be happy and bonded to his parents."

During the period between November 9, 2018, and May 9, 2019, the parents did not enroll in PCIT and Noah was not put in preschool. MGGM had only one visit, on March 23, 2019. Further, during this time period the family's residence changed and the parents did not appear to be forthcoming about their living situation, although none of their apparent residences appeared unsafe.

On the February 28, 2019, visit, the CS-CSW described Noah as lethargic and advised that his parents seek medical treatment. On March 7, 2019, Noah had a well-child exam visit at Kaiser Permanente Panorama City. The assessment was, "Well child. Growth and development within normal limits." Noah was also diagnosed with an ear infection and was prescribed medication.

On April 17, 2019, the Child Protection Hotline received an anonymous call indicating that MGGM had seen Noah the previous week and he appeared thinner, with "frail hair," intimidated, and scared. The caller said that Noah frequented a maternal aunt's home and suffered from night terrors and had mentioned that his "butt hurt." Further, the caller said that the child had told the CS-CSW that Father hits him and curses at him. An "Info to CSW" communication was generated and sent to the CS-CSW.

The CS-CSW went to see the child that day and he appeared scared that she was there to remove him. He calmed down after she reassured him that she was not there to remove him. The CS-CSW asked Mother to remove Noah's shirt and she observed cream on his back, which Mother said was for eczema. The CS-CSW noticed a bruise on Noah's back and a scab on his forearm. The CS-CSW took a picture of them. Mother said that Noah had fallen from his brother's bunk bed. In speaking to Noah, the CS-CSW reported that he said he loved his mother and father. He also said there was nothing wrong with his butt. He said Father does not call him bad names. He said that when he does something wrong, he gets hit; when asked where, he said he doesn't get hit. Noah appeared happy and smiling during the interview. The CS-CSW felt he was coached.

The next day, the CS-CSW made a referral to the Child Protection Hotline and emergency response. An ER-CSW was assigned the referral and later met with the family. She observed the bruise on Noah's back and arranged for a forensic exam at the Olive View Medical Hub the next day. She spoke with Noah, who appeared happy. He said he got the bruises when he fell off the bed. Noah denied any physical discipline, sexual abuse, domestic violence, or fear of his parents.

A report of the April 19, 2019, forensic exam at Olive View indicated that Noah was very happy and energetic and engaged with Mother. Other than the bruise on the back and

elbow and scab on his elbow, the physical exam indicated that the rest of the body was within normal limits. The report concluded, “It is plausible current markings/bruising . . . can be attributed to the incident that was reported by both mother and child” (the fall off the bed). No other physical findings were discovered during the examination.

On May 9, 2019, the ER-CSW consulted with the family’s prior CS-CSW (now an HSA), who indicated that she had always had concerns for Noah, was opposed to his return home, and felt that the parents are habitual liars who present well. She expressed concern for the bonding between Noah and parents and believed he was a targeted sibling.

On May 9, the ER-CSW also consulted with her supervising children’s social worker (ER-SCSW). It was decided to close out the referral, given that the family was already under court supervision. The allegations of physical abuse were found “inconclusive.” There was no further discussion about the alleged night terrors or the complaint that Noah’s butt hurt.

On May 13, the ER-SCSW consulted with the CS-SCSW and advised that the allegations could not be verified. The CS-SCSW indicated that because of various case concerns related to the parents not being compliant and truthful, the CS-CSW had initiated a warrant request for removal (a DCFS procedure).

On May 15, a call to the Child Protection Hotline stated that the MGGM reported that one of Noah’s maternal aunts had told her that Father beats Mother in front of the children and sometimes throws them out into the street. Further, the MGGM said that Noah spent the night at a maternal aunt’s home and woke up screaming in the middle of the night. He also told the maternal uncle that his butt hurt, and the uncle told the aunt that Noah was being sexually abused.

This Hotline referral was assigned to the same ER-CSW. On May 15, prior to any investigation of the referral, the CS-CSW submitted the removal order to the court, which signed the removal order the same day. There was disagreement among the emergency-response and continuing-services staff about the filing of the removal order. An attempt was made to withdraw it, but it had already been signed by the court.

On May 16 and May 20, 2019, the ER-CSW spoke with the maternal aunts and maternal uncle referenced by the MGGM. All unequivocally indicated that the allegations made to the Hotline were not true.

On May 20, the ER-CSW and the HSA saw the family at their new address in Palmdale. Mother denied all of the latest allegations; she also denied being pregnant. Father, too, denied the allegations. The workers also saw and spoke with Noah, who was alert and in good spirits. Noah denied sleeping over at the maternal aunt’s house, denied that his parents get in fights, and stated that he felt safe. He also pointed when asked to indicate his private parts, denied sex abuse, and denied that his butt ever hurts.

At a case conference on May 22 attended by the ER-CSW, the CS-CSW, the HSA, the ER-SCSW, and the Assistant Regional Administrator, it was agreed not to execute the

removal order pending the referral. It was agreed that DCFS would facilitate a child and family team (CFT) meeting with the family. Unsuccessful attempts were made through July 5 to schedule a CFT.

On June 6, Mother—who had previously denied being pregnant—gave birth to a baby boy. At the hospital, she initially denied that the baby was hers and claimed she was inseminated as a surrogate, but did not know she was pregnant. She eventually told the truth and said she was afraid of DCFS. Hospital personnel noted that Mother had had no prenatal care and they were concerned with Mother's mental health. The baby was healthy and was discharged with his parents.

On June 13, the ER-CSW consulted with the ER-SCSW and it was decided to promote Noah's (now) three siblings to a case because of concerns for Mother's mental health and her inability to comply with court orders.

On June 19, the May 15 referral was closed. The allegation of general neglect by Mother was substantiated. The allegations of abuse by Father were deemed inconclusive.

On June 28, the ER-CSW visited the family home. All children were seen. Noah was described as being in good spirits and reported that he was doing well.

On June 26, the court was informed that the April 18 referral was closed, but that a new referral had been generated on May 15 alleging the sexual abuse of Noah and domestic violence between the parents, and that the removal order granted on May 15 had not been served. DCFS recommended a 30-day continuance to address the outcome of the referral disposition for a possible new case filing as to Noah and his three siblings.

On July 5, Noah was hospitalized after parents said they found him in the apartment complex's pool. He passed away on July 6, 2019.

The death of Noah is under investigation by the Los Angeles Sheriff's Department. No further information is available at this time.

Conclusion

Given what is currently known, the primary issue in this case from a systemic perspective focuses on the removal order. There are three key questions. First, was it appropriate? Second, should it have been issued? Third, should the order have been executed and Noah removed?

For clarification purposes, a "removal order" is not an order from the court directing the department to remove a child from the home. It is an order authorizing a removal of a child whom the department believes is at risk when there are not exigent circumstances justifying a removal without a court order. If the removal order is not executed or served within 10 days, the department must seek a new removal order if exigent circumstances

do not exist. DCFS policy also mandates that the court that issued the removal order must be notified if the child is not removed.

On the first question posed above, it is the opinion of this writer that the removal order was not appropriate. While the affidavit was lengthy, the basis for removal was sketchy for several reasons. The affidavit itself consisted of prolonged discussions of the family's background that included descriptions of the 2014 petition (which absolved parents of responsibility and was dismissed), the 2016 petition that brought the family before the court, and the sequence of events leading to Noah's return to his parents in November 2018.

By all accounts, Noah was doing well until around April 2019 and the CS-CSW was considering recommending termination of the case at the next scheduled court hearing in May, despite the fact that the parents had not complied with the court order to participate in Parent Child Interactive Therapy, had not given the MGGM her regular visits, and had not always kept DCFS informed of their address. Those factors in and of themselves would not be sufficient for removal of the child, but could form a basis for the court to maintain jurisdiction.

The affidavit further referenced the April referral that focused primarily on the back bruise. However, following the forensic medical examination at the Olive View Medical Hub, that allegation was deemed inconclusive as the injury seemed consistent with the explanation given.

The affidavit also suggested that the parents were medically negligent because Noah was not taken to a doctor when he appeared lethargic on February 28, and was not taken to a doctor when he suffered the back bruise (the basis for the April referral). Except for a minor ear infection diagnosed at Noah's annual medical exam on March 7, he was deemed normal both by the annual exam and by his Hub examination.

Finally, the affidavit discussed in detail the serious allegations that were the source of the May referral. Those allegations, which included possible sexual abuse and domestic violence, had not been investigated at the time that the removal order was sought. These serious allegations could have been the sole basis for a removal order had they been substantiated in any way—which they never were.

When all of the above is considered as a whole, there was not a sufficient basis to seek a removal of Noah.

As to the second question, this writer believes that the court was correct in signing the removal order because of the serious allegations regarding sexual abuse and domestic violence. The court had no knowledge that those serious allegations had not been investigated.

As to the third question, it is clear that the decision to not execute the removal order was appropriate. Given the fact that the most serious allegations, stemming from the MGGM

and the only reasonable basis for removal, had not been investigated, the removal of Noah from his parents would have been a premature, if not inappropriate, action.

These conclusions are not meant in any way to denigrate the ability of social workers to use their instincts based on their education, knowledge, and experience. However, given that they have the significant authority to remove children from their homes, it must be very clear that there exists a sufficient factual basis to exercise that authority.

Recommendations

A. Improve Warrant/Removal Order Process

The DCFS policy for obtaining warrants and/or removal orders is found in DCFS policy 0070-570.10.[3] It needs review and revision in a number of ways. First, the process for obtaining a warrant or removal order needs to be clarified. It is not clear in existing cases whether a court petition pursuant to WIC 342 or WIC 387 must be filed before or after a removal order is obtained.

Once a warrant/removal order is obtained, the policy should be clear under what circumstances it should not be executed, including what level of supervisory approval and what specific documentation are necessary. A timeframe for notifying the juvenile court that a removal order the court has previously approved is not being executed should be included in the policy.

In addition, there should be ongoing training for those involved in the warrant process, including DCFS and County Counsel personnel. In this case, a concern was expressed as to whether or not a removal order should be sought. Additionally, a removal order was filed despite the fact that it contained specific information that had not been investigated.

Perhaps more important, DCFS data show that in 2018, removal orders were sought for 8,952 children. For 687 children, those requests were denied. Seven removal orders were not served. According to DCFS, departmental policy does not require staff to report if warrants are not served. That policy needs to change.

Further, while the overall rate of denials is less than 10 percent, that still means that removal orders were denied for hundreds of children. Therefore, it is recommended that DCFS undertake a review of its process to understand why there are so many denials. Is it a DCFS issue, a court issue, or both? Is DCFS seeking too many removals, or is the documentation for its requests insufficient? It is important to know the answers to these questions—ultimately, children's lives can be at stake.

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[3] The 2014 version of this policy was revised on July 21, 2019, to require DCFS Director approval to not execute a removal order issued by the court. The policy is currently under further review.

B. Necessity for Seeking Review of Court Orders

In Noah's case, the court issued important rulings over the objections of DCFS. The most significant to these occurred in November 2018, when the court terminated the suitable-placement order of Noah and returned him to his parents.

The hearing on November 9, 2018, was a status-review hearing pursuant to WIC 366.21(f). At that hearing, the court is required to return the child to the parents "unless the court finds, by a preponderance of the evidence, that the return of the child . . . would create a substantial risk to the safety, protection, or physical or emotional well-being of the child."

In this case, DCFS (through its attorney, County Counsel) argued that the evidence showed such a risk existed. The court disagreed and returned Noah to his parents. No further review of the court's ruling was sought by DCFS or County Counsel, despite their contention that the child *was* at risk and despite the fact that potential legal avenues are available to seek review of a court order. It should be clear that whenever the court issues an order that DCFS and County Counsel believe is contrary to the evidence and that places a child at risk, there is a legal and moral obligation to seek review of that order.

C. Adherence to Statutory Timelines for Dependency Court Cases

WIC 352(b) provides that " . . . if a minor has been removed from the parents' . . . custody, no continuance shall be granted that would result in the dispositional hearing . . . being completed longer than 60 days after the hearing at which the minor was ordered removed or detained, unless the court finds that there are exceptional circumstances requiring such a continuance. . . . In no event shall the court grant continuances that would cause the hearing . . . to be completed more than six months after the hearing pursuant to Section 319."

Noah and his sibling were the subjects of two petitions filed in the Dependency Court. The first case was filed in August 2014 and was dismissed prior to its adjudication hearing on May 21, 2015, a period of time just short of nine months. The recent case was filed and heard at initial hearing on November 21, 2016, and did not reach a disposition hearing until June 21, 2017, a period of time longer than five months.

Dependency matters—particularly those in which children have been detained from their parents—need to be adjudicated as quickly as possible. While it is ultimately the responsibility of the court to control proceedings, DCFS and County Counsel, as well as other parties, need to be watchful for delays in proceedings and should strongly advocate for closer adherence to the statutory timelines established for these proceedings.