Washington State Department of Social & Health Services

CA Children's Administration

Department of Social and Health Services
Children's Administration
Child Fatality Review

B.H.

May 1997
Date of Child's Birth

February 17, 2012
Date of Child's Death

July 16, 2012
Executive Review Date

Committee Member
Tim Abbey, Area Administrator (Spokane), Children's Administration, Region 1 (North)
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Mary Meinig, Director of the Office Children and Families Ombudsman

Presenter
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Facilitator
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74.13.640(d)

RCW 74.13.515

Executive Summary

On July 16, 2012, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened a Child Fatality Review (CFR)[1] of the case involving the death of 14 year old, B.H. (DOB: 05-97; DOD: 02-17-12). B.H. was a developmentally delayed legally free youth residing in state licensed foster care in Yakima, Washington at the time of his death. On February 17, 2012 B.H. was in the yard with the foster parents and other foster youth, and then left this area on foot. He traveled approximately one and a half miles along a two lane road that had a speed limit of 50 miles per hour. It was dark, wet and raining. B.H. walked onto the road and was struck by a mid-size SUV. B.H. was transported to the local hospital where resuscitation efforts were unsuccessful. Yakima County Medical Examiner's Office determined B.H.'s cause of death was massive head and body trauma, due to motor vehicle/pedestrian accident; manner: accidental.

CA conducts fatality reviews to identify practice strengths and areas needing improvement as well as systemic issues in an effort to improve performance and better serve children and families. The CFR committee members included CA staff and community members representing disciplines associated with the case. Committee members had no involvement in B.H.'s case. A chronology of B.H.'s family as well as licensing case records were prepared and provided to the CFR committee. A copy of the family's case file, the licensing files and CA briefing paper were also available to the committee. Committee members interviewed the social worker, supervisor, Division of Licensed Resources (DLR) investigator, DLR supervisor and the case manager from the Child Placing Agency (CPA) overseeing the licensed foster home assigned to the case at the time of B.H.'s death. During the course of the review the committee discussed the documented social work activities completed by CA staff from intake[2] to case closure. Specific areas of review included the DLR investigations, placement moves, and supervision plans. Following a review of B.H's family's history, his foster care placement history, case records, CA employees' interviews and discussion, the committee made findings and recommendations that are detailed at the end of this report.

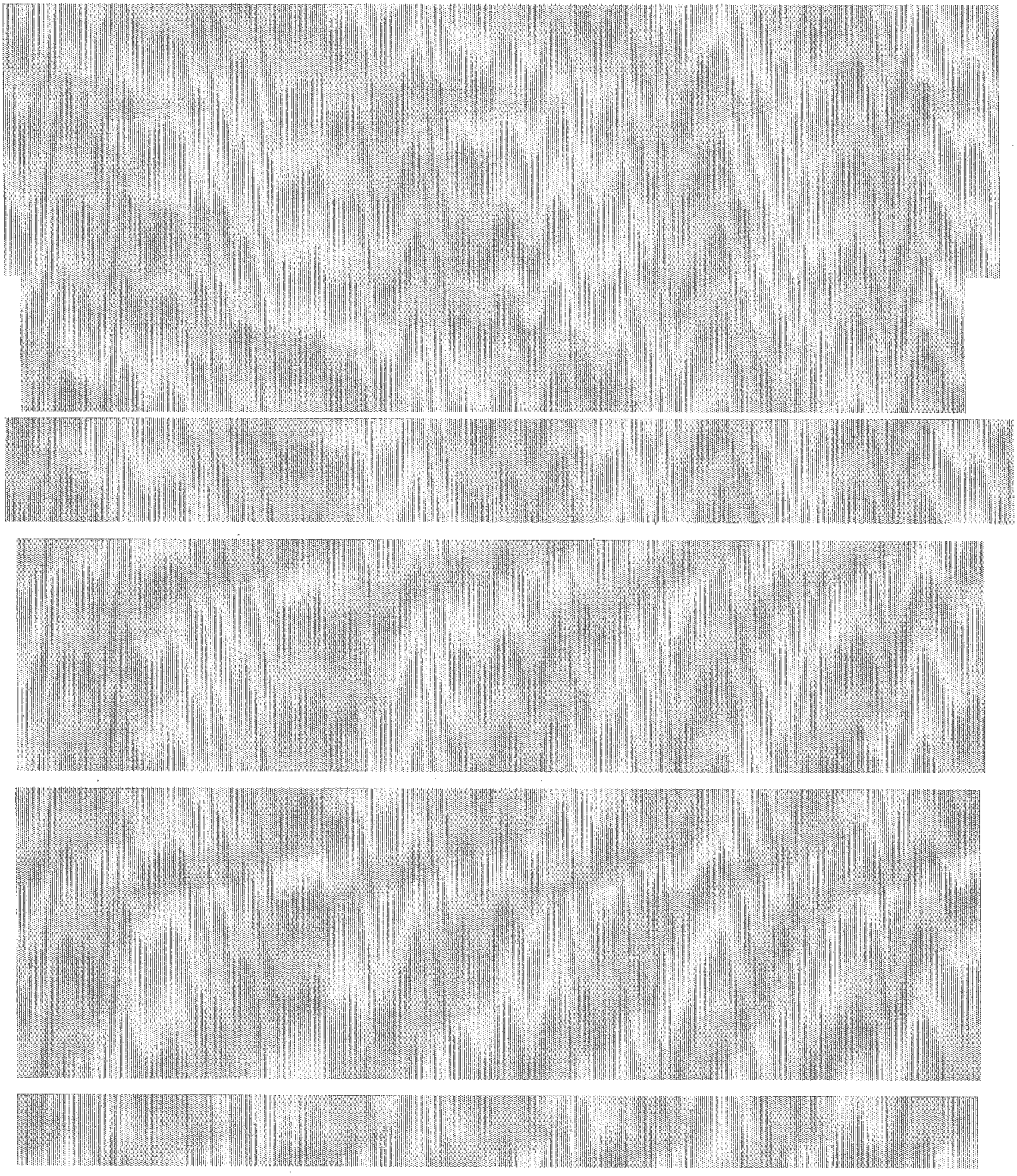
Case Overview **RCW 13.50.100**

B.H. was the middle sibling of three children

[1] Given its limited purpose, a Child Fatality Review should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. The Child Fatality Review 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 will only hear from DSHS employees and service providers. It does not hear the points of view of a child's parents and relatives, or those of other individuals associated with a deceased child's life or fatality. A Child Fatality Review is not intended to be a fact-finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's death. Nor is it the function or purpose of a Child Fatality Review to recommend personnel action against DSHS employees or other individuals.

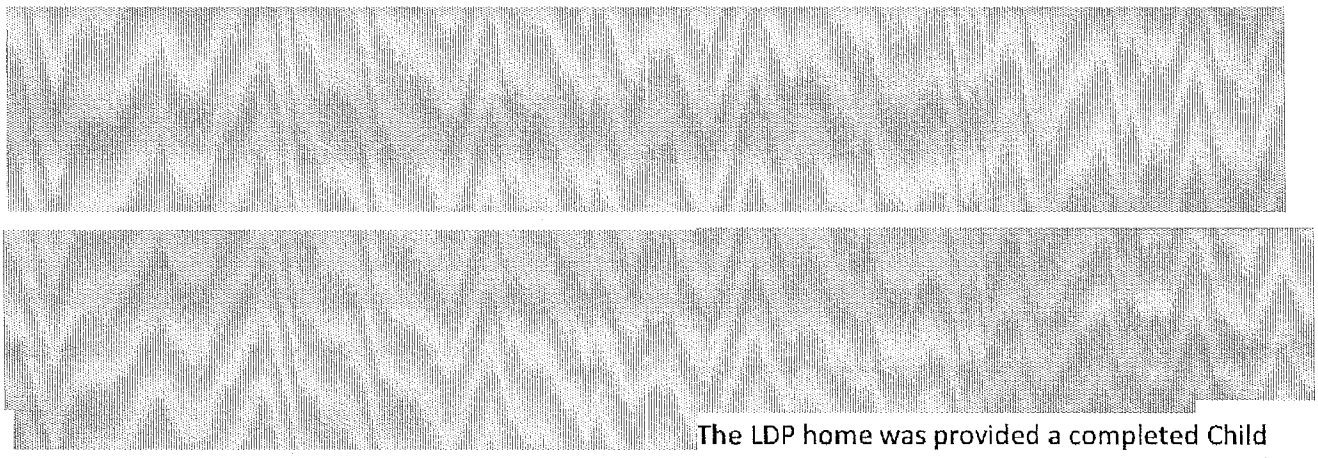
[2] An "Intake" is a report received by Children's Administration made by a person or persons who have reasonable cause to believe or suspect that a child was abused or neglected.

RCW 13.50.100



[3] The Youth Supervision and Safety Plan (supervision plan) can be used for youth who have high risk behaviors such as running away. The plan requires realistic and achievable action by the care provider. The plans also address activities from which the youth is restricted and the youth's monitoring needs. The current supervision plan form specifically states that it should not include supervision requirements such as, "line of sight, 24/7, or at all times".

RCW 13.50.100



The LDP home was provided a completed Child Information and Placement Referral form that outlined B.H.'s behaviors and the completed form also described an incident in which B.H. walked from Moxee to Terrace Heights without permission.

On February 17, 2012 CA was notified that B.H. had wandered away from the foster home onto Ahtanum Road, a two lane road in Yakima, and was hit by a car. Emergency Services were called and B.H. was taken to Memorial Hospital in Yakima where he was pronounced dead. It was reported to CA that B.H. had been outside the foster home working on a sprinkler. The foster parents discovered that B.H. did not go inside with the other children in the home and they went to check on him. The foster parents first checked where B.H. was working on the sprinkler and then began checking the rest of their 40 acre property. The foster parents were unable to locate B.H. so they drove down the road and observed the accident that had occurred in which B.H. was hit by a vehicle. During an interview with the DLR CPS investigator, the foster parents indicated they were aware they needed to supervise B.H. and check on him every 10 to 15 minutes and were aware he had wandered off on a couple of occasions in other foster homes. DLR CPS determined that the allegations of Negligent Treatment or Maltreatment by the foster parents was *unfounded.*[4]

In March 2012, the cause and manner of death was determined by the Yakima County Coroner's office. The cause of death was: massive head and body trauma, due to a motor vehicle/pedestrian accident and the manner of death was: accidental.

Committee Discussion

Committee members reviewed and discussed the documented social work activities completed by Children's Administration from intake to case closure. As a means to provide structure and context to reviewing social work practice, the committee was provided a case summary and had access to B.H's case file. In addition, the committee was provided information on policy and procedure as it relates to

[4] *Unfounded* is defined as follows: "[T]he determination following an investigation by child protective services that based on the available information it is more likely than not that child abuse or neglect did not occur or there is insufficient evidence for the department to determine whether the alleged child abuse or neglect did or did not occur." RCW 26.44.020(24).

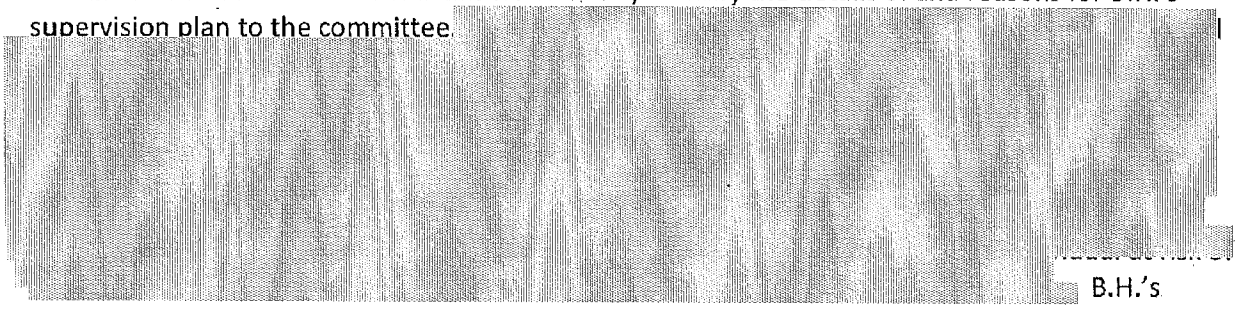
placement in both state licensed and private agency certified homes,[5] policy on supervision plans for youth in out-of-home placement, and policy regarding notification of parties when a new investigation is initiated by DLR and the youth identified as a victim is a state dependent. In this way, committee members were better able to evaluate the actions taken and decisions made by the Children's Administration. In addition to social work practice, discussions occurred around policy issues. The discussions largely focused on three areas: the use of out-of-home child safety plans, the licensing and training of foster homes, and the movement of foster children from one placement to the next. The committee interviewed the DLR CPS investigator, CFWS social worker, CFWS supervisor, private agency worker, and CASA.[6]

Findings

Based on the information available to the committee at the time of the review it appears that B.H. was left unsupervised for a short period of time. During that time, he left the property and proceeded down a road where he was eventually struck by a car. The committee focused the majority of its discussion on the supervision plan, placement decisions, licensing of the LDP foster home and the special developmental needs of B.H.

RCW 13.50.100

- The committee recognizes the difficulty involved in the care and supervision of developmentally delayed youth who require high levels of supervision. The committee found that the Children's Administration social worker was unable to clearly identify the details of and reasons for B.H.'s supervision plan to the committee.



B.H.'s primary safety concerns appeared to directly relate to B.H. wandering off as evidenced by two prior run events.

- The committee recognizes that it is difficult to locate appropriate foster home placements for foster children with special needs. The committee found that the placement decisions related to B.H.'s move from the FDP home to the next placement were reasonable. In addition, the committee found that the social worker had few viable placement options when the foster parents in the TDP home asked CA to move B.H. The social worker essentially had the options of returning

[5] The department has the sole legal authority to license or approve homes for the care of children in out-of-home placement; however, licensed child-placing agencies (often referred to as "private agencies") may "certify" or attest to the department that a foster home meets the licensing requirements. *See* RCW 74.15.040; WAC 388-148-0010; WAC 388-148-0070.

[6] Court Appointed Special Advocates (CASA) volunteers are appointed by judges to watch over and advocate for dependent abused and neglected children. Volunteer CASA's stay with each case until it is closed and the child is placed in a safe, permanent home.

B.H. to the FDP home or utilizing a new placement. The FDP home had requested a foster care reimbursement rate greater than that allowable for B.H.'s then current needs; [7]however, the committee found that the FDP home was provided incorrect information by the assigned social worker about B.H's level of need at the time of his last move. Regardless of the foster care reimbursement rate, it was unclear to the committee if the FDP home would have been a viable placement as the CASA and social worker reported that the FDP home had conflicting family needs that may have prevented the acceptance of B.H back into their home. The committee found that B.H.'s LDP was appropriate.

- The committee found that the social worker appropriately utilized the Family Team Decision Making (FTDM)[8] process prior to the placement of B.H. into the LDP home. The CASA expressed concern that she did not speak up at the FTDM about her concerns regarding B.H.'s needs, but she did report during the meeting that B.H. needed line of sight supervision. The CASA also reported that B.H and the foster father had developed a very good bond and B.H. appeared to really enjoy caring for the horses. In this case, the FTDM was designed to develop a plan around B.H.'s placement needs in the LDP foster home. There were no other viable placement alternatives presented at the FTDM.

- While the FTDM process was used appropriately, it did not fully address B.H.'s supervision needs in the placement as they related to his special needs. An FTDM should focus on both placement and any supervision needs of a foster child. The members of the FTDM discussed B.H.'s supervision needs, but did not develop a concrete supervision plan that was centered on his special developmental needs.

RCW 13.50.100

- The committee found that the assigned social worker did not inform the CASA of the allegation of [redacted] B.H. in the TDP as required by law.[9]

- The committee found insufficient documentation supporting the change of a CAPTA[10] finding of abuse or neglect by a caregiver in the LDP foster home. The committee was concerned that a CAPTA finding from August 1991 was changed from founded to inconclusive in 2006 after the foster parents were previously denied a license in June 2000 based on the founded finding and the fact that they did not fully disclose their history with CA on their Background Authorization form. The committee did not find the change inappropriate, but noted that the documentation in the record did not explain the reason for the changed finding.

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[7] Foster care reimbursement rates are established by using the foster care rate assessment tool based on the child's current needs and the circumstances of the foster parents. *See* WAC ch. 388-25.

[8] Family Team Decision Making (FTDM) meetings bring people together who are involved with the family to make critical decisions regarding the removal of child(ren) from their home, changes in out-of-home placement, and reunification or placement into a permanent home (CA Practices and Procedures Manual 4302).

[9] RCW 26.44.030(18).

RCW 13.50.100

- The committee found that a developmentally delayed child who was not physically or sexually aggressive was being placed in Behavioral Rehabilitation Services (BRS)[11] homes with physically and sexually aggressive youth.[12]

- The committee found inadequate documentation of medical and therapeutic treatment of B.H. following the allegec [redacted] in the TDP.

Recommendations

- The committee found that the assigned Children's Administration social worker did not notify the CASA that B.H. was the alleged victim of abuse or neglect in his TDP. The assigned social worker reported that she was unaware of the law regarding this issue. The committee expressed concern about the volume and frequency of changes of policies, laws, and procedures that Children's Administration staff are required to know. The committee recommends that Children's Administration ensure it has an effective way to communicate these changes to staff on an ongoing basis. Children's Administration should have a method to aid social workers in quickly and easily accessing laws, policies, and procedures.

- Foster parents who care for developmentally delayed children should be provided training related to these children's needs and supervision requirements. This recommendation should not prevent a developmentally delayed child from being placed in a foster home. This training should instead supplement training that is already provided to foster parents who care for developmentally delayed children.

- Efforts should be made to focus on recruiting and retaining homes that will be available to children with high needs (e.g. developmentally delayed children).

- Children's Administration and private agency workers need to be able to exchange information with each other about foster care applicants' previous licenses, denials, findings, and background checks. The committee recommends changing statutes that limit this exchange of information to allow it to occur.[13]

- The decision to reverse a founded finding made before 1998 (when the federal CAPTA law was enacted requiring that subjects be notified of and allowed to appeal founded findings) should be

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[10] Child Abuse Prevention and Treatment Act (CAPTA) (42 U.S.C.A. §5106g). In 1998 the federal CAPTA law was enacted requiring that subjects be notified of and allowed to appeal founded findings.

[11] Behavior Rehabilitation Services (BRS) are temporary intensive wraparound support and treatment programs for youth wit, high service needs and are used to safely stabilize youth and assist in achieving a permanent plan or a less intensive service (CA Practices and Procedures 4533).

[12] All youth identified as SAY/PAAY must have a signed Youth Supervision Plan (DSHS-15-352) prior to placement, but no later than 72 hours and the plan must be documented in FamLink within 7 calendar days. Youth identified as SAY/PAAY must *only* be placed with licensed caregivers who have completed the CA SAY/PAAY training. (CA Practices and Procedures Manual 4536).

[13] "An unfounded, screened-out, or inconclusive report may not be disclosed to a child-placing agency, private adoption agency, or any other provider licensed under chapter 74.15 RCW". RCW 26.44.031(4). "No unfounded allegation of child abuse or neglect ... may be disclosed to a child-placing agency, private adoption agency, or any other licensed provider." RCW 13.50.100(11).

approved at a higher management level than the Area Administrator when the subject of the finding is appealing so they may provide care for children or vulnerable adults. If the pre-CAPTA founded finding is reversed the electronic record should include the reason for reversal.

- The committee recommends increased local (Yakima area) communication between the Division of Developmental Disabilities and Children's Administration so that CA can obtain information related to eligibility, services, and resources for developmentally delayed children in foster care.