Children's Administration
Executive Child Fatality Review

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May 28, 2008

The Executive Review Team included:

- Children's Administration (CA) staff from Region 3 and 4.
- Native American Mental Health Specialist.
- Director of the Office of Family and Children's Ombudsman (OFCO).
- CA Indian Child Welfare Program Manager.
- Representatives of the Hoonah Association and Nooksack Tribe.

Note: The information in this report is confidential and may contain information not subject to disclosure. The report is based on information gathered from the case records, staff interviews, and the review of that information. The findings and recommendations are those of the Executive Review Team.

Executive Summary

On September 11, 2007, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened an Executive Child Fatality Review of the case involving the death of 15-year-old R[redacted]" C[redacted] (RC). A committee that included Tribal representatives, community professionals, and CA staff reviewed case documents and interviewed CA staff in an effort to examine child welfare practice, system collaboration, and service delivery.

RC died on December 11, 2006. At the time of his death, he was living with his guardian, Steve Horton. Mr. Horton was a licensed foster parent in Stevens County. He had no foster children in his home at the time RC's death. The medical examiner determined that RC's manner of death was accidental and cause was methadone ingestion. Mr. Horton had a prescription for methadone.

From 2001 until RC's death in December 2006, there were five referrals to the department that alleged licensing violations in the Horton foster home. Four of those referrals were received after Mr. Horton was licensed as a single foster parent and while he was RC's guardian. Those referrals alleged concerns regarding the condition of the home, family financial problems, supervision issues, concerns about nurture/care, and concerns for Mr. Horton's mental health. The licensing investigations found the allegations were "not valid". Many of the investigations resulted in compliance plans agreed to by Mr. Horton.

Cultural Sensitivity and Indian Child Welfare

The case was supervised and monitored prior to and during the establishment of the guardianship by the court and parties to the case. Parties included the Tribes who had intervened in the case. During the course of the review, Tribal representatives expressed that while they were in support of guardianship as the permanent plan, concerns about how the prospective guardians would support and honor the child's cultural heritage and Tribal connection were not considered. Once the guardianships were established, the department did not have authority to direct parenting decisions or have any input into maintaining Tribal or family connections. After the guardianship was established with Mr. Horton, the team found that he did not value and or support RC's cultural and Native heritage.

During the course of this review other issues were raised regarding sensitivity to Native American culture, communication with the Tribes, and authority for decision-making in Native American cases. Siblings did not have consistent contact with each other and their relationships were not encouraged. Maintaining connection with Tribes was not encouraged and responses to Tribal inquiries were reportedly not returned. Although the department requested that his siblings be allowed to attend RC's funeral, the court denied the request. While the team is not connecting these concerns to RC's death, they need to

be addressed by the department so that case management for Native American children can be improved, understanding of Native culture is developed, relationships with Tribes are strengthened, and roles and responsibilties are clarified in decision-making.

Findings and Recommendations

Dependency Guardianship Cases

Findings:

1. At various times during the guardianship, RC told his school teacher, social worker, grandmother, and others that he didn't want to go back to Mr. Horton's house. RC also told people that he wanted to visit his siblings and have communication with them. While the department knew what RC was saying, there was no action taken to follow-up on his requests.

2. Concerns were expressed about the quality of care that RC was receiving from Mr. Horton. These concerns included:
   - RC was not taking his medication.
   - RC did not have adequate clothing and food in the home.
   - Mr. Horton canceled therapy appointments and visits between RC and his siblings.
   - RC's therapist expressed concerns about Mr. Horton's ability to meet RC's needs.

3. A pattern of licensing referrals and concerns were noted during RC's guardianship in the Horton home.

Recommendations

1. A guardianship in any licensed home should receive a formal review when any type of Child Protective Services (CPS) referral or licensing complaint is received on the home.

2. When guardianships are established for Native children, all parties should ensure that the guardian will encourage and maintain communication with the Tribe(s), the siblings, and will support the child's cultural heritage.

Licensing

A dependency guardianship is an achieved permanent plan. Once the guardianship order is entered, the child is no longer considered to be in foster care. Although a proposed guardian who is not a relative must meet the minimum requirements for licensed foster parents, the guardian does not need to be licensed. As noted above, the Hortons were licensed as foster parents during the time the guardianship was in place. The license provided an opportunity for oversight of the home.

Findings:

1. The team noted a pattern of concerns regarding the Horton's foster care license and their home. While some of the reports have stand-alone significance, the pattern of concerns was missed. Of the concerns, five resulted in licensing referrals. If the pattern had been considered, the team believes the seriousness of the concerns would have become more clear and initiated a formal review.

These concerns included:

- Supervision and treatment of foster children in the home.
- Adequacy of Mr. Horton's finances to support the home, (e.g. power turned off, lack of food, etc.)
- Observations that Mr. Horton was passed out at the table during mealtimes.
- Mr. Horton's use of methadone for pain interfered with his memory and functioning.
- Mr. Horton failed to comply with numerous compliance agreements regarding safety and the conditions in the home.
- Mr. Horton cancelled therapy appointments.
- Mr. Horton was caring for a medically fragile child and was unable to provide information to medical providers about the child.
- Pornography in the home.

2. In August 2001, Mr. Horton reported to the department that he had been suicidal in February 2000.

3. The Executive Order requires that the responsibilities of licensing be kept separate from placement in order to avoid a conflict of interest. The licensor's role is to ensure that licensed providers meet and maintain the minimum licensing requirements. Licensors must address child safety and risk issues and may be able to preserve placement while the concerns are being addressed. However, licensors must not let preservation of the license take precedence over preservation of the placement. In this case, it appears that preservation of the license was the focus rather than the safety and well-being of RC.

Recommendations

1. Medical, psychological and substance abuse evaluations should serve to guide CA decisions on caregiver suitability. The evaluations alone should not be the only basis for licensing or denying a license to an applicant. The licensor should develop their own assessment based on the application, references, and their own observations.

2. The department must strengthen the relationship between the Division of Children and Family Services (DCFS) and the Division of Licensed Resources (DLR) through more focused training on clarification of roles.

Communication needs to be clear between:

- DCFS and DLR
- DCFS and Tribes
- DLR and Tribes
- CA headquarters/Office of Risk Management and Field (DCFS-DLR) regarding perceptions of line of authority

Working with Law Enforcement

Recommendation

1. The team did not have access to the law enforcement investigation of RC's death. If local law enforcement does not follow the agreed upon protocol or statute regarding the release of police reports and information pertaining to a dependent child, the Assistant Attorney General's (AAG) assistance should be requested in obtaining the documents.

Factors Influencing Placement and Supervision of the Case

Findings

1. During discussions regarding the guardianship decision, the department and the Nooksack Tribe were defendants in an action brought against them on RC's behalf. The Tribe and the department were involved in negotiations that resulted in a settlement of the tort claim. The impact of the tort action and resulting settlement on the decision-making and management of RC's case was reviewed. CA headquarters staff and the torts attorney had a role in overseeing that the settlement agreement was carried out. CA headquarters staff and the torts attorney believed that they were functioning in an advisory capacity to the region. The regional staff perceived that they did not have the authority to make routine case planning decisions without approval from CA headquarters.

2. Contact and communication with the Tribes ended between the date of the settlement and June 2004.

Recommendations

1. CA headquarters and Risk Management should have a defined role at key decision points.

2. Tribes need to be involved at the same key decision points.

3. Decision-making and authority lines between the field and CA headquarters should be well thought-out and organized when major events occur.

Fatality Review Process

Recommendations

1. Native American cases should always include Native reviewers.

2. Tribes should have adequate notice and input into the fatality review process.

3. Regional fatality reviews should be done by panels from outside the region. Regions should not be reviewing their own fatalities

Case Summary

RC's mother is a member of the Hoonah Tribe in Alaska and his father is a member of the Nooksack Tribe in Deming, Washington. At the review, Nooksack Tribal representatives stated that the Tribe recognizes dual-enrollment with Alaska Tribal members.

CPS involvement with RC's parents began in 1990 in the state of Alaska. Alaska's records reflect CPS referrals alleging abuse and neglect of the children while in the care of the parents. In 1992, the state of Alaska placed RC and an older sibling with a relative but RC's mother left a treatment program against medical advice and absconded with her children to Washington.

Later that same year, Washington CPS began receiving referrals about the family. RC and his older sibling were initially placed in out of home care in Washington in 1992. RC's mother gave birth to his two younger siblings (1993 and 1996) after moving to Washington.

The children have been in relative placements and foster care placements, as well as placements with their mother. The placements have been both voluntary and court ordered. The current dependencies were established in Stevens County in 1996. In 2001 court jurisdiction transferred to Spokane County. Both the Hoonah Tribe and Nooksack Tribe intervened in the dependencies.

In 2000, the children were moved from a relative placement in Deming, Washington and returned to foster care when RC's youngest sibling was critically injured by another child in the home. A lawsuit was filed against the state and the Nooksack Tribe on behalf of the children. A settlement agreement was reached in 2003 with a monetary settlement as well as agreements between the parties for follow-up evaluations and services for the children.

After their return to foster care in 2000, the children were initially placed together, but RC was later moved to a home separate from his siblings because of reported concerns about his behaviors.

In May 2002, the department filed guardianship petitions on behalf of all the children with the recommendation that all children enter in guardianships with their current foster parents. This proposed case plan did not go forward. The mother opposed the guardianship.

The Hoonah Tribe also notified the court of their intention to intervene in this matter. They believed the children should be placed in Alaska. The Hoonah Association stated they wanted to establish a guardianship for the children with a foster home in Hoonah, Alaska. The mother had moved to Sitka, Alaska and was residing with her mother. The mother stated that she was opposed to the placement of the children at the foster home.

The children's father resided in Western Washington at the time and was reportedly doing well in treatment. He agreed to the department's proposed guardianship order.

From 2001 until RC's death in December 2006, there were five referrals to the department that alleged licensing violations in the Horton foster home. Four of those referrals were received after Mr. Horton was licensed as a single foster parent and he was RC's guardian. Those referrals alleged concerns regarding the condition of the home, family financial problems, supervision issues, concerns about nurture/care, and concerns for Mr. Horton's mental health. The licensing investigations were "not valid," however, there were compliance plans written and agreed to by Mr. Horton.

In March 2003, Mrs. Horton moved out of the home. A licensing complaint had been received resulting in a compliance agreement with Mr. Horton regarding safety hazards in the home. Mr. Horton was reportedly out of compliance with the agreement. In December 2003, a licensing complaint was received reporting that Mr. Horton's electricity was going to be shut off because he illegally tapped into the neighbor's pump house and supplied his house with that electricity. There was also a report that children were left home alone. The home was inspected and a compliance agreement made with a plan of correction. The agreement was to be completed by February 2004. In May 2004, the compliance agreement was completed after an inspection of the home confirmed corrections. During the visit, the licensor spoke with Mrs. Horton who reported that Mr. Horton had been self-medicating with pain pills for ten years and she had observed him passing out. She told the licensor that her divorce from Mr. Horton would be finalized in June 2004.

RCW 74.13.500

In June 2004, Mr. Horton completed a psychological evaluation. [redacted]. The psychologist's opinion, however, was that Mr. Horton was capable of continuing to care for RC as long as there were not further indications of abuse of prescription medications. RC remained in a guardianship with Mr. Horton.

In September 2004, DLR received a report from Dr. Keith L. Hindeman outlining a medical assessment and pain management plan for Mr. Horton. In the report, Dr. Hindeman concluded that Mr. Horton had followed all recommendations and there was no evidence of impaired functioning and that his medical condition did not interfere with

his ability to be an effective foster parent. DLR, following-up with the foster home re-assessment, noted that RC was in counseling and that his therapist said that Mr. Horton needed to make some changes in activities for RC. There was concern that RC's emotional needs were not being met due to the isolation with the home, that the visits between the siblings had ended (reportedly due to car trouble), and that participation in Native American cultural events had also stopped. The re-assessment noted that the divorce had left Mr. Horton with less income, but that he had been able to meet the minimum licensing requirements with help from the licensor.

Later that same year, efforts began by the Indian Child Welfare (ICW) social worker to reconnect RC and his siblings with relatives in Alaska. The ICW social worker and two Nooksack Tribal members traveled to Alaska. A maternal uncle expressed a willingness to support the children's return to the community and ICW believed that the community could meet the children's needs. The Nooksack Tribal members supported the children's return to the Hoonah community. Relative members were identified who were willing to have the children live with them. The relatives were licensed foster parents with the State of Alaska. Meetings were held with DCFS managers and administrators in Region 1, Spokane. The ICW social worker documented that she was directed to continue with efforts to reunite the children with relatives in Alaska. There is nothing in the record to indicate that the guardian of RC was included in the discussion to move him to Alaska.

In May 2005, RC and two of his siblings visited relatives in Hoonah. Upon their return, a confrontation occurred between Mr. Horton and the ICW social worker. Mr. Horton reportedly yelled at the social worker. The social worker told the licensor and DLR supervisor about the confrontation.

Numerous concerns about how RC was doing in the Horton home began to arise in early 2006. RC's treating physician reported in March 2006 that RC had not been on his anti-depression medication since November 2005 and it appeared there was a poor relationship between RC and Mr. Horton. The school principal also reported concerns about Mr. Horton's care of RC. He told the licensor that the school had helped to supply RC with footwear and school supplies. RC had also missed school and had dropped out of basketball due to poor grades. In late 2006, the Hoonah Tribal attorney contacted the ICW social worker about his efforts to set-up a visit for the children in Alaska during the past summer. Efforts to schedule the visit had been unsuccessful.

In December 2006, RC died in his sleep at the Horton home. The ICW social worker for the children requested that the court allow RC's siblings to attend his funeral in Alaska. The guardians did not support the trip to Alaska and the trip was denied by the court.