Washington State Department of Social & Health Services

CA Children's Administration

Child Fatality Review

E.S.

November 2002
Date of Child's Birth

June 30, 2013
Date of Fatality

November 5, 2013
Child Fatality Review Date

Committee Members:
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Deena Parra, Foster Parent Liaison, Olive Crest
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RCW 74.13.640

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Executive Summary

On November 5, 2013, Children's Administration (CA) convened a Child Fatality Review[1] (CFR) Committee in response to the death of a ten-year-old male child. The deceased child will be referred to by his initials, E.S., in this report. At the time of his death, E.S. was in the custody of the Department of Social and Health Services pursuant to a juvenile court dependency proceeding and living in a licensed foster home while receiving Behavioral Rehabilitation Services (BRS).[2] E.S.'s foster home was certified for licensing by a private agency contracted by CA to provide both child placing[3] services and BRS.

The incident initiating this review occurred on June 30, 2013, when E.S. died while swimming in a river during an outing to a public park with his foster family. Emergency personnel were called to the park after E.S. was swept away by the river current. After an approximate forty minute search, emergency personnel found E.S. in the river. He was unresponsive and had no pulse. He was transported to a local hospital where resuscitation efforts were unsuccessful and he was pronounced dead.

When a child dies from alleged child abuse or neglect and the child's family had received services from CA within a year of the child's death, Washington state law requires CA to conduct a CFR. The review is conducted by a team of CA staff and community members with relevant expertise from diverse disciplines. Neither CA staff nor any other committee members had previous direct involvement with the case. The primary focus of the review was the service delivery provided to E.S. by the child placing agency, BRS services and the Division of Licensed Resources (DLR).[4]

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[1] Given its limited purpose, a Child Fatality Review (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 deceased child's life or death. 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 or near fatal injury Nor is it the function or purpose of a Child Fatality Review to recommend personnel action against DSHS employees or other individuals.

[2] BRS is a temporary intensive wraparound support and treatment program provided by contracted private agencies in which the primary objective is the stabilization of behavioral concerns which interfere with the child's ability to maintain stability and continuity in multiple life domains.

[3] The department may license a child placing agency, including a tribal CPA, to operate foster home, staffed residential home, and/or group care facilities. The child placing agency is only authorized to "certify" or attest to the department that the foster home meets the licensing requirements. [Source-Washington Administrative Code 388-148-0070]

[4] The Division of Licensed Resources (DLR) was established by Executive Order to improve the health and safety of children in out-of-home care, to strengthen monitoring and licensing of all licensed care resources, and to separate

Prior to the review, each committee member received a summary of E.S.'s family case history, a chronology of licensing-related activities and un-redacted licensing-related documents. Additional documents were made available to the Committee at the time of the review. These included medical and law enforcement reports, records provided by the private agency responsible for certifying the foster parents for licensing, training and informational materials related to child safety provided to foster parents and copies of relevant CA policies, manuals and Washington Administrative Codes.[5]

During the course of the review, the CFR Committee members interviewed the DLR licensor and supervisor. Additionally, Committee members consulted with a program consultant from CA about contracts for BRS.

Following review of the case file documents, interviews, and discussion regarding service activities and decisions, the Committee made findings and recommendations which are detailed at the end of this report.

Case Overview **RCW 74.13.515**

Family case summary

[redacted] On January 5, 2011, E.S. was placed in the care and custody of Children's Administration pursuant to a juvenile court proceeding and moved from his home to a residential treatment facility. With the exception of one unsuccessful trial return home, E.S. continued to live in foster care until his death.

On June 21, 2011, E.S. was first placed with the foster parents involved in this incident. He left their home a few months later on September 16, 2011 but returned on November 5, 2011 and remained until his death on June 30, 2013. While in foster care, E.S. received specialized services from BRS to address his behavioral needs.

Foster home summary

The foster parents were licensed by DLR on May 5, 2011 to provide foster care after first becoming certified as meeting foster home licensing requirements by a

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regulatory oversight from placement activities. The division is composed of the Office of Foster Care Licensing (OFCL), and a unit of investigators charged with investigation of allegations of child abuse and/or neglect in licensed child care homes and facilities.[Source: DSHS Operations Manual 2240]

[5] Regulations of executive branch agencies are issued by authority of statutes. Like legislation and the Constitution, regulations are a source of primary law in Washington state. The WAC codifies the regulations and arranges them by subject or agency.[Source:www.leg.wa.gov]

child placing agency. The same agency was also contracted to provide BRS services to E.S. The foster parents were initially licensed to care for four children between the ages of 6-18 years of age. In February of 2012, the foster parents moved to a smaller home and their licensing capacity was reduced to three children. Prior to E.S's death, the foster parents had one prior unfounded allegation of child abuse and neglect and two licensing infractions that were determined to not be valid.

On June 30, 2013, Children's Administration was notified by an employee of a county coroner's office of E.S.'s death by drowning while swimming in a river. At the time of the incident, E.S. was on an outing to a public park with his foster parents and two other foster youth. All three of the foster youth required specialized care to address their behavioral, emotional and developmental needs. During the outing, two of the three foster youth were allowed to swim without personal flotation devices in a river accessible from within the park boundaries. While wading across the river, E.S. was swept away by the current and was unable to keep his head above the water. Emergency personnel were called to the park and began rescue attempts. Forty minutes later E.S. was found submerged under water in a snag of trees. He had no pulse and was unresponsive. E.S was pronounced dead after resuscitation efforts at the river and later at a local hospital were unsuccessful. The death was certified by a medical professional as an accidental drowning.

Both DLR and law enforcement conducted investigations of this incident. The police report indicated if E.S. had been wearing a life jacket his death probably could have been prevented. No criminal charges were filed against the foster parents. The DLR investigation resulted in founded findings of child neglect by the foster parents for allowing E.S. and the other foster youth to swim without personal flotation devices. The DLR investigation also confirmed there were a number of signs posted in the park where E.S. died warning of the dangers of swimming in the river.

Committee Discussion

The Committee discussed in-depth the contractual relationship between CA and the private agency involved in this incident. The Committee examined the CA contracts process for services such as certifying potential foster homes as meeting licensing requirements and providing BRS services. The Committee noted the complex contracting agreements between CA and the private agency involved in providing care to E.S. The Committee explored how CA provided oversight to the contracting private agency to ensure the agency adhered to licensing and contracting requirements while providing safe and high quality care

to children. The Committee learned from interviews conducted during the review that the staff responsible for the licensing and contracting oversight of the involved private agency, as well as CA's regional program consultant for BRS services, are now meeting monthly to improve service coordination and communication.

The Committee reviewed how contracted private agencies determine if a potential foster home is capable of providing licensed foster care and how contracted private agencies monitor and support foster homes following licensing. The Committee discussed both the general training requirements for foster parents and specialized training when foster parents care for children with special needs. After learning CA does not require private agencies to be accredited by an independent organization, the Committee discussed if accreditation would increase the quality of care provided to foster children served by child placing agencies.

The Committee reviewed the documentation indicating E.S. was visited monthly in his foster home by his CA social worker and also had frequent contact by staff from the contracted private agency. The Committee questioned how the responsibility to monitor the safety and well-being needs of foster children is shared by social workers and licensing staff from both private agencies and CA. The Committee discussed how E.S.'s foster parents were informed of E.S's behavioral needs at the time of placement and how information about E.S. was exchanged between the various professionals involved with his care.

The Committee questioned if CA and private agencies collaborate when determining how many foster children to place in a particular home and if the individual needs of foster children are considered at the time of placement. The Committee discussed how the contracted private agency and CA responded to the report of alleged child abuse and the licensing infractions in E.S's foster home. The Committee discussed what additional supports are provided foster families caring for foster children with special needs.

In response to the cause of E.S.'s death, the Committee discussed how foster parents and CA staff are trained and informed about water safety for children in foster or relative care. The Committee reviewed a variety of training materials, CA's Guidelines for Foster Child Activities, licensing checklists and the specific WAC addressing water safety for foster children.

The Committee acknowledged the thorough investigation of E.S.'s death conducted by the CA social worker and agreed with the investigative findings.

While determining the critical incident was not a result of error or oversight by CA or the contracted CPA, the Committee's findings and recommendations listed below highlight opportunities to improve practice.

Findings

1. The Committee believes the home study completed by the private agency during the process of certifying E.S.'s foster parents to become licensed to provide foster care did not contain sufficient information to fully assess the foster parents' skills and abilities to provide specialized foster care.
2. The Committee believes the child placing agency should not have allowed the placement of three children with a wide spectrum of developmental, cognitive and behavioral needs in the home of newly licensed foster parents with limited prior parenting experience. Additionally, the Committee believes the foster family would have likely benefitted from additional support with the care of three foster children with special needs and from more frequent in-home visits by the agency providing contracted child placing and BRS services.
3. The Committee found no documentation to confirm the foster parents were in compliance with the 30 hours of annual training required of foster parents providing therapeutic BRS foster care.[6]
4. While acknowledging E.S.'s death was not related to fire safety, the Committee did note one of the CA social workers conducting monthly health and safety visits[7] with E.S. routinely asked E.S. if fire drills were conducted in his foster home. The Committee believes the social worker, after learning from E.S that fire drills had not been practiced for some time in the foster home, should have notified the DLR licensor.

Recommendations

1. By March 2014, CA should convene a workgroup consisting of professionals representing water safety, foster parenting, public health, law enforcement, the Division of Licensed Resources, and CA's contracted training provider to consider the following:
    - Update WAC 388-148-0170 (relating to the water safety of foster children) with specific instruction about when to require foster children to use United States Coast Guard-approved personal flotation devices.

[6] CA's Behavioral Rehabilitative Services Handbook (pages 23, 44 and 45).
[7] CA social workers are required to visit with all children in person on a monthly basis if the case is open for services. The goal of these visits is to ensure the child is safe and the child's basic well-being needs are being met.

- Expand WAC 388-148-0170 to require safety and supervision plans when a foster home is in close proximity to an open body of water such as a pond or stream.
- Develop written guidelines on water safety for use by DLR staff responsible for creating safety and supervision plans for licensed home and facilities.
- Revise CA's Guidelines for Foster Child Activities (DSHS Form 22-533) to include specific guidance about participation in swimming, boating and water recreation by children in foster care.

2. Develop and provide social workers with training on the risk and prevention of childhood injuries. The Committee recommends CA consider using existing training materials readily available from organizations promoting injury prevention.
3. Revise the Foster Home Inspection Checklist (DSHS form 10-183) to include a specific section about water safety in foster homes.
4. At the time of initial licensing and licensing renewal, require foster parents to complete training on the risk and prevention of childhood injuries. The Committee recommends the training include information on the proper use of safety equipment such as bicycle helmets, car seats and personal flotation devices.
5. Update CA's Placement Agreement form (DSHS form 15-281) to indicate the out-of-home placement provider has read and agreed to comply with the Guidelines for Foster Child Activities.
6. The Committee recommends CA conduct annual on-site reviews of CPAs as a strategy to CPA compliance with the myriad of laws, administrative codes and policies relevant to foster care licensing and contracting.