Children's Administration
Executive Child Fatality Review

R.B.

January 21, 2011
Date of Child's Death

June 2, 2011
Executive Review Date

Committee Members
Larry Caranza, Social Worker, Nak Nu We Sha, Yakama Nation
Bob Cox, Mental Health Professional, Behavioral Health, Yakama Nation
Jackie Davidson, Greater Columbia Regional Support Network
Nancy Dufraine, Indian Child Welfare Program Manager, Children's Administration
Berta Norton, Area Administrator, Children's Administration
Robert Rodriquez, Child Protective Services Program Manager, Children's Administration
Nate Sitton, Behavioral Rehabilitative Services Program Manager, Children's Administration
Stella Washines, Tribal Council Member, Yakama Nation

Observer/Invitee
David Lees, Prosecutor, Yakama Nation Office of the Prosecutor, Yakama Nation
Mary Meinig, Director, Office of the Family and Children's Ombudsman

Facilitator
Marilee Roberts, Practice Consultant, Field Operations, Children's Administration

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Executive Summary

On June 2, 2011, the Department of Social and Health Services (DSHS), Children's Administration (CA) convened an Executive Child Fatality Review (ECFR)[1] of the case involving the death of a 15-year old Yakama Nation Tribal member, R.B. (DOB 12-1995). R.B. was a dependent of the Yakama Nation with case management services provided by the state of Washington. A committee[2] that included Tribal representatives, community professionals, and CA staff reviewed the case documents and interviewed CA staff in an effort to examine child welfare practices, system collaboration, and service delivery.

On January 21, 2011 at approximately 7:40 p.m., Cypress House[3] staff reported to CA they were contacted by the Snohomish County Medical Examiner (SCME) and Washington State Patrol (WSP) requesting information (fingerprints) regarding R.B.; WSP notified Cypress House that they believed R.B. had jumped off a freeway overpass (Interstate 5) at approximately 2:30 p.m. and died. At the time of his death R.B. was residing at Cypress House, a staffed residential facility for youth in Snohomish County, Washington.

From May 1998 until his death, R.B. had been in the care and custody of the Yakama Nation pursuant to Tribal Court jurisdiction and had been placed in out-of-home care. During this time he had been in 22 placements with the most recent placements, those between June 2009 and January 2011, being in staffed residential facilities. In early January 2011, R.B. had been accepted and was awaiting placement in a Children's Long-Term Inpatient Program (CLIP)[4] when he was placed at Cypress House.

Committee members received case documents including a case summary regarding R.B.'s family. In addition, un-redacted copies of the family's case file, summary information regarding R.B.'s recent placements, Division of Licensed Resources investigation regarding R.B.'s death in a licensed facility and information from CA's Behavioral Rehabilitation Services (BRS) handbook were made available. Committee members also had the opportunity to meet and interview two CA staff members; the social worker and social work supervisor assigned to the case at the time of R.B.'s death.

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[1] Given its limited purpose, a Child Fatality Review by Children's Administration should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. A review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers and the panel may be precluded from receiving some documents that may be relevant to the issues in a case because of federal or state confidentiality laws and regulations. A review panel has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. The panel may 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 take personnel action or recommend such action against DSHS employees or other individuals.

[2] Ms. Washines was unavoidably called away and was not able to attend the full review, however was provided a copy of the final document for review and approval. Mr. Lees was invited by Ms. Washines to the review.

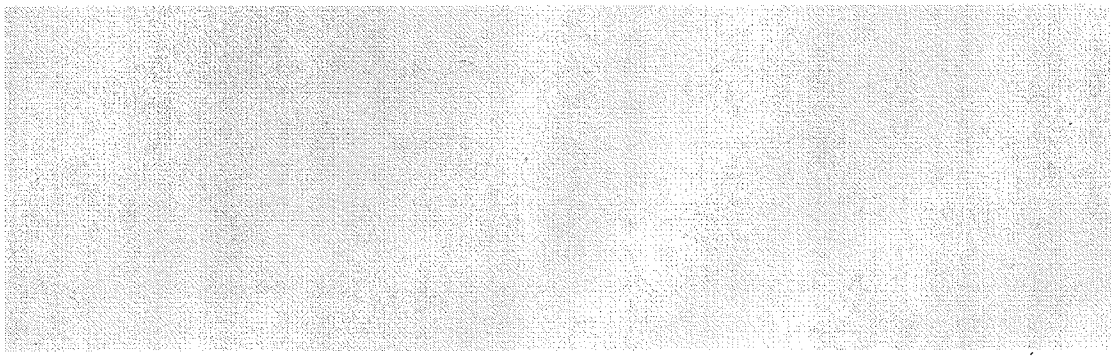
[3] Cypress House is an unlocked staffed residential facility in Snohomish County licensed by Children's Administration, Division of Licensed Resources.

[4] CLIP provides psychiatric inpatient services for the children and youth of Washington State. There are 91 CLIP beds in the state of Washington located at Child Study and Treatment (47 beds), a state operated psychiatric hospital for children and three contracted Residential Treatment Facilities (44 beds).

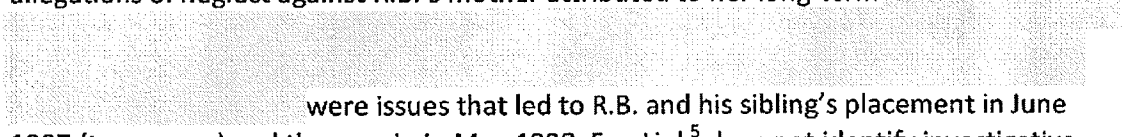
During the course of the review, committee members discussed issues related to the coordination of communication between service providers, foster parents, and other professionals involved. In addition, the committee members addressed issues related to accessibility of services within a youth's own community, training and support for foster parents and residential facility staff, and delivery of mental health services.

Following review of the family's history, case records and discussion, the committee members made findings and recommendations that are detailed at the end of this report.

Case Overview



R.B.'s CPS history as a child victim includes six intakes between April 1997 and May 1998 where his mother is identified as the subject of abuse or neglect of her children. Five of the six intakes were screened in for investigation with one intake identified as CPS Risk Only and opened for services. The five intakes screened for investigation referenced allegations of neglect against R.B.'s mother attributed to her long-term



were issues that led to R.B. and his sibling's placement in June 1997 (temporary) and then again in May 1998. FamLink[5] does not identify investigative findings for the five intakes; however this family's case remained opened for services during this time (April 1997-May 1998) until protective custody was granted in May 1998.

Service and Placement Information

A dependency was established as to R.B. in May 1998 in Yakama Tribal Court. This family was provided services prior to placement in out-of home-care and throughout the dependency by the Yakama Nation, as well as by CA under a local agreement with the Yakama Nation. Unfortunately, R.B.'s parents failed to consistently access identified services intended to address

Active efforts to encourage parental engagement in services occurred prior to the death of R.B.'s mother in 2001. In June 2005, the Yakama Tribal Court vacated R.B.'s father from the service plan because he could not be considered a placement

[5] FamLink is Children's Administration's management information system. FamLink became operational in January 2009 and replaced CA's previous information system, CAMIS.

option due to his incarceration. This order released CA from the responsibility of offering or providing remedial services to R.B.'s father.

After entering out-of-home care in May 1998, R.B. and his sibling were placed in four foster homes within three years. The duration of each of these placements varied, with the longest placement being 2 years. However, in June 2001 R.B. and his siblings were placed in a Yakama Nation foster home where they remained for 3½ years. In October 2001 while placed in this home, the children's mother committed suicide. The stability of this placement, assisted the young children in dealing with their mother's death while remaining in a stable environment. Placement was stable in this two-parent home until the unexpected death of the foster father in September 2004. At the request of the grieving foster mother, the children were removed and placed in a relative's home.

From September 2004 to June of 2009 R.B.'s placement changed thirteen times. During this five year period Children's Administration worked in partnership with the Yakama Nation and Service Alternatives[6] to find a placement that would best meet his needs. Despite the stability of the previous placement (June 2001-September 2004), R.B. struggled significantly in new homes,

In June 2005, R.B. began receiving additional Services were intended to address

In December 2006, after another disrupted placement, R.B. was assessed for Behavioral Rehabilitation Services[7] (BRS) and placed in several Service Alternatives homes. In June 2009, led to placement in a more supervised environment at Northwest Idaho Children's Home (NICH). While at NICH, R.B. was monitored closely by staff as well as involved in Continued concerns regarding led CA to initiate an application to support placement in a Children's Long-Term Inpatient Program (CLIP) facility in August 2010[8].

[6] Service Alternatives is a multi-faceted human services agency providing services which include residential services, wraparound/kinship services, and therapeutic foster care among others.
[7] Behavioral Rehabilitation Services is a temporary intensive wraparound support and treatment program for identified youth. Services are intended to increase a child's behavioral and placement stability in order to increase potential to reach permanency.
[8] Application was evaluated and accepted by the state CLIP committee in early January 2011.

Placement at NICH disrupted in November 2010 after an incident which led to R.B.'s placement at the Nez Perce Juvenile Detention facility until mid-December 2010. On November 29, 2010 a CLIP staffing was held with the local Regional Support Network (RSN)[9]. R.B. was found to be eligible for a CLIP bed; however he was placed on a wait list pending bed availability. In addition to review and approval by the local RSN, the social worker shared the plan and received support from the Local Indian Child Welfare Act Committee (LICWAC). The LICWAC committee also encouraged CA to continue researching other options and resources for R.B.

On December 17, 2010, R.B. was returned to his home community and placed in a secure crisis facility, EPIC. Lack of availability of CLIP beds and program parameters at EPIC necessitated the placement of R.B. at Cypress House in Lynnwood, WA in early January 2011. The Cypress House placement was intended to be a temporary placement until a CLIP facility was available. R.B. was told of the plan and according to documentation, understood and was prepared to enter the CLIP facility when available. This information along with LICWAC's knowledge of the plan was presented to and approved by the Yakama Nation's Tribal Court on January 18, 2011. However, a CLIP bed did not become available prior to R.B.'s death on January 21, 2011.

Team Discussion and Findings

- Communications – At various times during the dependency, information regarding family history such as mental health, child protective services, cultural preferences, and service outcomes did not appear to be consistently conveyed to all providers or caregivers. Committee members noted specific information regarding a youth's behaviors or special needs must be conveyed to providers and caregivers in order to assist in developing safety and service plans critical to child safety and placement success.

  Complex cases require diligent efforts to ensure communication and coordination of services. Service providers and caregivers need information regarding past and current service successes and outcomes for purposes of future case planning and development. This concept was referred by the committee members as 'bringing history forward' to ensure continuity and consistency in care.

- Case Coordination (Safety Planning) - During a document review and in speaking with the assigned social worker and supervisor, questions arose concerning whether critical information referencing the youth's recent behavioral issues[10] was made available to Cypress House residential staff.

[9] In 1989 the Washington Legislature passed legislation creating county-based Regional Support Networks to design and administer local mental health systems to meet the unique needs of people with mental health issues.

[10] Information specific to and CLIP bed application.

A review of the BRS packet sent to Cypress House (an unlocked staffed residential facility) and e-mails between CA staff and Cypress House indicates that information regarding and an incident at NICH in which R.B. was provided. As a result, the safety plan for R.B. while in care at Cypress House identified and running away as key issues. Frequency of supervision while in the program included constant visual and earshot[11] supervision. The safety plan developed by Cypress House with CA's approval referenced a staff/client ratio of 1:3 when traveling with no other additional supervision recommended. The safety plan was developed in collaboration with CA as required by policy.
The review committee felt the safety plan could have been enhanced to include additional supervision given R.B.'s
Current BRS funding supports programs, when determined necessary, to request additional funding to allow for increased supervision. Exploration of CA policy and additional funding sources to support additional supervision could have been included during the development of the safety plan.

- Case Complexity – Committee members discussed the complexity of cases where placements are affected by a youth's special needs and where multiple systems (mental health, child welfare, and juvenile justice) are involved.
Committee members noted that a significant number of services were provided to R .B. which included multiple

and structured group care among others. The discussion included the complexity of this case and limited services within R.B.'s home community that precipitated CA to explore and identify more intensive services outside his home community.

As a result of this discussion the committee also considered decision-making regarding the timing for CLIP placement applications. The review committee suggested CA may want to consider accessing more secure placement settings for youth with complex behavioral and mental health needs earlier in the case as issues are identified. They found the use of unlocked staffed residential facilities[13] (e.g. NICH or Cypress House) or psychiatric hospitalization outside a youth's home community is accessed only after all other local resources have been exhausted regardless of a youth's needs. Given limited community resources for youth who present with complex mental health and behavioral issues, placement in such facilities at the time of diagnosis may provide the most comprehensive and

[11] 'Constant visual and earshot supervision' is the term used in the Individual Behavior Management/Safety Plan utilized by Cypress House.
[12] Evaluations included
[13] Washington State does not allow dependent non-adjudicated youth to be placed or housed in a locked facility.

effective services for a youth. This could support early intervention and placement in a secure environment that maximizes treatment options and success.

- Providers - Mental Health Training and Support – Committee members discussed the training and education needs for foster parents, residential facility, and CA staff when working with youth with intensive mental health and behavioral issues. The committee identified a need to develop a range of care providers who, coupled with additional training and added supports, are able to sustain placement of youth who have special needs. With added case and behavior management support for least restrictive[14] setting providers, a youth may be able to receive services within his home community.

Recommendations

- Communications and Case Complexity – CA must ensure a complete case history is conveyed to care givers and service providers (e.g. medical providers, mental health professionals, care providers, etc.) to provide a baseline for case planning. When multiple agencies and service providers over time have worked or are working with a youth and family or have referred them for intervention; a thorough overview of the case must be shared. In addition to the packet of information forwarded to a care provider[15], information provided must include a comprehensive summary of the case history, service intervention and significant events to date.

  The review committee suggested this discussion should occur in person or telephonically prior to placement to ensure appropriate case plan development in the proposed home/facility. CA can utilize several existing venues where this information can be shared (e.g. Multiple Disciplinary Teams, Shared Planning Meetings, Family Team Decision Making Meetings) and assist in developing communications across systems and ensure a comprehensive plan of care is developed[16]. At minimum staff participating in such staffings should include the assigned CA social worker and supervisor, BRS facility staff and the CA Regional BRS Program Manager. As noted above a comprehensive staffing may have led to a request for additional supervision supported by BRS funding sources.

- Provider Training –Currently CA offers training to foster parents regarding Sexually Aggressive Youth (SAY) and Physically Aggressive and Assaultive Youth (PAAY). In order for a care provider to care for youth who has been identified as SAY or PAAY, they must attend training referencing these topic areas.

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[14] Least Restrictive Care refers to family based care options such as relative placement or foster care as opposed to residential or group care.

[15] Foster parent receives a Child Placement Referral form. Residential facilities receive a Behavioral Rehabilitation Services packet. Both documents provide information regarding a youth and his/her family's history with CA.

[16] A plan can include additional funding to allow for increased supervision.

CA may choose to consider the development of additional training opportunities that address the complexity of mental health and behavioral issues in children and adolescents. This enhanced training will support care providers, CA staff and its partners in addressing issues related to youth with special needs and may support and assist in sustaining least restrictive placements for youth.

Training opportunities which introduce and provide specific information related to mental health and their related behavioral issues can support care providers and social workers in caring for youth diagnosed with such issues. Training such as medication management, accessing community resources such as the Designated Mental Health Professional[17] (DMHP), intervention strategies, redirecting behaviors, safety planning and monitoring[18] were several topics suggested by the review committee.

[17] Provides assessment to determine if a person is a danger to self or others or suffering from grave disabilities.

[18] CA has initiated a new safety assessment and safety planning framework for all staff. Child Safety Framework training is scheduled for August 2011 through November 2011 and is mandated for all CA staff.