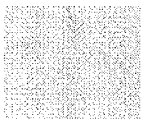
Children's Administration

Executive Child Fatality Review



November 22, 2008
Date of Children's Death

December 2, 2010
Executive Review Date

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RCW 74.13.500

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Executive Summary

On November 22, 2008 Children's Administration (CA) Central Intake (CI) received an intake from a program manager at Compass Health reporting the deaths of 11 year old and 10 year old The referent stated that during the late night/early morning hours that day a fire erupted and raged out of control at the Arlington home of M.L. and S.L., who were licensed foster parents caring for and three other foster children at the time. It was reported that the smoke alarms in the home were working. The foster parents, their 19 year old and 10 year old daughters, another adult relative, and three foster children in the home escaped with minor burns and smoke inhalation and did not require hospitalization. and perished in the fire due to asphyxiation. Both children were in the custody of the Department of Social and Health Services pursuant to juvenile court dependency proceedings at the time of their death.

At the time the intake was made, the cause for the fire was unknown but assumed to be accidental. As a result, the intake screened out for Division of Licensed Resources Child Protective Services[1] (DLR/CPS) investigation. Arlington Fire Department and Snohomish County Sheriff subsequently investigated the circumstances of the fire. The preliminary assessment made by fire personnel concluded that the fire had been accidental in nature and caused by a faulty electrical outlet. This was later to be determined to be inaccurate.

Further investigation by the Sheriff's Office investigators determined that the fire had been accidentally started by 10 year old , another foster child residing in the home. confessed that he had been playing with a barbeque lighter in his room and that he accidentally set his bedding on fire. The fire quickly grew too large for him to control and then spread throughout the rest of the house. Investigators did not believe that the boy intended to burn the home. However, the fire was the direct cause of the deaths of and

In late March 2009, once the police and fire investigations into the fire determined that the fire had not been caused by an electrical problem and had been started by with a lighter he found at the foster home, an intake was created and CA Region 3 Intake accepted the intake identifying the foster parents, M.L. and S.L., as alleged subjects of Negligent Treatment/Maltreatment. An investigation by DLR/CPS was conducted and following interviews and review of police documents, the foster parents were not found to be negligent in their supervision of the children in their care. Witnesses in the home all stated that no one was allowed to have matches or a lighter and interview with law enforcement supported that he had retrieved the lighter from the garbage after the foster father had thrown it out. The foster parents were unaware of this. There was no evidence to suggest that had any history of or known propensity for fire setting.

In June 2010, was formally charged with conspiracy to commit second-degree manslaughter in Snohomish County Juvenile Court. On January 26, 2011, pleaded guilty to these charges and the Court granted a deferred prosecution. will be on community supervision for a year and will participate in counseling and community service.

[1] Division of Licensed Resources child protective services investigates allegations of child abuse and neglect in licensed foster homes.

In accordance with CA Operations Manual[2] and the Revised Code of Washington[3] (RCW), a Regional Child Fatality Review (CFR) was convened in April 2009. Upon review of the April 2009 CFR by the Office of Family and Children's Ombudsman and CA Headquarters staff it was agreed that due to additional questions, an Executive Child Fatality Review[4] (ECFR) would be convened. The review would examine the respective roles between CA and child placing agencies, particularly those agencies that license and monitor foster homes. The review is intended to examine the roles and responsibilities of the respective agencies regarding licensing and license oversight, which includes changes in the home such as family composition, home construction (re-modeling as in this case) and re-location, supervision of children, communication, and program content.

The fatality review committee members included CA staff and community members who had no involvement in the case. Committee members received case documents including: detailed chronologies and family history regarding the foster family, and the families of , , and and the Snohomish County Sheriff's Report. Available to committee members at the time of the Executive Child Fatality Review were un-redacted copies of the foster home regional and private agency licensing files, a copy of the CA Behavioral Rehabilitation Services (BRS) handbook, and copies of pertinent Washington Administrative Code (WAC) pertaining to foster home licensing. During the course of the review the committee members had the opportunity to meet and interview two professionals from Compass Health, the private child placing agency that certified and monitored the foster home. They were the Compass Health foster home licensor, and the Compass Health program manager of the Children's Hospitalization Alternative Program (CHAP), a program that provides intensive services and specialized foster care for youth with significant mental health and behavioral needs.

Case Overview

Foster Home

M.L. and S.L. have been licensed foster parents since May 2001. They were originally licensed to care for one child; however over the course of the next several years they expanded their capacity and were licensed in July 2007 to care for five children between the ages of 6 and 17 years old. They are currently licensed through Compass Health, a private child placing agency in Snohomish County as a therapeutic

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[2] CA Operations Manual 5160, Administrative Incident Reporting Timelines

[3] RCW 74.13.640 (2) states: "Upon conclusion of a child fatality review required pursuant to subsection (1) of this section, the department shall within one hundred eight days following the fatality issue a report on the results of the review, unless an extension has been granted by the governor."

[4] 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.

foster home. There have been four DLR licensing infractions/complaints; three for supervision (October 2006, December 2007 and August 2008) and one for discipline (November 2008). Outcomes of the respective licensing infractions resulted in invalid findings. The November 2008 DLR/CPS intake and licensing complaint were open at the time of the November 2008 fire, however were determined not related to the fire incident or subsequent investigation.

In July 2006 the foster parents discussed with Compass Health a desire to increase the size of their home to support caring for additional foster children and employing other adults to support and assist in the care. Compass Health told the foster parents this would entail developing a staffed residential program and recommended they submit a proposal for such a program.

In November 2006, the foster parents met with Compass Health and staff from the Snohomish County Juvenile Facility regarding their proposal to purchase a property which would support their developing a program that would increase their placement capacity and provide a means to recruit and train other adults to become licensed foster parents. In January 2007 the foster parents submitted a proposal to establish a Treatment Foster Home for kids with serious behavior problems and/or mental health issues. They proposed to operate the treatment foster home utilizing a team-parenting approach. Their proposal did not include a plan to develop a staffed residential program, but a program that would support the adults residing on the property to provide respite care while developing their skills to become licensed foster parents. Compass Health recommended that the foster parents develop a program proposal and submit for consideration.

In July 2007 the foster family moved to a new home in Arlington, WA. This home would serve as the residence to implement their proposal regarding the January 2007 Treatment Foster Home program. The purchased home was approximately 4,200 square feet situated on five acres. The large 2-story home also included a fully finished basement with 2 additional bedrooms and bathrooms. During the re-licensing process in July 2007 the foster parents said they planned to increase the square footage of the home by 6,000 square feet by extending the second floor and adding two bedrooms to the existing four rooms (for a total of 6) and 2 bathrooms. The entire second floor would be for foster children. Their biological child would have her own room on the middle floor and the foster parents would have a master suite along with an additional bedroom in the finished basement. In addition to door alarms on the upstairs bedrooms, they would utilize an audio monitor system to have audio access to the upstairs rooms as another means to provide supervision.

Compass Health case records[5] indicate the re-modeling planned by the foster parents began sometime in early/mid 2007. The foster parents submitted a fire evacuation plan and/or floor plan of the home as part of re-licensing in May 2007. Compass Health conducted Foster Home Health and Safety Checks every 90 days between April 2007 and November 2008, with the last visit occurring in October 2008. Documentation from these home visits states that while construction/re-modeling was underway on the top floor of the home, it did not appear to pose any health or safety risk to the children placed in the

[5] Compass Health and Children's Administration Division of Licensed Resources files.

home. The construction was blocked off and inaccessible by the children in the home. Compass Health licensor had visited the home on several occasions and observed the construction area and determined the home did not require a waiver[6]. The October 2008 Foster Home Health and Safety Checklist notes smoke alarms and fire extinguishers were in working order and procedures for evacuation were posted and regularly reviewed with the children. The file also states the family conducted a fire drill in July 2008, four months before the fatal fire.

On the night of the fire, sleeping arrangements were as follows[7]:

- Foster parents were in their master suite in the basement of the home with audio monitors in operation.
- and were in their respective rooms on the middle/main floor of the home. Both of these rooms had been modified during construction to qualify as a bedroom.
- two other foster children and the foster parents' own children were in separate rooms on the top floor of the home. 's room was directly above 's room.

, age 11, was placed into foster care from 6-27-02 until the time of his death on 11-22-08.

, age 10, was placed into foster care for two separate placement episodes; from 9-28-00 to 9-6-02 (age 2-4 years) and from 12-1-05 (age 7) to the time of his death on 11-22-08.

[6] WAC 388-148-0135: Requires foster homes to report to their licensor any changes in their home. This foster home complied with this WAC by notifying Compass Health of the intended re-model and participated in several home inspections with Compass Health to assess the safety of the home.

[7] Home visit by Compass Health Foster Care Licensor in October 2008 confirmed the sleeping arrangements in the home and that all rooms used for sleeping met licensing standards.

[redacted]

age 10, was placed in foster care in July 2005 at age 7 ½ years

[redacted]

Shortly after the fire in November 2008, admitted to investigators he found a discarded grill lighter in the trash in the foster home and when playing with it on the night of 11-22-08 he accidentally set the sheets of his bed on fire. stated he attempted to put the fire out, but it raged out of control quickly and he was unable to control the fire. At the time, he sustained minor injuries and was treated and released along with other surviving household members.

[8] Includes CA case file, medical records, counseling records and school records.

Committee Discussion

During the course of the review, committee members discussed the relationship between CA and child placing agencies (CPA) including the monitoring of CPA licensed foster homes, training and other requirements for therapeutic foster homes, policies regarding the number of children receiving Behavioral Rehabilitation Services[9] (BRS) in a facility, fire safety precautions and prevention in licensed facilities, and information sharing between CA and partner agencies.

Review committee members discussed the responsibilities for monitoring facilities licensed by child placing agencies, specifically the different roles of the Division of Licensed Resources (DLR) Regional Licensor and the CPA licensor. They also discussed the training requirements for treatment/therapeutic foster homes, as well as licensing regulations around fire safety/prevention. The review committee members determined that the foster home had followed the existing Washington Administrative Code regarding fire safety. The foster parents had submitted a fire evacuation plan and conducted quarterly, planned fire drills. The home had smoke alarms, fire extinguishers, and fire ladders in the closet of each bedroom, and the foster parents reportedly used a baby monitor at night to monitor the children upstairs as it was a three story home and the foster parents slept in the basement level with children sleeping one and two floors away. The review committee expressed concern that given the size and layout of the home, and the number of children in the home with significant behavioral and emotional issues, the supervision in the home, particularly at night, may have been inadequate to ensure the safety of the children.

Review committee members inquired about the placement limitations for children identified as needing BRS services in treatment/therapeutic foster homes. Per the DSHS CA BRS Contractor Handbook Chapter 9 CPA contractors who provide treatment foster care homes under the BRS contract shall have "no more than three treatment foster care children placed in a foster home at one time unless a sibling group is placed together or there is a therapeutic basis for the placement of more than three children in the home." The foster home had five foster children placed in their home at the time of the fire. Two children, and another foster child, were identified as BRS placements. was in an assessment bed since he returned to the foster home three days before the fire but had been previously identified as BRS, and the other two children though not technically identified as BRS, had histories of significant emotional/behavioral problems. Given the significant needs of the children placed in the home, the review committee members discussed the need for a high level of supervision in the home around the clock.

Review committee members inquired whether the Compass Health licensor had any concerns regarding any health or safety hazards in the foster home prior to the fire, specifically relating to the construction that was occurring, as well as whether there were any waivers in place. The licensor indicated that the functional part of the home was well separated from the construction zone, preventing the children from getting into the construction area, and that there were no safety concerns identified within the house. When the licensor assumed her role as licensor for the foster home four months before the fire, she indicated that there were no waivers in place and the construction had already been going on for some time.

[9] Per DSHS CA BRS Handbook: "The Behavior Rehabilitation Services (BRS) is a temporary intensive wraparound support and treatment program for youth with extreme, high level service needs used to safely stabilize youth and assist in achieving a permanent plan or a less intensive service.

Review committee members noted that there were numerous professionals involved with the foster family and children placed in the home. Compass Health case aides and case managers who were in the home weekly did not note any safety concerns at the foster home. CA social workers also visited the foster home monthly and no observable health or safety concerns were noted.

Review committee members expressed concern regarding the lack of communication and information sharing between CA and Compass Health following the fatal fire. The Compass Health licensor and program manager indicated that they were not involved in a debriefing regarding the circumstances of the fire and related criminal investigation, nor were they involved in the Regional Child Fatality Review in April 2009. The review committee discussed the importance of ensuring communications between CA and the private agency as a means to ensure continued service delivery to children who may have remained in the home following the fire.

Review Committee Findings and Recommendations

The review committee made the following findings and recommendations based on interviews, review of the case records, and department policy and procedure, the Revised Code of Washington (RCW) and Washington Administrative Code (WAC).

Findings and recommendations from the April 2009 review were discussed during the December 2010 review. Review team members agreed with the April 2009 findings and recommendations and they are incorporated below.

Findings

The review committee noted that Compass Health foster homes are considered therapeutic foster homes which provide care to children with special needs; specifically behavioral and mental health needs. The children placed in such homes require an increased level of supervision to monitor and manage their behaviors. In addition, therapeutic foster homes receive increased levels of reimbursement based on the identified needs of each child. Given the unique needs of the children in therapeutic foster homes the review team made the following findings:

- The committee found that the foster home met relevant Washington Administrative Code requirements referencing fire safety. However, given the number and location of children placed in the home, committee members identified areas where the home was not adequately equipped or prepared for a fire emergency. Specifically the committee identified:
    - Smoke alarms were located only in the main area of the home near both staircases rather than in each bedroom and in other hallways in the home.
    - The submitted fire evacuation plan (as required by licensing) in the case file did not identify exits, exit routes, or location of smoke alarms.
    - Fire drill practices may not have sufficiently prepared the occupants in the home for a fire emergency or need to evacuate.
    - The sleeping arrangements[10] in the home limited adult supervision and access to children during night time hours. Given the age and identified special needs of the children, increased supervision and monitoring was needed.

[10] Foster parents' bedroom was located in the basement of the three story home.

- The review committee found many professionals (Compass Health and Children's Administration staff) regularly worked with this family. Visits to the home were frequent with records indicating that a case manager from Compass Health or a social worker from CA was in the home almost weekly for purposes of health and safety visits, counseling, support, and monitoring. It was determined that the collective responsibility of all professionals entering the home be aware of the safety features in the home including those that address fire prevention and evacuation planning. The team found that children residing in any home or facility should be included in evacuation planning and practice procedures to ensure that they have an understanding of how to respond in the event of a fire.

- Washington Administrative Code 388-148-0220[11] requires a fire inspection by the Washington State Patrol/Fire Protection Bureau (WSP/FPB) if a group care facility or staffed residential home is licensed for six or more children. All foster homes and those staffed residential homes licensed for five or fewer children are required to have inspections only if deemed necessary by the licensor or local ordinances[12].

The foster parents had communicated their intent to expand the capacity of their home and were in the process of constructing additions to the home. This home was not licensed as a group care facility or staffed residential facility. It was evident to the committee that the foster parents were interested in serving special needs and BRS children; however fire inspections by WSP/FPB were not required by statute.

The committee found that while two of the five children were not technically children who were receiving Behavioral Rehabilitation Services (BRS), both of those children were children who would qualify for BRS. Given the number of children in the home and the heightened need for monitoring and managing their behaviors, the review committee found this home had informally transitioned to a BRS facility. BRS homes are similar to a staffed residential facility which suggests that additional inspection procedures for emergency situations and supervision may have been warranted.

- Committee members found communications and coordination between Children's Administration and Compass Health following the fire was neither effective nor consistent. Compass Health had received no dispositional information on investigations by law enforcement or fire officials regarding the incident and outcomes. It is unknown why CA did not consult or meet with Compass Health regarding the fire investigation and subsequent interviews. Limited communication between parties restricted safety planning for other children placed in the foster home and for the family or visitors to the home. This limited communication also restricted the ability of Compass Health staff to provide supervision and monitoring of the home.

[11] WAC 388-148-0220

[12] No local ordinances were identified during the review necessitating an inspection.

Recommendations

- Fire Safety Training – In collaboration with and approval of the State Fire Marshall or local fire department, develop and implement a training program for CA, Child Placing Agencies, Tribal partners, foster parents, group homes, etc. that focuses on the following:
    a. Fire prevention
    b. Fire preparation for evacuation
    c. Development of appropriate fire evacuation plans
    d. Smoke Alarms – location and operation*
    e. Fire Drills
    f. Emergencies – What to expect
    g. Assessing fire safety

  Recommended training methods such as video or web-based training can be developed to effectively and efficiently deliver the training.

  * The Snohomish County Fire Prevention Installation Guide recommends smoke alarms shall be installed in the following locations: in each sleeping room, outside each separate sleeping area in the immediate vicinity of the bedrooms, and in each additional story or dwelling, including basements. Alarms should be ceiling mounted and not installed near windows, doors or ducts where drafts might interfere with their operation.

- Given the special needs of the children placed in this home, the layout of the bedroom/sleeping arrangements in the home may not have been adequate to ensure an adequate level of monitoring of the foster children. It is recommended that generally the location of foster parents' bedrooms should be accessible and within audible range to the bedrooms of foster children, especially those with special needs or behavioral issues, to ensure supervision and monitoring during night time hours. This level of supervision may be supplemented by other CA approved monitoring devices.

- Convene a work group to discuss capacity issues in foster homes[13] serving children with special needs. Review should include obtaining clarity in definition between a therapeutic foster home, a BRS residential facility, and group homes. Defining the difference between these type of residences provides allowances for the type and number of children placed, staff to child ratios, payment structure, and monitoring and management expectations by licensors and CA staff.

- Communications – Immediately following a critical incident in a facility certified by a child placing agency, CA should convene a committee representative of the parties involved to ensure communication, address child safety, and the coordination of services as applicable. Recommend appointing a committee leader/single point of contact to ensure dissemination of information to all parties. If law enforcement or an active criminal case is ongoing, the committee believes that information critical to ensure child safety can be shared in a manner sensitive to matters related to the criminal investigation or case.

[13] Include in the discussion various home types: foster, therapeutic foster, specialized, BRS and group homes.