

# **A CHILD'S DEATH IN FOSTER CARE An Unavoidable Tragedy?**

## **SUMMARY**

The 2008-2009 Santa Barbara County Civil Grand Jury wanted to know if the June 2008 death of a child in foster care could have been prevented by Santa Barbara County Child Welfare Services (CWS), the agency that placed him in that home. To this end, the Jury interviewed social workers involved in the case, their supervisors, administrators, and the Director of Social Services. Voluminous written records were reviewed. A privileged document was not provided the Grand Jury, consequently the Grand Jury was unable to completely confirm that social workers followed all established procedures. The documents that were reviewed indicate that established procedures were followed. Nonetheless, the Jury noted excessive compartmentalization of duties and inadequate face-to-face communication among social workers in the agency. The Jury makes recommendations to improve information gathering, review of cases, and communication within the agency.

## **BACKGROUND**

On June 11, 2008, a three-year-old child died in a foster home in Santa Maria. The foster mother, who was the child's aunt, and her boyfriend were arrested and accused of causing his death. The tragedy of child homicide is compounded in this case by the fact that the child was a dependent of the Court, under the protection of Child Welfare Services (CWS), and died in a foster home where he was placed by that agency and the Court.

While human behavior can never be predicted reliably, CWS is charged with investigating foster parents and foster placements to ensure that any child placed there will be well cared for and safe. Further, CWS is charged with the responsibility for monitoring the children placed by them into foster care. Injury or death to a child in foster care is, fortunately, a rare event. What went wrong in this case? Was something overlooked? Was it possible to predict the tragic outcome? Is there anything that can be done or should be changed to prevent a similar tragedy in the future? These are the questions the 2008-2009 Santa Barbara County Civil Grand Jury sought to answer.

Child Welfare Services has several divisions or units which are responsible for the various functions or phases of caring for children at risk of abuse or neglect:

- **Central Intake Unit (Hotline):** Receives and processes all incoming information about child abuse and neglect and decides if the complaint should be investigated.
- **Assessment and Investigations Unit (AIU):** There are three AIUs, one each in Santa Barbara, Santa Maria and Lompoc. Their primary responsibility is to review, investigate and assess referral allegations of child abuse and neglect.

## **A CHILD'S DEATH IN FOSTER CARE**

---

- **Court Services Unit:** Workers from the Court Services Unit attend all CWS Court proceedings and present cases to the Court with any updates **and** recommendations as to current status of the case, and provide written feedback to the social workers regarding the outcomes of all Court proceedings.
- **Family Services Unit:** Provides case management to children and families who are considered to be at risk, but whose parents are willing to engage in services without Court involvement. They assist the family to maintain the children in the care of their parents.
- **Ongoing Unit:** Oversees the Family Reunification and Family Maintenance cases from disposition to either dismissal or long-term placement or adoption. They ensure that continued regular visitation occurs.
- **System of Care Unit:** Provides services like the Ongoing Unit to families with greater mental health and therapeutic needs.
- **Permanency (Adoption) Unit:** If the Court decides that a child cannot safely return to the care of the parents, the Ongoing Unit will transfer the case to the Permanency Unit for long-term placement management, including adoptions.
- **Foster Care Licensing/Relative Approval Unit:** Licenses foster homes and approves homes of relatives.

Reports of child abuse or neglect come from many sources, including schools, doctors, emergency rooms, neighbors, relatives and frequently the police. All incoming information is received by the Central Intake Unit, which is available 24-hours a day seven days a week. Social workers assigned to this unit assess whether the information received meets child abuse/neglect criteria. If the information received indicates a need for investigation, the case is referred to the Assessment and Investigations Unit (AIU) in the appropriate region (Santa Barbara, Lompoc or Santa Maria). The worker receiving the call determines the urgency of the situation. If urgent, a social worker, often accompanied by the police, makes a site visit to assess if the child is in danger. In less urgent situations, the investigation may take place several days later. The investigation may consist of home visits and interviews with the child, the family, and anyone else who may have relevant information. If a child is deemed to be in danger, he/she can be removed from the home and placed in temporary emergency foster care. Removal from the home is not the only option. Depending on the safety and risk level, the social worker may implement various plans for working with the family to ensure the child's safety.

If the child is placed in long-term foster care, or is left in the home but further services are needed, the Ongoing Unit takes over the child's supervision. This unit oversees all Family Reunification and Family Maintenance services. If the child is placed in a foster home, visits are made by a social worker on at least a monthly basis.

In cases where the AIU social worker recommends maintaining the child in the care of the parents, the Family Services Unit provides case management, develops a plan, and monitors the child with frequent visits.

In all cases where the child is removed from the family, reunification is the main goal whenever possible. There is a 12-month period (with a possible 6-month extension)

## **A CHILD'S DEATH IN FOSTER CARE**

---

during which family reunification is attempted. A case plan is developed, which may include training, counseling, and often drug abuse treatment for the parent(s). If family reunification cannot be accomplished in the allotted time, and the Court agrees, parental rights may be terminated and the case is transferred to the Permanency Unit for long-term foster care, guardianship, or adoption.

A court hearing is held within 72 hours of the child's removal from the home. The Court requires that the child be represented by an attorney. The parents and CWS also may be represented. Subsequent court hearings are held during the various phases of foster care placement, possible family reunification, termination of parental rights and adoption. CWS makes recommendations to the Court, but the ultimate decision to remove a child from his/her home during any of these phases is made by a juvenile court judge. The Court Services Unit investigates and prepares reports for the court hearings and a worker from that unit attends all court hearings.

All foster homes must be licensed. This is the responsibility of the Foster Care Licensing Unit. There are established criteria for evaluating and licensing foster homes, and training requirements for foster parents. A criminal background check is conducted on all prospective foster parents. Until this incident, criteria for relative foster homes were somewhat different and less stringent than for non-relative foster homes. Relatives are given preference for foster care and the majority of the children end up in homes of relatives.

There are written policies and procedures for most of the tasks accomplished by the social workers. In addition, there are numerous, lengthy forms and checklists that are used in assessing allegations of child abuse or neglect and evaluating suitability of foster homes. The Structured Decision Making (SDM)<sup>®</sup> system, used by Santa Barbara County CWS, is commonly employed throughout California and other states. It is an approach to child protective services that uses clearly defined and consistently applied decision-making criteria for screening for investigation, determining response priority, identifying immediate threatened harm, and estimating the risk of future abuse and neglect. Child and family needs and strengths are identified and considered in developing and monitoring progress toward a case plan. It has been subjected to studies validating its efficacy.

Written records are kept of all assessments, evaluations, and all contacts with or relating to the child or the foster home (Delivered Services Log). These records are maintained on computers and are available to other social workers involved in the case.

## **A CHILD'S DEATH IN FOSTER CARE**

---

### **METHODOLOGY**

Jury members interviewed the Director of Social Services, Child Welfare Services workers involved with this case and their supervisors, and the deceased child's attorney. Numerous documents, including the case service file (Delivered Services Log), records of evaluations of the foster home, policies for evaluating foster homes, the autopsy report, police reports, and court records were reviewed. Subsequent to the child's death, CWS requested an independent review of the case by another county's social services department. A copy of their report was obtained and reviewed by the Jury. In addition, Jury members reviewed statistical data regarding child abuse reports available on the internet from data collected by University of California, Berkeley.<sup>1</sup>

The Grand Jury's investigation was limited by the fact that there is an on-going criminal investigation. Some key individuals could not be interviewed. In addition, CWS did not provide to the Jury a privileged internal document of its own investigation of the case; consequently the Jury was unable to fully complete its investigation.

### **OBSERVATIONS AND ANALYSIS**

The child was removed from his home due to allegations of child endangerment and placed with his aunt in March 2006, and on May 1, 2006 was declared a Juvenile Court Dependent. Other family members in the aunt's home at this time were the aunt's boyfriend and their two children, one about the foster child's age, the other four years older. In August 2007, the birth of a baby and other family problems contributed significantly to the level of stress in the home.

During the 18 months following the child's being declared a court dependent, plans were developed by the Ongoing Unit to permit his eventual reunification with his biological mother. These plans failed, and on April 21, 2008 the mother's parental rights were terminated by the Court.

Reports from social workers visiting the child in the foster home were, for the most part, positive, stating that he was doing well, and seemed happy there. He had some behavior and speech problems, for which he and the foster family received counseling from an agency contracted by Social Services. Some concerns did arise, however. There were some complaints from neighbors reporting yelling and the child crying, and one complaint of possible neglect of another child in the family (the child's cousin). All of these allegations were investigated by the Assessment and Investigation Unit and determined to be unfounded. It was noted that the foster child had a temper and "loved to scream". At times, he was observed scratching his own face. Several times he was noted to have bruises on his body and face and scratches on his face. Upon inquiry by social workers from the Ongoing Unit, these bruises were attributed to his younger cousin, and on one occasion to his falling out of a bunk bed. The child himself pointed to his cousin

---

<sup>1</sup> [http://cssr.berkeley.edu/ucb\\_childwelfare/](http://cssr.berkeley.edu/ucb_childwelfare/)

## **A CHILD'S DEATH IN FOSTER CARE**

---

when asked who caused the “boo-boos”. The foster mother complied with direction from the workers that he should not sleep in the upper bunk.

After the birth of the foster mother’s baby in August 2007, there were some indications that the family was under increased stress. The foster child was noted to scream and get upset more frequently. He would cry when he had to return to the foster home after visiting with his biological mother. He had been fully toilet trained, but now again required diapers. The bruising was noted more frequently. In February 2008, the social worker offered to remove him from the home, either temporarily for respite, or permanently if the foster mother felt overwhelmed. Although in March 2008, her boyfriend expressed to a social worker some reservations about adopting the child, the aunt continued to express the desire to keep and permanently adopt him. After the biological mother’s parental rights were terminated in April, 2008, the case was transferred to the Permanency (Adoption) Unit. The transfer summary stated that the worker was not sure if the family was appropriate for adopting him. She was concerned about stress on the family and the aunt’s ability to set limits on the mother’s visits with the child as ordered by the Court. There were also concerns that the children were inadequately supervised, resulting in the cuts and bruising. There was, however, never any concern expressed about possible abuse of the child by either foster parent.

Several social work staff were involved in this case. The initial evaluation of the home prior to placement was done by a worker from the Licensing/Relative Approval Unit. The primary case worker, who made the monthly visits, was from the Ongoing Unit. A supervisor took over when the primary worker was not available. Social work aides and interns also were involved. Allegations of abuse were investigated by yet another worker from the Assessment and Investigations Unit. Workers from the Court Services Unit were also involved. During interviews with the various staff, the Jury noted a tendency for workers to focus on just their area of responsibility and often were not aware of the whole picture. Although records are kept, the Jury found a lack of consistent, direct communication between one social worker and another as the child moved through the system.

Throughout his stay with his aunt, the child and the aunt were visited frequently by social workers of CWS and a contract counseling agency. All reports of issues were investigated by CWS, and investigators were satisfied with the explanations. Department personnel followed the procedures in place at the time. There was no evidence that social workers interviewed or spoke with other children in the home or to all available relatives. Retrospectively, the point could be raised that the cumulative impact of all these issues should have raised a “red flag”. While CWS staff recognized the need for improved parenting skills and contracted for outside support to meet that need, in no interview was there any concern raised that the child might be a victim of abuse.

In the report from the other county, a number of suggestions were made for improvement. The Jury was told some of these were enacted. The Jury also was told the new policies had been handed down through the ranks, but found no evidence that management had

## **A CHILD'S DEATH IN FOSTER CARE**

---

followed up to see if this was done. Some staff told the Jury they were unaware of any policy and procedural changes.

### **CONCLUSION**

As far as the Grand Jury could ascertain, workers in this case followed established procedures. While, in retrospect, it could be said that there were some errors in judgment, there was no indication that the child was being overtly abused by any adult in the home. Perhaps there was inadequate supervision of the children, resulting in the bruises noted. Indications that the family was under increased stress after the birth of an infant and other family problems were not acted upon. Since CWS did not provide the Jury a privileged internal document of its own investigation of the case, the Jury was unable to complete its investigation.

However, the Grand Jury found that procedures needed improvement and some information sources were not used by CWS. The Jury also found that communication between social workers in the different divisions was deficient. Some policy changes were implemented as a result of the recommendations by the reviewer from the other county, but not all social workers interviewed were aware of them.

### **FINDINGS AND RECOMMENDATIONS**

#### **Finding 1**

While agency policies and procedures were apparently followed by workers involved in this case, indications that all was not well with the foster family were overlooked.

#### **Recommendation 1**

That Child Welfare Services implement a policy of regular, periodic review of ongoing cases with all involved workers and supervisors to detect patterns or changes in the foster home situation which might give rise to concern for the safety and welfare of the child.

#### **Finding 2**

There is inadequate communication among various workers involved in the care of a foster child.

#### **Recommendation 2**

That Child Welfare Services implement a policy to ensure there are face-to-face discussions between workers involved with a child, particularly when there is a transfer of the case from one division to another or a complaint is received.

## A CHILD'S DEATH IN FOSTER CARE

---

### **Finding 3**

Some sources of information about the care of the foster child in the home were overlooked.

### **Recommendation 3**

That Child Welfare Services make it policy to interview periodically all people involved, including the foster child, all adults and children living in the home, and extended family, as a means of continually assessing the appropriateness of the placement.

### **Finding 4**

Not all staff were not aware of policies recently implemented by Child Welfare Services.

### **Recommendation 4**

That Child Welfare Services management ensure all staff are instructed in new policies and procedures.

## **REQUEST FOR RESPONSE**

In accordance with *Section 933.05 of the California Penal Code* each agency and government body affected by or named in this report is requested to respond in writing to the findings and recommendations in a timely manner. The following are the affected agencies for this report with the mandated response time for each.

### **Santa Barbara County Department of Social Services – 60 days**

Findings 1, 2, 3, 4

Recommendations 1, 2, 3, 4