COMMONWEALTH of VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

Office of the Commissioner

Martin D. Brown
COMMISSIONER

July 18, 2012

Mr. Robert R. Morin, Jr., Director
Virginia Beach Department of Human Services
3432 Virginia Beach Blvd.
Virginia Beach, VA 23452

Dear Mr. Morin:

This letter is to formally transmit the "Special Review Report" completed by the Child Welfare League of America on Braxton Taylor, dated July 16, 2012.

It is the Department's expectation that an acceptable Corrective Action Plan (CAP) be completed by August 20, 2012. It is expected that the CAP be completed in conjunction and aligned with the Quality Management Review of the Child Welfare Division of the Virginia Beach Department of Human Services. As always, the Department's staff stands ready to assist you and your staff to improve services for the citizens of Virginia Beach.

Thank you for your cooperation during this review. Please extend our gratitude to your staff and others who participated in this review. As I have stated from the outset, it is important that we learn from the past so that we can improve now and in the future.

Sincerely,

Paul D. McWhinney
Deputy Commissioner – Programs

cc: Martin D. Brown, Commissioner

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Special Review Report

COMPLETED BY

Child Welfare League of America

July 16, 2012

RE: BT
DOB: 4/7/2009
DOD: 2/7/2010

Table of Contents

Introduction and Scope

In February of 2012, the Commonwealth of Virginia, Department of Social Services (VA DSS) issued a Solicitation Request for Proposal (RFP) seeking a qualified vendor to conduct an external Child Fatality Review of a specific foster care/foster child case. At the time of the child's death, he was in the care and custody of the Virginia Beach Department of Human Services (VBDHS). The Child Welfare League of America (CWLA) was the selected vendor. Per the requirements of the RFP, CWLA agreed to the following process for conducting this child fatality review:

1. Review case records, and relevant policies/procedures.
2. Begin on site process with an Entrance Meeting, including State and City officials/ managers, as well as all staff to be interviewed.
3. Conduct individual and small group interviews (when appropriate) and include, but not be limited to:

> "…all foster parents to this child; the CPS worker who oversaw the removal; appropriate supervisors and Chief of Services; foster care worker and supervisor; staff member and/or supervisor who approved foster parents; staff responsible for foster family's continued certification; staff who wrote and approved home studies; staff responsible for monitoring the foster home; any staff in Resource Family Unit who may have had contact with the foster parents for coverage, training, consultation, etc.; person who trains foster parents for the local department; record of training attendance by foster parents; relevant pediatrician, Guardian Ad Litem (GAL) and City Attorney; Chair of the local Child Fatality Review Team that reviewed fatality; any babysitters, if known…"

4. Draft an initial report.
5. Facilitate an Exit Meeting with child welfare staff, State and City officials/ managers to:
    a. Examine the Draft Report for accuracy; discuss key findings and recommendations;
    b. Create an experience of restoration and closure for the child welfare team.
6. Issue a final report to designated State officials.

Report Content

The report highlights related literature and research, and links the facts of the case with findings and recommendations, examining the following core areas:

1. Review of the fatality and events precipitating the fatality;
2. Assessment of practice in this case in relation to best practices;
3. Quality of supervision and training connected to the facts of this case;
4. Relevant policies and procedures;
5. Larger systems' issues; and,
6. Recommendations supporting efforts to ensure minimization of future fatalities.

The Special Review process used by CWLA is designed as a quality improvement tool that aims to improve service delivery and enhance an agency's capacity to ensure the safety, permanency and well-being of the children/youth and families who are in need of its programs. The goal of this Special Review was to conduct interviews and activities in a respectful manner that encouraged open dialogue, with an emphasis on an effective transfer of learning to practice in the field.

In order to better educate, protect and support clients and families nested within child welfare agencies, it is important to understand the interacting systems of which they are a part. As the structure of child welfare services has evolved, it has become evident that a contemporary system must at once work toward ensuring the safety of high-risk children and families while supporting parents and extended families not involved in the formal CPS system to keep their own children safe in their homes and communities. It is stable family structures, capable community networks, and competent professional support that can best nurture children and youth, and keep them safe.

Special Review Process

By design, the "Special Review Process" used by CWLA is a quality improvement tool that examines the circumstances of a child's death in a non-forensic, comprehensive, learning model context. In order to look at the aforementioned core areas, the CWLA Team employed the following process:

- Read all pertinent case record files, including but not limited to:
    - Intake/Assessment
    - Foster Care Services
    - Family Resource Case Material
    - CPS Investigations
    - Medical Records/Correspondence
    - Legal Records/Correspondence
    - Media Related Articles
- Read appropriate policy, protocols and/or guidelines as written by The Commonwealth of Virginia, Department of Social Services and/or The City of Virginia Beach, Department of Human Services.
- Conducted an "Entrance Meeting" including all managers and staff who had involvement in the case or with the foster parents.
- Interviewed all managers, staff, legal and medical personnel involved in the case, as well as the first foster family with whom BT had been placed.
- Wrote a Draft Report
- Conducted an "Exit Meeting" with all managers and staff who were present at the "Entrance Meeting."
- Revised/edited the draft based on Exit Meeting feedback, and completed a final report.

By conducting this Special Review in a respectful manner and with open dialogue, the goal was to provide an opportunity for managers and staff alike to apply the learning from this case to all the children and families for whom they are responsible.

Part I

Case Summary

BT's untimely death occurred on February 7, 2010. His death was ruled a homicide, the result of head trauma, by the Medical Examiner, local law enforcement and State Police. His former foster parent was arrested and charged with murder in the second degree.

At the time of BT's birth, his parents were reportedly homeless and living at a shelter hotel, sharing a room with the father's friend. Following BT's birth, the hospital social worker notified the Virginia Beach Department of Human Services of the parent's homelessness and the birth mother's history. Both mother and BT were tested for substances, the results of which were negative. Hospital SW reported discussing with mother her substance use before and during pregnancy. Mother told the social worker that three of her children were living with BT's maternal grandmother (MGM) in a different state. She also stated that she had a fourth child (the youngest), whom she had placed with a cousin "because she couldn't have children." Mother provided the social worker with contact information for the MGM, and some information regarding the residence of her cousin.

During a discussion with BT's Father, he expressed concern to the social worker that he and Mother would not be able to parent the baby. The social worker informed VBDHS of Mother's medical records and history. Mother did not disclose any prior involvement with Child Protective Services (CPS).

VBDHS then contacted CPS in MGM's state for any further information on Mother and/or her CPS history. A criminal history search was initiated and Mother was found to have a history of marijuana and cocaine possession, as well as driving offenses.

On 4/8/09 VBDHS accepted the report and the case was assigned for investigation, including a Risk and Needs Assessment.

On 4/8/09, VBDHS met with Mother at the hospital to gather information from her.

During this interview, a "Protective Agreement" was signed by both Mother and the VBDHS representative. This agreement stated the following:

- Mother would allow a representative from VBDHS to visit with her;
- Mother agreed not to leave the hospital with BT without permission;

- Mother agreed to engage with and participate in services provided via a designated community agency.

The Protective Agreement was signed by both Mother and VBDHS representative on 4/8/09. A "Safety Assessment Checklist" was also completed on this date, and it was determined that BT would be "unsafe" if allowed to remain in Mother's care/custody. The definition of "unsafe" as noted on the Safety Assessment Checklist is as follows: "Without controlling intervention(s) a child is in immediate danger of moderate to serious harm. Emergency removal or court action is required to insure safety of the child(ren)."

The case record indicates that prior to leaving the hospital, VBDHS observed BT in the nursery. It was noted that BT "appeared to be healthy."

The case record indicates that on 4/8/09 the hospital social worker contacted VBDHS to report that both Father and Mother had left the hospital and did not leave any forwarding information. It was also reported that that the hospital had not received any calls from either Father or Mother regarding BT. Mother was to be discharged on 4/9/09.

On 4/9/09, VBDHS attempted to visit Mother and Father at the address they had provided. Since there was no response at the address a business card was left. Later in the day, VBDHS was contacted by an individual who stated he lived at the address where VBDHS had visited. The person reported not having any children, denied any involvement with social services, and stated that Mother and Father had stayed in the room for a couple of days but left, their whereabouts unknown.

The case record indicates that on 4/10/09 there was a face-to-face meeting at Court to discuss the status of the case and determine if an Emergency Removal should be granted. Present at this meeting were VBDHS, the Judge, the City Attorney, Attorneys for Mother and Father, and a Guardian Ad Litem (GAL). An Emergency Removal was granted, with the Preliminary Removal court hearing scheduled for April 14, 2009. As of 4/10/09, BT was in the protective custody of the VBDHS.

On 4/10/09 BT was discharged from the hospital and placed into foster care by VBDHS.

On April 14, 2009, the VBDHS attempted another visit to the same shelter hotel previously visited. The same individual answered the door and again stated that neither Mother nor Father was in the room and their whereabouts were unknown. Once again, the VBDHS left a business card and asked to be contacted if either parent returned to the room.

On 4/14/09, the Preliminary Removal Hearing was held. All of the aforementioned individuals were present; neither Mother nor Father appeared in

court for this hearing. The Judge ordered a finding of abuse/neglect of BT by Mother and Father. The next court hearing was scheduled for 6/2/09.

The case record contains extensive medical information regarding BT's birth and subsequent tests, including Apgar scores, toxicology/drug screens, feeding history, hearing screens, Neonatal Abstinence Scores, etc. Of utmost importance, it was determined that while BT was exposed to drugs in utero, he was not born addicted, but did exhibit some symptoms of withdrawal. It was noted that two days after his birth, BT was "climbing rapidly on the withdrawal scoring." His temperature was on the rise, as well, and he had a "high-pitched cry and moderate tremors" when disturbed. It was also noted that he was sleeping "less than an hour after being fed and is gagging on pacifiers." He also had large amounts of watery stool. Despite these early challenges, a detailed final discharge summary stated that in all facets of physical well-being, BT was a "healthy-appearing, vigorous infant." No "acute distress" was noted. The discharge instructions noted that he was to be placed into foster care, and that he should be seen by a primary care provider within two days for follow up.

On 4/15/2009, VBDHS received a call from Mother's attorney, stating that Mother had checked into another hotel/inn on 4/9/09, but there was no indication that she was still there. The attorney also provided VBDHS with an address for Father.

The case record indicates that on 4/16/09, VBDHS made telephone contact with a local provider to make a referral for services for Mother, in the event she was located and wanted to participate in such services. Later on the same date, the service provider called VBDHS to state that contact with Mother had been made, but she stated that she was being evicted from the hotel/inn. When asked if she wanted to participate in available services, Mother declined.

On 4/15/09 VBDHS received a call from the GAL inquiring as to the whereabouts of Mother. The information was shared that Mother was being evicted and that she did not want services offered to her via the local community provider.

On 5/8/09, VBDHS staff received a letter from Mother stating that she was in jail. Mother expressed an interest in having her son returned to her once she was released from jail.

On 5/12/09, a "transition meeting" was held between VBDHS staff and the City Attorney. The following recommendations being made:

- No parental visitation would occur at that particular time;
- Mother should undergo a parenting capacity and psychological evaluation, as well as substance abuse treatment;
- Father should undergo substance evaluation and/or treatment; and,
- BT would remain in foster care.

The case record notes regarding this meeting indicate that BT's foster home placement was going well. He reportedly held his body in a very rigid manner and exhibited some tremors. A brief sentence indicated that since BT had "medical issues," an alternate placement "may need to be considered for management purposes." With regard to a case plan, the case record indicates that Mother had expressed a desire to regain custody of her child. Mother was incarcerated and would be spending the next five months in a structured treatment program while in jail.

The case record contains an extensive and clearly written "Foster Care Service Plan, Part A", signed by the appropriate VBDHS staff. This plan detailed the expectations that Mother and Father needed to meet in order for them to be considered as a resource for BT. It also outlined the programs and/or services VBDHS would provide to assist the parents in achieving and maintaining stated goals. The date of this plan was May 13, 2009.

A case staffing was held on 5/27/09, at which time the case was formally designated as "Founded Physical Abuse Level 1" against Mother and it was decided that the case would be "transferred for services."

On 5/27/09, BT was screened by the Department sponsored infant program, was found to be "developmentally on task," and did not require further services.

On 6/2/09, VBDHS received a call from the MGM. A return telephone call by VBDHS revealed that Mother's parents had not seen or heard from her for approximately 17 months. The grandparents stated an interest in caring for BT. That information was given to the appropriate VBDHS staff.

A Risk Assessment was conducted on BT on 6/3/09. It was determined that his risk level was "high," based upon having been exposed to substances prior to his birth. It was further concluded that his placement in foster care and Mother's prior history and current incarceration heightened his risk level.

On 6/5/09, the VBDHS staff conducted an assessment of Mother's service needs.

On 6/16/09 VBDHS met with Mother at the jail. Mother was advised of the "Founded Level 1" disposition of the investigation that had just been completed. She was also told that the case would be transferred to another unit within the VBDHS. Mother again stated that she would be in jail for 4-5 months. She also stated that she would like to have custody of her child and inquired as to how that might occur. Mother was advised that she would need to discuss this further with VBDHS. When asked about BT's father, Mother stated that she did not know his whereabouts, but believed would not be able to provide for BT. A brief discussion about Mother's parents followed. Though they had expressed an interest in providing care for BT, Mother felt that they were already burdened by caring for her other children. Prior to the end of this meeting, Mother asked

about paternity testing and was informed that the court had ordered such a test for Father. It was later determined that Father was also in jail, and a paternity test was conducted while he was in jail.

The case record indicates that from June 19 – July 3 2009, BT was placed into respite care. The respite evaluation completed by the caregivers states that BT was "wonderful, very easy going and pleasant disposition." It further documented that he was not "sleeping through the night yet," but "happy to visit."

The case record indicates that from 8/19/09 – 8/22/09, BT was in a respite placement. The evaluation from the respite family states that BT was "very sweet and easy going baby." It also stated that he was "easy to calm when he cried."

On 8/21/09, VBDHS completed the agency's Family Assessment and Planning Team Referral Packet (FAPT) in which the services and/or programs needed by Mother, Father, and BT were detailed.

On 10/16/09, the case record indicates that BT was taken for his 6-month well-child visit. He was found to be healthy and developmentally on target. The pediatrician recommended that BT return at nine months for a "well baby check."

From October 9 – 12, 2009, BT was in a respite home. The report from the caregiver stated that he was "very laid back and only a little restless at bed time. He was further described as "a good baby."

On 10/27/09, a "Foster Care Service Plan Review" was completed. At that time, BT had been in foster care for six months. Despite the fact that the "program goal" was "return to own home," the review narrative states that no progress had been made toward this goal, as both Mother and Father had remained incarcerated. The narrative also notes that both parents maintained telephone and/or written correspondence with VBDHS regarding the "health and well-being" of their son. Additionally, VBDHS had provided pictures of BT to the parents. Other information contained in the Foster Care Service Plan review notes that on August 24, 2009, Mother notified VBDHS that she had been released from jail. Mother did not respond to attempts by VBDHS to arrange for a meeting to discuss reunification and visitation due to being arrested again on August 29, 2009. At the time of this arrest, Mother informed VBDHS that she was scheduled to be released on December 16, 2009.

On November 9, 2009, BT was transferred to another foster home. This transfer resulted from a request that BT be moved to a home where, should he become available for adoption, his next placement would become his permanent home. The foster parents knew they were not in a position to adopt and thought it best for him to be moved sooner rather than later. It was known from the time that BT was placed with the first foster family that they would not be in a position to provide a permanent home for him in the event that his permanency goal was

changed to adoption. In addition, foster parents were caring for another child with intensive needs, and handling the two placements was too challenging. The case record contains the "FC Change Form," documenting the request to move BT to another foster home.

On November 9, 2009, the case record indicates that the new foster mother went to BT's pediatrician's office to ask about his medical history. After receiving approval to discuss BT's medical history, the pediatrician provided answers to the foster parent's questions and assured her that BT was healthy and developmentally on target. He also provided some information relative to feeding BT in order to help reduce his reflux/spitting up.

The case record indicates that VBDHS visited the new foster home within days of BT's 11/9/09 placement.

On November 18, 2009, the Guardian Ad Litem (GAL) was notified of BT's move. The case record indicates that between 11/18/09 and 11/24/09, the GAL made several attempts to contact the new foster parents to schedule a "convenient" time for a home visit. On November 24, 2009, contact was finally made. Upon advising the foster mother that she would like to make a home visit, the GAL was "denied access to the child." Notations from the GAL indicate the foster mother stated that she and her husband were preparing to go out of town for the holiday and would not be returning until November 30, 2009. The foster mother also stated that although VBDHS was going to visit the home that day (11/24), the GAL was not to visit, as it "would be an inconvenience for her and her husband." According to the case record, the GAL informed the foster mother of her role and right to be given access to the child upon request. Reportedly, the foster mother remained "argumentative and uncooperative." The GAL scheduled a home visit for December 1, 2009.

On 12/21/09, a follow-up FAPT was held. It was noted that Mother had been released from jail on 12/16/09, and VBDHS requested funding for bus passes in order for Mother to complete services and visit with BT.

Also on this date, VBDHS completed the second Child and Adolescent Needs and Strengths (CANS) rating scale on BT. The first of these was completed in March 2009. This scale is used to rate the strengths and needs of the child and the planned caregiver in several domains, providing guidance in decision-making relative to permanency and/or placement needs.

On 12/22/09 VBDHS held a meeting with foster parents to discuss the necessity of complying with GAL's requests for visits, and adhering to Department protocol concerning medical appointments. BT accompanied foster parents to this meeting and VBDHS staff reported that he seemed alert and interactive.

On January 27, 2010, Mother had her first supervised visit with BT. At the time of the visit, the "Visitation Checklist/Summary" noted that BT's "nose, mouth and

lips raw d/t teething." A "slight reddish bruise" on his forehead was also noted, and stated the bruise was due to his "falling." Mother was noted to be engaged and appropriate during this visit.

The medical records indicate that on 1/27/2010, the foster mother scheduled BT for his nine-month well baby check for 2/3/2010. The records further indicate that on 2/2/2010, the foster mother cancelled the appointment, but then one minute later, rescheduled the appointment for 2/12/2010.

On 2/3/10 VBDHS made another referral for BT to be evaluated through the Department's Infant Program. This new referral was based upon the caretaker's report of "regression in achievement of developmental milestones." The caretaker further reported that BT "was crawling, but stopped, and was having difficulty maintaining crawling position."

On February 4, 2010, VBDHS made a home visit to the foster home. According to information obtained during interviews with VBDHS, BT was asleep in his crib in his bedroom. Photographs taken during this visit were not developed until after BT's death.

On 2/6/2010, the case record indicates that at approximately 9 AM, the foster mother placed a call to 911 because BT was not breathing. The foster mother related to the dispatcher that she had fed BT and then went downstairs to put in a load of laundry. When she returned to his room she found him "unresponsive." During an interview with social services personnel later that same day, foster mother explained that BT was having increased tremors and that his teeth were bothering him. She related that the previous night she had left BT with her husband while she shopped from 7 PM to approximately 9:30 PM. Upon her return home, there was a power failure. The foster parents put BT to bed, covering him with extra blankets to keep him warm. Reportedly, the foster father left for work the next morning. Foster mother stated that she got up at 5:30 AM, and that BT was still asleep. Foster mother reported going to his room to wake him; she then went to let the dog out and make a bottle for BT. Foster mother reported that she undid his swaddling, changed his diaper, and went back downstairs to do a load of laundry. Upon returning upstairs, foster mother reported she found him not breathing and limp, with his eyes diverging.

In a separate interview on the day of BT's admission to the hospital, foster father related that he had been out of town on a work-related trip from 1/31 until early the morning of 2/5/10. The foster father reported that prior to leaving town, BT was "doing well," including the fact that he was sitting "normally." He stated that upon his return home, BT was a "different baby." He also noted that when he left town, BT was "eating normally." The foster father further related that the night prior to BT's hospitalization (2/5), he was worried about him. On that night while caring for him, he described BT as shaking "like a vibrator" on and off for over three hours. He further stated that "it did not seem as if he was there" and his eyes were just "staring." Upon giving BT a bath, the foster father reported he that

noticed BT was not sitting up as usual, and that he was also having trouble eating, which had not been the case prior to his leaving town. Foster father changed BT's diaper but reported that he did not notice any inguinal bruises. He confirmed that when BT first arrived at their home that he did roll on the changing table, but that he had not noticed that of late. He also stated that foster mother had not mentioned that BT had fallen earlier in the week.

The case record notes that when the paramedics arrived at the foster home they saw BT lying on a table, and the foster mother performing CPR on him. The paramedics then transferred him to the ambulance. BT was found to have no pulse, and when placed on a cardiac monitor, he had pulseless electrical activity. CPR was continued, and BT was intubated and ventilated with a bag mask. Epinephrine was given to restore his cardiac rhythm. BT was taken to one hospital emergency room, but upon arrival, had no spontaneous respirations. His pupils were fixed. He had bruises over his right groin and was found to have a subdural hematoma. Subsequently, he was transferred to another hospital and admitted to the Pediatric Intensive Care Unit (PICU). Due to concerns for inflicted trauma, VBDHS was notified and an investigation was begun.

The case record indicates that by the evening of 2/6/2010, BT had lost cranial nerve reflexes. An Apnea test was performed to assess effective respiration. He failed that test. On the morning of 2/7/2010, his brain death was confirmed via an electroencephalogram (EEG), which revealed no brain activity.

Medical Examiner's Report/Autopsy Findings

The autopsy performed on BT was extensive. Great care was taken to thoroughly examine all potential issues from a medical standpoint that might have contributed to his death. It was determined that BT's Cause of Death was "Inflicted Brain Injury." The Manner of Death was determined to be "Homicide."

The Medical Examiner's Report was signed on February 9, 2010. With the exception of his heart, all of BT's organs were donated.

Part II - Foster Family

This section of the Special Review Report includes information relevant to BT's second foster parents, with whom he was placed from 11/9/09 until his death.

Foster Parent Application and Licensing

KG and BK, who had been married for 2 ½ years at the time, applied to become foster parents on 7/12/09. Foster Home Study visits were conducted on 7/9/09 in the office, and 9/9/09 and 9/24/09 in the applicants' home. Background checks including Central Registry, Criminal Offense Records checks, and fingerprint checks by FBI and VA State Police were completed in July 2009.

On 7/9/09, KG and BK completed the Adult-Adolescent Parenting Inventory (AAPI-2).

Reports of physical examinations were received, dated 9/25/09 for BK, and 9/28/09 for KG. Neither report noted medical concerns; both applicants were reported to be in good health.

Vaccine history reports for the family's three dogs were dated 10/9/09.

Two telephone reference checks were completed on 10/12/09. A third reference check was completed via e-mail exchange on 10/29/09.

The foster home record indicates that the Approval Committee met on 10/19/09, reviewed the home study, and approved KG and BK as foster parents for up to 8 children, ages 0 – 8.

On 10/21/09, a letter of approval was sent to the family.

BT was placed with foster parents on 11/9/09. A standard foster placement agreement was signed. It did not include child-specific information other than BT's name, birth date and gender.

As is recounted in Part I, on the day of placement, KG took BT to his pediatrician.

Records indicate that there was an emergency placement of a seven-year-old with the foster family from 12/13/09 to 12/14/09. The record does not include additional information about this placement.

The record includes 12/17/09 correspondence from VBDHS to foster parents indicating that their three-month monitoring visit was due by 1/31/09.

On 12/22/09 VBDHS held a meeting with foster parents to discuss the necessity of compliance with GAL's requests for visits, and adherence to Department protocol concerning medical appointments.

On 1/28/10, VBDHS completed a routine compliance monitoring visit to the foster home. Foster mother reported no problems or concerns. She discussed having an interest in adopting BT, and expressed interest in having a second foster placement. BT was reported to be asleep.

On 2/2/10, KG called the pediatrician's office to cancel an appointment that had been scheduled for 2/3/10. Minutes later, she called again to reschedule the appointment for 2/12/10.

On 2/2/10 KG called the Department's Infant Program to ask questions about feeding.

On 2/6/10, KG called 911 reporting that BT was unresponsive. She began infant CPR, which she continued until EMTs arrived. BT was transported to the hospital, where it was determined that his injuries and condition were inconsistent with KG's statements. Hospital staff reported possible abuse to VBDHS and an investigation ensued. Multiple interviews were conducted by police, VBDHS staff, and the Child Abuse Program Pediatric Forensic Team.

Investigation Completion and Finding

The case record indicates that on 4/15/10, VBDHS completed the investigation of BT's foster mother. The results were a finding of "Level I Abuse/Neglect."

Arrest

On 2/17/10, KG was charged with murder in the second degree in the death of BT.

Court Disposition

On 11/3/11, KG was found guilty of Voluntary Manslaughter, and was sentenced to ten years in the Virginia Department of Corrections.

Part III - Findings and Recommendations

There has been much discussion in the media and within the agency about responsibility for BT's death. The CWLA Team believes that there were policies, procedures, decision-points, and actions throughout the life of the case that collectively contributed to the outcome. The CWLA Team did not find any one specific action or decision point that, had it been done differently, would have saved BT's life. BT's second foster mother was convicted for inflicting his injuries, and it was her actions that led to his death. The purpose of this Special Review, however, is not to lay blame or to recount what is already widely known. Rather, among the most important purposes of this Special Review is to identify learning opportunities from BT's life and death, and to examine all of the factors that contributed to the eventual outcome. Ultimately, it is the CWLA Team's intent that BT's legacy will be the learning and change inspired by this Special Review.

The sections that follow address the CWLA Team's findings and recommendations for organizational learning, staff development, and improvement of agency systems, policies and practices at the state, regional and local levels. Findings and recommendations synthesize information obtained through interviews, review of case records and documents, as well as from review of relevant best practices, research and literature. Special Review participants were afforded opportunity to provide feedback to a preliminary draft and to contribute to shaping these recommendations.

Best Efforts

The CWLA Team acknowledges and applauds best efforts evident in the work on this case:

- Despite significant apprehension, participants were invested in the interview process, in providing information as requested, and in beginning to explore learning from their experiences. The CWLA Team appreciates the openness and cooperation of all participants in the Review process.
- In response to BT's death, on 02/16/10, VBDHS issued a memo to all staff concerning "Protocol Up-Dates" effective immediately. These included:
    - that required monthly visits, must include face-to-face assessment of child well-being, interaction with the child, and visual assessment of non-verbal children to ensure that they are free from physical injury;
    - weekly face-to-face visits for all children who are not school age and not attending child care;
    - SWs expected to read the home study of foster parents within one week of assignment of a new child on their caseload;
    - steps to be taken in the event of a mark or bruise on a child;

- immediate development of pictures taken with film cameras, when shots are taken outside the agency of children's bruises/marks; and assessment of photos by CPS supervisor or intake SW;
- injury recognition training for social workers;
- face-to-face visits with foster parents to discuss service plans and whenever significant events require.

- VBDHS has a Review Committee process for approval of foster and adoptive homes. The Committee, comprised of Resource staff and rotating representation of Supervisors, reviews home studies of applicants before approval. The Committee has instituted use of a rating scale to assist members with home study review.
- In April 2010, VBDHS instituted "Baby Care 101" training to ensure that all foster parents have basic information about the needs and care of infants. This is required training for foster parents before taking infant placements. Resource parents who have never had parenting experience are no longer considered for infants for their first placements.

Child Fatality Review Process

Until the CWLA Special Review, there had not been a comprehensive review of BT's case. VBDHS staff had reviewed segments of the work, Quality Improvement staff had reviewed the case record, legal staff had reviewed the case in preparation for court processes, and some staff had been interviewed for a review by the Hampton Roads Child Fatality Review Team. Some needed improvements had been identified, and some corrective actions had been taken (as identified above, some actions were taken within a week of BT's death), but there had not been a holistic review of the case.

Interviews indicated that the Child Fatality Review Team's review of cases is not comprehensive, and is intended to identify patterns and trends rather than the particulars of an individual case. The review of BT's death did not include interviews with key staff that had some of the most salient information. A written report has not been issued, as the role of the group is to issue annual aggregate reports rather than case specific reports.

According to The Virginia State Child Fatality Review Team's annual report in 2011:

> The Virginia State Child Fatality Review Team was established by the General Assembly in 1995. The purpose of the state Team "is to review child deaths in Virginia of children less that 18 years old to ensure that child deaths are analyzed in a systematic way . . ." The Team conducts death reviews to learn about the causes and circumstances of individual deaths in order to develop recommendations for prevention, education, and training that may reduce child deaths in the future."[1]

[1] Child Abuse and Neglect Fatalities In Hampton Roads, FY 2011 One-Year Report http://media2.wavy.com/html/PDFs/Fatality%20Report%20FY%202011.pdf

The Virginia Department of Health website includes the following description of the Hampton Roads Child Fatality Review Team:

> The Hampton Roads Regional Child Fatality Review Team began in August 1994. The meeting was convened by the Hampton Roads Committee to Prevent Child Abuse and Children's Hospital of The King's Daughters with the purpose of establishing a local response to the problem of child fatalities. The Hampton Roads Team serves a large and diverse geographic area. It includes the cities of Hampton, Chesapeake, Newport News, Williamsburg, Norfolk, Portsmouth, Virginia Beach, Suffolk, and Franklin as well as the counties of Accomack, Brunswick, Isle of Wight, Surry, Southampton, Northampton, Greensville, Sussex, James City and York/Poquoson.[2]

A Regional Review site visit had been completed shortly before the CWLA Team's site visit. The Regional Team reviewed records and practice relative to a sample of cases, but will not issue a report concerning any individual case.

Interviews during the CWLA Team's site visit indicated that although staff had been asked questions about their work in relation to BT, his family, and his foster parents, they had not had an opportunity to collectively review and reflect on their work.

Recommendations:

- The CWLA Team recommends that local DHS develop a critical case review process to be used whenever there is a child fatality or serious incident involving a child in the care or custody of VBDHS. Regional and/or State personnel may be able to recommend for consideration appropriate models from other jurisdictions within Virginia. The CWLA Team can offer contacts in other states willing to discuss their critical case review models.
- A more comprehensive interdisciplinary review of fatalities by the Virginia State Child Fatality Review Team and/or a local or regional counterpart would be helpful for cases with agency involvement at the time of death. Virginia authorities can consult the National Center on Child Fatality Review[3] and/or the National Resource Center for Child Death Review[4] for review process models, tools, technical assistance, resources, and collaboration with colleagues.
- The CWLA Team recommends that reviews be conducted through a quality improvement lens that dedicates the process to learning, rather than identification of persons/groups to blame for tragic outcomes.

Serious Incident Protocol and Debriefings

Immediately following the death of a child, emphasis is naturally on coordination of investigation, communication with and reporting to appropriate local, regional and state officials and law enforcement contacts. It is essential that crisis is managed effectively and that people with a "need to know" are informed efficiently and promptly. There must be processes for identifying the information

[2] Retrieved from: http://www.vdh.virginia.gov/medExam/FatalityReviewSurveillance/ChildFatality.htm
[3] ICAN Associates, Inc., 4024 N. Durfee Ave., El Monte, California 91732 http://ican-ncfr.org/
[4] 1115 Massachusetts Ave NW, Washington, DC 20005, http://www.childdeathreview.org/

that can be made public and information already publicly available, and for managing media inquiries respectfully.

Interviews with staff across programs and area of responsibility indicated that in the hours and days after BT's death, requests for information were numerous and frequent. Although there are clear expectations in VA DSS Guidance concerning the steps to be taken when a child dies, VBDHS staff stated that there was not a clear protocol or mechanism for responding, especially to media requests. An internal critical incident report form was completed and is included in the case record; there is no evidence that a State form was completed after BT's death.

On another dimension, VBDHS professionals indicated that the implication of a foster parent in the death of a child in care had a powerful effect on their relationships with other foster parents. The level of trust between child welfare staff and their clients was perceived as compromised in some cases, and was considered a safety concern for front-line staff carrying-out legitimate removals and/or transitions of children into foster care. During the foster parent training group that was in process at the time, VBDHS staff discussed the difficulties for foster parents when a child in care dies. In addition, a mandatory training for all foster parents was held to discuss changes in VBDHS protocol.

Affording affected individuals the opportunity to debrief and process grief and loss is necessary to a healthy functioning organization; however, efforts to debrief staff and to communicate to internal personnel with a connection to the child and family sometimes receive less attention than they should. After BT's death, some people involved with him and his family became aware of his death as a result of media reports, or through police or media contact.

Interviewed staff stated that formal and informal opportunities to discuss the case, review their contributions and gain support for feelings of grief and loss were restricted because of media and forensic investigations. There was limited opportunity for debriefing, but because of confidentiality, most staff were not privy to specific information about the case, which contributed to accusations, rumors, and circulation of misinformation. At the time of the CWLA Team's site visit, it was apparent that people had formed strong, but not necessarily informed, opinions concerning events of the case. Misinformation is detrimental to collegial relationships within the agency and with professionals in other departments and community-based services. Although this Special Review occurred more than two years after BT's death, it was apparent that many people are still emotionally raw from their experiences in this case, and that action could be taken to encourage healing.

Some staff expressed the opinion that counseling should be mandatory for all involved staff after a fatality in a family they have served. Staff also concurred that VBDHS could benefit from a protocol for responding to serious incidents and fatalities to ensure that necessary information can be gleaned from records, media requests can be handled expeditiously, and staff can manage increased demands while continuing to attend to other responsibilities.

In June 2012, VBDHS implemented a staff wellness program, in response to the growing awareness of the importance of supporting staff.

An organized, cohesive, and timely mechanism for responding to critical incidents is essential to sound management of any agency or organization, whether or not it operates within the child welfare array of services. Emphasis on critical incident management within child welfare organizations, which surged in the United States after the 1995 bombing of the Alfred P. Murrah Building in Oklahoma City, has become a primary focus of organizational preparedness for natural disasters and critical incidents.

Recommendations:

- The CWLA Team recommends that State and Regional officials, in consultation with relevant legal personnel, consider developing a system for investigation of deaths and critical incidents when the child is in placement with an agency foster or adoptive family. Many states have reciprocal arrangements, whereby investigations can be assigned to another jurisdiction.
- VBDHS should follow VA DSS protocol for responding to child deaths.
- VBDHS should provide debriefing to all involved staff as soon as possible after each critical incident and fatality. Debriefing protocol should be developed to address who must be informed, how they will be informed and by whom, as well as how confidentiality will be respected and maintained. When feasible, such debriefings should include community providers that have provided services in the case.
- VBDHS should take advantage of state and regional resources to assist with facilitating debriefings or training/coaching facilitators.
- VBDHS should develop a protocol for notifying previous workers when there is a fatality or critical incident on a case.
- VBDHS should use the VA DSS Child Fatality Reporting Form[5] and should maintain a copy in the case record.
- VBDHS should ensure that when there is a critical incident or fatality, each staff person directly involved with the case is offered individual counseling, either through EAP or another qualified professional.
- VBDHS leaders should make concerted efforts to correct misinformation about BT's death, and to squelch continuing, counter-productive finger pointing.
- The article "When a Child Welfare Client Dies: An Agency-Centered Perspective"[6] should be shared with all managers, supervisors and

[5] VA DSS Guidance 11.8 Appendix A: Child Fatality Information Form

[6] Child Welfare, 2004 (4), Child Welfare League of America

staff to increase understanding of the support needed when there is a client fatality.

Connecting the Dots

It is often true in child welfare work that collective observations, information and expertise are required to make fragments of case information into a coherent whole. This is especially true in BT's case. There were many individual pieces of information that in isolation did not seem concerning or alarming, but when compiled, paint a picture that is significantly altered.

- KG reported her medical and personal history differently during her home study process than she did during discussions with other VBDHS staff. The discrepancies were not identified until after BT's death. They led to the decision (see Best Efforts section above) to require assigned workers to read the home studies of foster parents when children are newly placed.
- In application, and during training and home study process KG denied motivation to adopt, but on the date of BT's placement with her, she reported to the pediatrician that she was planning to adopt BT if his goal changed to adoption.
- KG had several unpleasant interactions: with the pediatrician's office on the day of BT's placement with her (as a result she requested that VBDHS change BT to another pediatrician); with the GAL, who wanted to schedule a home visit, and KG declined; with VBDHS Resource staff as they explained her role and responsibilities after these two incidents;
- On 1/27/09 during a visit with his mother, BT had bruises and abrasions on his face. He appeared not to be feeling well. KG explained that he was not feeling well because he was teething, and that a bruise on his forehead happened when he bumped his head while trying to crawl. During investigation after BT's death, KG stated that BT had stopped crawling soon after Thanksgiving.
- Explanations for BT's facial bruise seemed plausible to staff, who were not familiar enough with motor development to know that such a head bump is not consistent with crawling.
- Infant program staff had telephone conversations with KG during which she identified herself as a new foster parent. The questions she asked led infant program staff to believe she was asking about a newborn, as she described feeding with a dropper. Infant staff reported that her voice did not indicate serious concern about BT's well-being.

Recommendations:

- VBDHS should work to improve communication between Resource staff and CPS and Foster Care staff so that observations may be shared, compared, and inconsistencies identified.
- Workers should identify and share their areas of expertise, so that colleagues have resources within VBDHS for consultation, particularly regarding infant growth and development, and normal vs. concerning behavior for children of all developmental stages.
- Infant program staff recommended that they institute a process for communicating with the assigned worker when contacted by a VBDHS foster parent.

Foster Care Issues

The ability of a child welfare organization to provide quality foster care to children in need of placement is essential to its ability to fulfill its mission and statutory responsibilities. Integral to meeting goals to ensure children's safety, permanency and well-being, foster care functions require specialized skill, excellent communication, and commitment to consideration of each child's individual needs. The child welfare organization has the responsibility to ensure that it is taking every possible precaution to screen foster and adoptive parents thoroughly enough to be reasonably certain that when approved, the family will provide the expected level of care for the child.

When a child's injury or death is attributed to a foster parent, the system must explore whether its policies and procedures were contributing factors. The CWLA Team recognizes that in the immediate aftermath of BT's death, VBDHS took action to make some necessary changes to foster care practice, and other changes were in the planning stages or early stages of implementation at the time of the Review. This report necessarily reflects the facts of this case and the resultant findings; therefore, while some changes to practice are reportedly in process, the CWLA Team has included herein only those changes for which documentation has been provided.

Foster Parent Training

The Virginia DSS Guidance Manual for foster care states[7]:

> **1.5.6.1 Training requirements**
>
> The LDSS shall ensure that pre-service training is provided for resource, foster and adoptive family home providers, using a VDSS-approved curriculum, and completion of the training shall be documented in the provider's file. Each provider shall satisfy the pre-service training requirements. Certain curricula have been verified to meet the required competencies: Parent Resources for Information, Development and Education (PRIDE), Model Approach to Partnerships in Parenting (MAPP), and Parents as Tender Healers (PATH). The Department supports PRIDE as the preferred curriculum. **All other curricula must be approved by the VDSS in order to satisfy the pre-service requirement.**

[7] DSS Guidance Manuals are retrievable online at: http://www.dss.virginia.gov/family/fc/

Parent Resources for Information, Development, and Education (PRIDE)[8] — CWLA's model for developing and supporting foster families and adoptive families — has been identified as Virginia's preferred curriculum. Integral to PRIDE is the belief that "protecting and nurturing children at risk and strengthening all their families (birth, foster, or adoptive) requires teamwork among individuals with diverse knowledge and skills, all working from a shared vision and toward a common goal." Foster and adoptive parents are essential members of the professional team.

The PRIDE model is designed to teach knowledge and skills in five essential competency categories for foster parents and adoptive parents:

- Protecting and nurturing children;
- Meeting children's developmental needs, and addressing developmental delays;
- Supporting relationships between children and their families;
- Connecting children to safe, nurturing relationships intended to last a lifetime; and,
- Working as a member of a professional team.

The group process involving at least two trainers, one of whom should be a foster parent, and the sequence, timing and content of personal home visits and interviews are essential to the success of the PRIDE model. The information presented and discussed in each module builds upon the content of previous classes. Forging relationships between staff and trainees is also essential to the success of the model. Because observations of the trainers are so important to the efficacy of the PRIDE model, trainers are consistent for each group, and trainers are expected to complete the home studies for participants in their cohort.

VBDHS does not use PRIDE or one of the recognized models. The curriculum covers required core subjects and addresses PRIDE competencies; however, it does not promote the level of foster parent professionalism that PRIDE is intended to inspire. Nor does it adhere to the premises that trainers should be consistent throughout the process and that the same person(s) should complete training and home study.

Although records indicate that KG and BK participated in foster parent training, staff interviews contradicted that information, indicating that BK did not actually attend training. Because of his military schedule, he was unable to attend training during the summer of '09. He was therefore not required to attend, and VBDHS staff did not have the opportunity to observe the couple's interactions and relationship during training. The couple was approved to foster parent without his participation in training. Staff stated that they are now requiring both members of couples to attend pre-service training, regardless of military schedules.

[8] http://www.cwla.org/programs/trieschman/pride.htm

Recommendations:

- VBDHS should use a recommended pre-service training curriculum, should implement the curriculum and home study process as developed, and should adhere to the interview protocols as designed.
- Trainers should ensure that each training group is staffed appropriately by appropriately credentialed staff and foster parent trainers.
- VBDHS should continue to present information about infant care, including prevention of Shaken Baby Syndrome, to foster and adoptive parents.
- VBDHS should develop training concerning the core principles of PRIDE for all child welfare personnel, including CPS investigators, social workers, supervisors, and managers to ensure that personnel interacting with foster parents have a thorough understanding of the expected role and professionalism of foster parents.

Family Assessment/Home Study Process and Content

BT's second foster parents were not assessed adequately. Their home study included information that was inaccurate, misleading and was contradicted by later developments. For example, the home study states that the couple did not have infertility issues, but during the investigation, KG reported that she had had several miscarriages.

Virginia Guidance states:

> As part of the approval process, the LDSS shall conduct a family assessment. This family assessment shall address all elements required by regulation and be documented by a combination of narrative and other data collection formats, and shall be signed and dated by the individual completing the assessment and the director of the LDSS or his designee. The information contained in the Mutual Family Assessment Report 032-04-0060-00-eng (04/10) shall consist of demographic information including:
>
> > Age of applicant.
> >
> > Marital status and history.
> >
> > Family composition and history.
> >
> > List of agency individuals involved in completing the assessment process and their roles.
> >
> > Information indicating that the provider has been given and understands the standards for sleeping space and maintaining a safe environment as listed in Section 1.5.4.3.
> >
> > ***1.6.2 Assessing applicant's knowledge, abilities, attitudes, relationships, and capacity to foster and/or adopt***, states:
> >
> > Narrative documentation shall include information from the interviews, references, observations, and other available information, and shall be used to assess and document the applicant's skills to foster and/or adopt. Decisions to approve may also be based on information gained through discussions, recommendations, etc. and should assess that the applicant:
> >
> > Is knowledgeable about the necessary care for children and is physically and mentally capable of providing the necessary care for children.
> >
> > Is able to articulate a reasonable process for managing emergencies and

ensuring the adequate care, safety, and protection of children.

Expresses attitudes that demonstrate the capacity to love and nurture a child born to someone else.

Values children's birth family and other significant relationships.

Expresses appropriate motivation to foster or adopt.

Shows stability in all household relationships.

Has the financial resources to provide for current and ongoing household needs

The VBDHS family assessment/home study process did not adequately address these issues.

The medical reference form used by VBDHS asked for minimal information from the physician and was not thorough enough for staff to be able to make an adequate assessment of current health status, and relevant health history. Much more information is needed to make determinations about suitability to parent, especially for applicants who might be considered as prospective adopters. VBDHS is now requiring releases of information so that, as needed, staff may follow-up with treating physicians, psychiatrists, therapists, and other professionals. The current physical examination form includes more detailed information than was included when KG and BK applied.

Foster Mother indicated that she used Methadone for pain management for a chronic condition in her knee. While the medical report from her physician does not indicate concern about her ability to provide care for a child, there is no evidence that staff discussed with her the side effects of Methadone, their potential impact on her or her ability to care safely for a child.

VBDHS uses the AAPI[9] as a component of the family assessment process. The AAPI-2 scores, which included several areas of moderate risk for both KG and BK, are included in the home study report. There is not discussion of the meaning of those scores, or any indication that VBDHS staff used the results to explore relevant issues and attitudes toward parenting with the applicants.

During Special Review discussions, VBDHS staff indicated that in retrospect they could identify pieces that would have made the foster care home study process more thorough. They agreed that in future cases, more probing questions should be asked about history of abuse, experiences in adolescence, relationships with parents and other extended family members, previous experiences with counseling, support network. In addition, corroborating evidence could be sought when foster/adoptive parent applicants' autobiographical information seems highly unusual.

Since BT's death, VBDHS has implemented Virginia's Mutual Family Assessment:

> A process that includes both a study of the physical home as well as the prospective provider(s). It is mutual in that while the LDSS maintains final authority on the decision to

[9] AAPI-2 Guide, retrieved online 6/2/12 at: http://nurturingparenting.com/images/cmsfiles/aapi-2_development_guide.pdf

approve or not approve, assessment is done with families as opposed to families.[10]

In 2011, the Department received 42 assessment applications; 16 resource families were approved and 26 applications were closed.

Interviews indicated that although they are asking more probing questions and have declined to approve some families, in general, VBDHS staff expect foster and adoptive parent applicants to screen themselves out or withdraw from training when they are not appropriate and/or when the realities of fostering or adopting are inconsistent with their desires and expectations. While that thinking might be acceptable for many, if not most, applicants, it is not consistent with current best practices. In their 2011 workbook for screeners, Dickerson, Allen, and Pollack[11] assert that screeners should use a forensic model to interview applicants, because, "unlike a social worker involved in a therapeutic interview, a screener identifies antisocial tendencies in a client, not to counsel, but to evaluate for unacceptable behavior."

Recommendations:

- The CWLA Team recommends that all Resource staff and relevant State and Regional personnel read How to Screen Adoptive and Foster Parents[12].
- Staff should receive competency-based training to ensure that their questions during interviews elicit the information required to complete a thorough assessment of applicants.
- Workers should receive competency-based training concerning how to glean important information from foster parent applicants who have difficulty sharing personal information about themselves or their families.
- VBDHS should review required staff qualifications to ensure that workers have the skills, experience, and education to assess, license, re-license and support foster and adoptive parents. CWLA Standards suggest that minimum qualifications for resource staff should include a Masters degree in social work or a related field.[13]

Placement of Infants and Young Children

The December 2008 issue of *Permanency Today* summarizes important research findings concerning infants in foster care:

> Once in foster care, infants and toddlers are more likely than older children to stay in foster care longer than a year and to experience multiple placements. If they are

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[10] http://www.dss.virginia.gov/files/division/dfs/fc/intro_page/guidance_manuals/other/Resource_Family_Guidance_2011.pdf definitions,

[11] Dickerson, Allen & Pollack, How to Screen Adoptive and Foster Parents, NASW Press, 2011, p. 11

[12] Ibid.

[13] CWLA Standards for Excellence in Foster Care Services, CWLA, 1995

> reunified, they are more likely than older children to re-enter foster care (Dicker and Gordon, 2004). These disruptions are often linked to problems with attachment and bonding (Schwartz, Ortega, Guo, & Fishman, 1994) and adverse outcomes are particularly acute among babies who enter foster care in the first three months of life (Wulczyn and Hislop, University of Chicago, 2002). More than 50% of infants and toddlers in foster care are at high risk for neurological and cognitive development impairments and nearly half of all foster children have behavioral or emotional problems (Vandivere, Chalk, & Moore, 2003).[14]

In spite of these statistics, matching of infants with foster homes in the United States is often done for expediency and not with consideration for the best fit. Although it is well known that multiple moves for a child are contrary to best practice and contribute to attachment difficulties,[15] potential adverse effects are given less consideration than they should be.

BT's case raises important questions about VBDHS's capacity to meet the needs of infants and young children, given the lack of available foster homes appropriate to serve them. Research on infant and early childhood development emphasizes the essential role of caregivers on brain development and learning.[16] Staff were unanimous in their opinion that VBDHS does not have a sufficient number of foster parents willing and able to take placements of young children, especially infants with medical needs. Interviewed staff indicated that infants are sometimes placed in any foster homes with openings.

Upon discharge from the hospital after birth, BT was placed with experienced foster parents capable of monitoring him for possible complications due to Mother's substance use during pregnancy. The first foster family was unable to consider adoption, and correctly advocated for BT's placement with a family that could adopt him if the goal were to change from reunification to adoption.

Recommendations:

- VBDHS should recruit and cultivate relationships with prospective foster parents who have the special skills and knowledge to care for infants and young children, whose homes can accommodate young children, who are not working outside the home, who have the interest and capacity for caring for infants and young children, and the ability and interest in becoming permanent resources should the need for adoption arise.
- VBDHS should develop protocols for the placement of infants in foster homes and for communicating clearly the decisions that may and may not be made by foster parents independently.
- VBDHS should consult *Ensuring the Healthy Development of Infants in Foster Care: A Guide for Judges, Advocates and Child Welfare*

[14] Options Counseling, Permanency Planning Today, December 2008, National Resource Center for Family Centered Practice and Permanency Planning
[15] Perry, Bruce D., *Bonding And Attachment In Maltreated Children*, Child Trauma Academy, 2001
[16] Stamm, Jill, *Wired for Success,* Infant Brain Development, Arizona State, 2009

Professionals[17] for an excellent foundation for considerations that should be made when making placement decisions for infants.

- VBDHS should offer a range of appropriate pre-service and in-service training with regard to infant and child development that should be reinforced by supervisors and leadership.

Permanency and Concurrent Planning

Practice in BT's case was contrary to Virginia DSS Guidance concerning permanency planning and concurrent planning. In spite of numerous citations in VA DSS Guidance supporting the concept of concurrent planning, promoting the idea that placement stability and adoption by foster parents is positive and the seeking relative placements, BT was placed in a foster home that could not meet his need for permanency.

Virginia DSS Guidance includes the following definitions:

> **Permanency:** Permanency for children means establishing family connections and placement options for children in order to provide a lifetime of commitment, continuity of care, a sense of belonging, and a legal and social status that goes beyond the child's temporary foster care placement.
>
> **Permanency Planning:** An array of social work and legal efforts directed toward securing safe, nurturing, life-long families for children in foster care.
>
> **Permanency Planning Indicator:** A tool used in concurrent planning to assess the likelihood of reunification. It assists the service worker in determining if a child should be placed with a resource family.
>
> **Resource Parent:** A provider who has completed the dual approval process and has been approved as both a foster and adoptive family home provider. The provider is committed to support reunification and to be prepared to adopt the child if the child and family do not reunify.

Additionally, Guidance states:

> **Explore permanency with caregivers**: In addition to full disclosure to parents about concurrent planning, equal candor shall be used with all other parties involved, including the child, the court, the foster parents, CASA, attorneys, and relatives.

Case records indicate that BT's mother had 4 other children, three of whom were placed with MGM and one who was placed with a cousin. The case record documents a call to grandparents, and discussion with grandfather, who expressed interest in taking custody of BT. Later entries indicate that the family determined that it was unable to care for BT. There is not documentation of the specific discussion with Mother's cousin, although there is documentation of her inability to care for BT because she was caring for his sibling, and had adopted another child. The record does not document efforts to seek or discuss the possibility of placement with any other relatives.

[17] Sheryl Dicker and Elysa Gordon, Ensuring the Healthy Development of Infants in Foster Care: A Guide for Judges, Advocates and Child Welfare Professionals, Zero to Three Policy Center, January 2004 retrieved online from: http://www.courts.state.ny.us/ip/justiceforchildren/PDF/Infant%20Booklet.pdf

Although current practice, VA DSS Guidance, and CFSR indicators support concurrent planning, interviews indicated that VBDHS staff do not support placement of infants with prospective adoptive parents.

Recommendations:

- All VBDHS staff should be trained concerning VA DSS Guidance regarding permanency and concurrent planning.
- VBDHS staff should follow VA DSS Guidance concerning permanency planning, concurrent planning, and resource families' adoption from foster care.
- The CWLA Team recommends Child Welfare Information Gateway's April 2012 *Issue Brief on Concurrent Planning: What the Evidence Shows*.[18]

Transfer of Placement

BT was transferred from his first foster home, foster parents requested to meet with new foster parents to discuss his schedule, needs and preferences, and to answer questions. Staff reported that since they were concerned that BT's first foster family would mention permanency and the possibility of adoption, they decided against having the foster parents meet each other at transfer. Instead, the worker met the first foster parent at the door, took BT from them, and transferred BT to his new foster parents.

During interviews staff recalled having given written information to BT's second foster parents that was obtained from his first foster parents; however, a copy of that written information is not included in the case record. The foster placement agreement did not include information about his medical history, sleeping, eating and toileting habits, his likes and dislikes, or his relationships with his caretakers.

Recommendation:

- VBDHS should develop protocol for removal or transfer of infants that includes obtaining and documenting basic information, at minimum, the child's schedule, care, (including such things as sleep position, current and past formula and diet, feeding issues, and bathing), health, preferences, and relationships with current and former caretakers.
- VBDHS should establish protocol for the physical transfer of placements, including direct contact between foster/adoptive parents, including circumstances, if any, under which such contact should not occur.

Caseloads

Interviews indicated that many workers perceive their workload as "impossible," some CPS workers have caseloads as high as 40, turnover among CPS workers

[18] http://www.childwelfare.gov/pubs/issue_briefs/concurrent_evidence/index.cfm

and temporary workers is high, and staff report high stress levels, illness, and absenteeism. A data report provided to the CWLA Team indicates that 41.26% of cases were overdue, and that on the date of the report, half of CPS workers had caseloads of 20 or more. There was conflicting information from managers, however, indicating that caseloads are not consistently high and that vacancies and turnover rates are not higher than other comparable VA jurisdictions.

Recommendation:

- The agency should produce accurate reports of the current caseloads as of May 31, 2012, and a report of the vacancies and turnover rates for each month of the past fiscal year. These reports should be posted and shared with all VBDHS staff to promote transparent efforts to address identified staffing and caseload difficulties.
- To facilitate open discussion of workload issues, State and Regional authorities should provide to VBDHS (and this should also be posted and shared with all VBDHS staff) current child welfare caseload/workload data for comparable jurisdictions elsewhere in Virginia, as well as for nearby jurisdictions.
- The Child Welfare Workload Compendium[19] is a recommended source of statistics, policy, legislation and other relevant information from throughout the U.S. that can provide context for discussion of caseload/workload issues.
- VBDHS should strive to adhere to caseload numbers and ratios recommended in CWLA Standards of Excellence for Child Protective Services[20], Foster Care[21] and Adoption[22], and should develop a plan for achieving those numbers and ratios.

Supervision

While VBDHS staff interviewed indicated that they have access to a supervisor in a crisis situation, models and frequency of supervision vary from unit to unit and supervisor to supervisor. There is not a standard expectation concerning availability of scheduled, individual supervision, although 1:1 consultation with a supervisor appears to be available when necessary. The number of direct reports to managers also varies widely; the Adult and Family Services Division Director has 18 direct reports, which is far too many for any individual to supervise well.

Consistent, high-quality supervision of child welfare staff is essential to ensuring the safety, permanency, and well-being of children, and vital to a dedicated, committed workforce of people ready, willing and able to promote the best

[19] http://www.childwelfare.gov/management/workforce/compendium/
[20] CWLA Standards of Excellence for Child Protective Services
[21] CWLA Standards of Excellence for Foster Care
[22] CWLA Standards of Excellence for Adoption

interests of children and families. Inadequate supervision contributes to challenges in worker growth, development and retention.

In recent years, child welfare systems have collaborated to develop consensus on the parameters of supervision for child welfare agencies. The National Center for National Resource Center for Family-Centered Practice and Permanency Planning[23] and the National Child Welfare Resource Center for Organizational Improvement[24] teamed to publish a comprehensive guide for developing supervision models, policy and practice[25], which sets the following criteria:

1. clearly articulate in writing the organization's practice philosophy and approach and acknowledge the statutory and policy requirements that shape agency practice;
2. identify the functions and specific job responsibilities of child welfare supervisors;
    - administrative supervision
    - educational supervision
    - supportive supervision
3. recognize the centrality of supervisors' building and maintaining relationships with their supervisees and others to carrying out their supervisory responsibilities effectively;
4. mandate explicit and manageable standards for caseload size and supervisor-supervisee ratios;
5. define expectations with regard to the frequency and format for supervision of frontline practitioners;
6. clarify the organization's expectations for ongoing evaluation of frontline practitioners;
7. support supervisors in their roles as unit leaders and change agents by:
    - systematically including them in quality assurance activities, program evaluation,
    and redesign of information systems, forms, and procedures;
    - training supervisors first for all policy and practice changes;
    - involving them in the recruitment, selection, and training of new frontline practitioners; and
    - frequently recognizing their own and their units' accomplishments.

Recommendations:

- VBDHS managers, in cooperation with State and Regional officials, should establish a task force to examine current supervisory structure, responsibilities and ratios, and should compare current status with recommended practices.
- The task force should establish expectations for child welfare supervision within VBDHS, and should develop a plan of action for implementing expectations.
- The CWLA Team recommends that VBDHS take immediate action to reduce the number of direct reports to the Division Director.

[23] http://nrcfcppp.org/
[24] http://muskie.usm.maine.edu/helpkids/
[25] Building a Model and Framework for Child Welfare Supervision
http://muskie.usm.maine.edu/helpkids/rcpdfs/BuildingAModelandFrameworkforCWSupervision.pdf

Organizational Structure and Leadership

A Child Welfare Information Gateway[26] fact sheet indicates that, as of early 2012, there are nine states with state-supervised, county-administered systems, and three additional states with hybrid systems. These systems, which include Virginia, have complexities beyond those of state-administered child welfare systems. Among the challenges, is the tendency for responsibilities to become compartmentalized, for silos to develop, and for each entity to attend to its responsibilities without full consideration of the other's perspective and expertise. The tendency toward silos is exacerbated in a locally-administered system such as VBDHS, which is responsible for oversight and delivery of many human services.

It is important for State, Regional, and Virginia Beach leaders to understand that "critical incidents present opportunities for leaders to teach important lessons."[27] Each leader has the opportunity to learn from this case and to help others learn from it as well.

To survive and thrive in the world of child welfare, workers and supervisors must be resilient and hardy. A task of quality leadership is to build hardiness among those affected by the leaders. To develop hardiness, leaders must build:

- A sense of control through choosing tasks that are challenging but within the person's skill level
- Commitment with the offer of more rewards than punishment
- An attitude of challenge, by encouraging people to see change as full of possibilities.[28]

Characteristics common to effective leaders, regardless of the realm in which they lead, is that they are "honest, forward-looking, inspiring and competent."[29]

This case and Special Review provide excellent opportunities for leaders to examine their own characteristics of leadership and their roles in developing hardiness among their staff.

At the Exit Meeting for this Special Review, conducted on June 13, 2012, the CWLA Team invited participants to contribute their recommendations concerning leadership. A VBDHS team developed the recommendations that follow. The CWLA Team encourages VBDHS to implement these recommendations and to continue to engage in productive leadership discussion.

Recommendations:

- Deputy Director and Division Director will complete the activities of the process improvement work groups that have been underway since May 2012. Areas being focused on are policy, training, and teleworking.

[26] http://www.childwelfare.gov/pubs/factsheets/services.pdf
[27] Kouzes & Posner, The Leadership Challenge 4th Edition, John Wiley & Sons, Inc. 2007, p. 89
[28] ibid, p. 208-9
[29] ibid, p. 29

- Supervisors will implement the outcomes from the workgroups to their staff, monitor the on-going process for improvements, and make recommendations for modifications.
- Starting in July of 2012, the Department Director will participate in a 360-degree communication review. Upon completion of the review the Leadership Team will follow the recommendations of the Organizational Development Office and each member will participate in a 360 review, as well.
- Division Director will implement a semiannual survey to elicit feedback from foster families regarding the communication and effectiveness of social workers and supervisors.
- Department Director will lead discussion with the Leadership Team to examine organizational structure and to make changes to address the number of direct reports, span of supervision and to improve communication. The Team will utilize the documents and information provided by the CWLA consultants.
- All levels of leadership will be expected to stay abreast of state of the art practices, trends, etc. by participating in training, conferences and networking opportunities. All level of leadership are expected to evaluate the effectiveness of current practices and business processes on a continuous basis
- All levels of leadership are expected to create an atmosphere of trust by being realistic, by communicating and updating plans for change and by following through on decisions, etc.
- All levels of leadership are expected to provide support and respect for staff by being role models, by collecting information before making decisions or judgments, and by treating staff with respect.
- All levels of leadership are expected to have the following competencies:
    1. Knowledge base as appropriate- It should be noted here that while it is not practical to expect detailed knowledge in every area of the organization, there should be sufficient subject matter expertise in all divisions that the Department Director and Deputy Director can access for detail information.
    2. Strong communication and listening skills
    3. Effective problem solving skills
    4. The ability to provide support for staff in a professional manner.

Appendix A – Guidance

In reviewing Virginia DSS Guidance, the CWLA Team identified the following Guidance sections as the most salient to this case:

Foster Care Manual	
1.2	Definitions
2.7.1	Addressing five critical decision points
2.7.2	Participants in Family Partnership Meetings
6.1	Placement to Achieve Permanency - Introduction
6.2.2.2	Visitation and communication with family
6.2.2.4	Pursuing permanent placement options
6.2.2.5	Using approved and licensed providers
6.9	Procedures for placement changes
6.13	Placement in resource family homes
7.4	Concurrent planning
7.4.1	Six processes that support concurrent planning
7.4.2	Three practices essential for concurrent planning
Resource Families Manual	
1.5.6	Pre-service training
1.5.6.2	Core Competencies
Child Protective Services Manual	
11.1	Child Death - Introduction
11.2	Report a child death
11.2.1	Report a child death to regional Medical Examiner
11.2.2	Report child death to local Commonwealth's Attorney and law enforcement
11.3	Submit preliminary child death information to CPS Regional Specialist
11.3.1	Submit preliminary information concerning the child death
11.3.1.1	Logistical information
11.3.1.2	Demographic information
11.3.1.3	Reporting requirements
11.3.1.4	Circumstances surrounding the child's death
11.3.1.5	LDSS's plan of action
11.4	CPS Regional Specialist to monitor investigation and provide technical assistance to LDSS
11.4.1	Final child death report and review
11.4.1.1	Child Fatality information Form
11.5	Local, regional, and state child fatality reviews
11.5.2	Local and regional child death review teams
11.6	State Child Fatality Review Team
11.6.1	Guidelines for release of information in a child death
11.7	Retention of CPS report involving a child death
11.8	Appendix A: Child Fatality Information Form