Activities and Recommendations

Covering the period
through December 31, 2002

Office of the
Family & Children's
Ombudsman

2002 annual report

May 2003

To the Residents of Washington State:

I am pleased to present the Year 2002 report of the Office of the Family and Children's Ombudsman.

Last year was marked by a significant change at the Ombudsman. After serving nearly six years as the Ombudsman's first director, Vickie Wallen left her post in July 2002 to care for her new son. Under Ms. Wallen's leadership, the Ombudsman achieved a high degree of credibility and respect among our diverse range of stakeholders, including DSHS service recipients, legislators, community professionals, child and family advocates, agency workers, and the public. You can be assured that we at the Ombudsman will continue working hard to maintain the credibility and respect earned during Ms. Wallen's tenure.

The year also encompassed a tremendous amount of activity. Last year, the Ombudsman received a record number of complaints. The increase in complaints is not unusual. Over the past five years, our work of responding to inquiries and investigating complaints has accelerated dramatically. Inquiries made by families and citizens have *more than doubled,* while the number of complaints filed with our office has *increased 90 percent*.

Responding effectively to the dramatic increase in workload has been one of our biggest challenges in recent years. Because the Ombudsman has not been fully staffed since 2001, this challenge has been especially daunting. However, we are implementing significant work-process efficiencies and making extra effort to maintain a high level of responsiveness to those who contact our office.

Although slowed by the lack of a permanent director, our work on systemic issues continues. Several safety-improvement recommendations contained in the Ombudsman's 2001 report on the Washington School for the Deaf were adopted by the 2002 Legislature. In addition, the 2002 Legislature convened a work group and considered legislation that responded to concerns raised in several Ombudsman reports about the state's inadequate response to repeated reports of child neglect. Our investigation of DSHS's process for reviewing the fatalities of children served by Child Protective and Child Welfare Services continues. We hope to complete it within the next year.

Before closing, I want to acknowledge the contributions of Rosie Oreskovich to our state. As the Assistant Secretary of the DSHS Children's Administration, Ms. Oreskovich, devoted virtually all of her time and energy to strengthening the system that serves abused and neglected children, and their families. Her unexpected death earlier this year brings not only sadness, but a sense of deep loss among those of us who know of her life-long commitment to helping vulnerable children and families. Rosie's remarkable life of public service is an inspiration.

On behalf of all of us at the Office of the Family and Children's Ombudsman, I want to thank you for your interest in our work. We greatly appreciate the opportunity to serve as a voice for the families and children of Washington State.

Sincerely,

Mary Meinig
Acting Director Ombudsman

Advisory Committee

Western Washington Committee

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Children's Hospital and Regional
Medical Center, Seattle

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YWCA of Clark County
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Relatives Raising Children Program,
Tacoma

Gary Preble
Private Attorney, Olympia

Virginia Wilkins
Clallam County Court Appointed
Special Advocates, Port Angeles

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Foster Parents Association of
Washington State, Anacortes

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Child, Adolescent, and
Adult Psychiatrist, Silverdale

Robert Lipke
Lummi Nation Child Protection
Project, Bellingham

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Seattle

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Child Protective Services, Tacoma

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School of Social Work, Seattle

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Kids Partnership, Seattle

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Mary Ann Warren
Catholic Family
And Child Service, Wenatchee

Laurie Leaverton
Yakima County
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Yakima

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Parents Are Vital in Education,
Sunnyside

Patty Orona
Foster Parents Association
Of Washington State, Yakima

Dean Mitchell
Moses Lake Police Department,
Moses Lake

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Spokane

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Special Advocates, Spokane

Art Harper
Foster Parent Liaison,
Spokane

Windy Tevlin
Whitman County
Court Appointed Special Advocate,
Colfax

Joyce and Miles Stookey
Second Timers Support Group,
Spokane

Rosey Thurman
Team Child,
Spokane

Dave Williams
Casey Family Partners,
Spokane

Greg Casey
Private Attorney,
Spokane

Rand O. Young
Spokane County Juvenile
Court Services, Spokane

EXECUTIVE SUMMARY

The Office of the Family and Children's Ombudsman was established by the Washington State Legislature in 1996. The Ombudsman investigates complaints involving children and families receiving child protection or child welfare services, or any child reported to be at risk of abuse, neglect or other harm.

The Ombudsman also monitors the state's protection of children's safety in state-operated and –regulated facilities. In addition, the Legislature directed the Ombudsman to recommend system-wide improvements that benefit children and families.

The Ombudsman's Role:

- Listen to Families and Citizens
- Respond to Complaints
- Take Action on Behalf of Children and Families
- Improve the System

The Ombudsman is required by law to submit an annual report to the Governor and the members of the Legislative Children's Oversight Committee. The report is to include an analysis of the Ombudsman's work and recommendations for improving the child protection and child welfare system.

This report provides an account of the Ombudsman's activities through August 2002. It also contains several cases handled by the Ombudsman that illustrate how the office works to help DSHS avert and correct avoidable errors. In addition, the report summarizes the Ombudsman's system-improvement recommendations and activities through 2002.

The Role of the Ombudsman

The Ombudsman operates as an independent agency under the Office of the Governor. Acting as an impartial fact finder and not as an advocate, the Ombudsman provides families and citizens with an avenue through which they can obtain an independent and impartial review of the decisions made by the Department of Social and Health Services (DSHS) and other agencies.

The Ombudsman performs its duties by focusing its resources – 6 full-time staff (when fully staffed) and a biennial budget of nearly 1 million dollars – on four work activities: Listening to Families and Citizens; Responding to Complaints; Taking Action on Behalf of Children and Families; and Improving the System.

Listening to Families and Citizens

A fundamental aspect of the Ombudsman's work is to listen carefully to families and citizens. Careful listening enables the Ombudsman to respond effectively to questions and concerns. It also allows the

office to identify recurring problems faced by families and children throughout the system so they can be investigated and addressed.

Since 1998, the number of contacts made to the Ombudsman by family members and citizens has increased dramatically (the first year in which the Ombudsman was able to obtain data over a 12-month period). Between 1998 and 2002, the number of inquiries received by the Ombudsman more than doubled to 1462. The number of complaints filed with the Ombudsman during this period increased 90 percent.

In 2002, the Ombudsman received 438 complaints – an all-time high. Most complaints were filed by parents and other family members. Complaints most frequently identified DSHS's allegedly inappropriate response to reported child abuse or neglect as the issue of concern. Referrals of families and citizens to the Ombudsman by DSHS workers and local service providers accounted for 42 percent of the complaints filed with the office. Since 1998, referrals by DSHS workers and local service providers have grown by about 20 percent.

Responding to Complaints

The Ombudsman spends more time investigating and analyzing complaints than on any other activity. Sound investigations and analyses enable the Ombudsman to respond effectively when action is required to change an agency's conduct or accurately identify problematic policies and practices that require further study. They also allow the Ombudsman to back up DSHS or another agency when it is unfairly criticized for properly carrying out its statutory duties.

Between September 1, 2001 and August 31, 2002, the Ombudsman completed nearly 400 complaint investigations – an all-time high. The vast majority (86 percent) were standard, non-emergent investigations. Of these, nearly 75 percent were closed because the Ombudsman determined that an intervention was not warranted, while 25 percent were closed because they were successfully resolved after the Ombudsman became involved.

Fourteen percent of the investigations completed during the reporting period were emergent, i.e., initiated immediately upon receipt of the complaint. Of these, 55 percent were closed because the Ombudsman determined that an intervention was not warranted, while 45 percent were closed because they were successfully resolved after the Ombudsman became involved. Emergent investigations most often involved complaints about a child's safety.

Taking Action on Behalf of Children and Families

The Ombudsman takes action when it has determined that intervention is necessary to avert or correct a harmful oversight or mistake by DSHS or another agency. If the Ombudsman concludes that an agency is acting in a manner that is outside of the agency's authority or clearly unreasonable, and the act could result in foreseeable harm to a child or parent, the Ombudsman induces the agency to address the problem.

The Ombudsman takes action in the following ways: Prompting DSHS to take a "closer look" by bringing the concern to the agency's attention; facilitating information sharing to ensure that all

pertinent information is considered before the agency makes a critical decision; mediating professional disagreements to avoid delayed decisions; and sharing the Ombudsman's investigation findings and analyses with DSHS so the agency can correct a decision or course of action. Through these actions, the Ombudsman is often successful in resolving legitimate concerns about the safety of a child or the well being of a parent or child.

Improving the System

After complaint investigations, the activity that the Ombudsman spends the most time on is identifying and investigating broad-based problems in the child protection and child welfare system. The Ombudsman's findings and recommendations are published in public reports to agency officials and state policy makers.

To avoid duplicating other system-improvement efforts and target its limited resources on the issues of most importance to parents and children, the Ombudsman developed specific criteria for selecting systemic issues for investigation. Utilizing these criteria, the Ombudsman has initiated several systemic investigations since the office became operational in 1997.

The Ombudsman's systemic investigations have led to significant improvements in state law and agency policy and practice. Areas targeted by the Ombudsman for improvement include: child sexual abuse interviews and investigations; school districts' compliance with the mandatory child abuse and neglect reporting law; the representation of children by guardians ad litem; CPS's response to cases involving chronic child neglect; biased case-worker decision making; young people's experience in foster care; and oversight of student safety at the residential Washington School for the Deaf.

ROLE OF THE OMBUDSMAN

The Ombudsman was established by the Washington State Legislature in 1996, following the death of 3-year-old Louria Grace, who was killed by her mother while under the supervision of the Department of Social and Health Services (DSHS) and after years of youth-on-youth sexual abuse came to light at the DSHS-licensed OK Boys Ranch.

As well, the office was established during a time of growing concern about DSHS's participation in the Wenatchee child sexual abuse investigations. In each instance, families and citizens who previously had reported concerns about DSHS's conduct lacked an appropriate agency to turn to for an independent review when DSHS did not address their concerns.

In creating the Ombudsman, the Legislature sought to provide families and citizens with an avenue through which they could obtain an independent and impartial review of DSHS decisions (See RCW 43.06A). The Legislature also intended for the Ombudsman to intervene to induce DSHS to revisit or change a problematic decision that has placed a child or family at risk of harm and to recommend improvements to system-wide problems.

The Office of the Family and Children's Ombudsman was established to investigate complaints involving children and families receiving child protection or child welfare services, or any child reported to be at risk of abuse, neglect or other harm.

The Ombudsman was also established to monitor the state's protection of children's safety in state-operated and -regulated facilities. In addition, the Legislature directed the Ombudsman to recommend system-wide improvements that benefit children and families. The Ombudsman carries out its duties with independence and impartiality.

Independence

The Ombudsman's independence allows it to perform its duties with freedom and objectivity. The Ombudsman operates as an independent agency under the Office of the Governor. The Ombudsman is located in Tukwila and conducts its operations independently of the Governor's Office in Olympia. The Ombudsman director serves a specified term of office and is required by law to work independently of DSHS.

Authority

The Legislature empowered the Ombudsman by providing it with broad access to confidential information, while also protecting the confidentiality of the Ombudsman's investigative records and the identities of individuals who contact the office. State law provides the Ombudsman with direct access to confidential DSHS records and the agency's computerized case-management system. The office is authorized to receive confidential information from other agencies and service providers, as well (including mental health professionals, guardians ad litem, and assistant attorneys general.)

State law also authorizes the Ombudsman to maintain the confidentiality of its investigative records and the identity of individuals who contact the office to request information or file a complaint. These provisions enhance the quality of the Ombudsman's investigations. They also encourage individuals to come forward with information and concerns without fear of possible retaliation by others.

While the Ombudsman is not authorized to make, change or set aside a law, policy or an agency practice or decision, the office can publish its investigative findings and system-improvement recommendations in public reports to the Governor and the Legislature. The Ombudsman's ability to identify and publicly expose a problematic law, policy, and agency practice or decision provides the office with significant influence.

In addition, the Ombudsman derives influence from its close proximity to the Governor and the Legislature. The Ombudsman director is appointed by and reports directly to the Governor. The director's appointment is subject to confirmation by the Washington State Senate. The Ombudsman's budget, general operations, and system-improvement recommendations are reviewed by the Legislative Children's Oversight Committee.

Staff

Acting Director-Ombudsman
Mary Meinig has served as an ombudsman with the office since it opened in 1997. Previously, Ms. Meinig maintained a successful clinical and consulting practice specializing in treating abused and traumatized children and their families. Her previous experience also includes working in special education, child protective services and children's residential treatment settings. Ms. Meinig is nationally known for her work developing Family Resolution Therapy, a protocol for the long-term management of relationships in abusive families. Ms. Meinig is a graduate of Central Washington University, and received a Master of Social Work degree from the University of Washington. She is a Licensed Independent Clinical Social Worker and member of the Academy of Certified Social Workers.

Ombudsman
Patrick Dowd is an attorney with extensive experience representing indigent parents and children involved in dependency actions. Prior to joining the Ombudsman in December 1999, Mr. Dowd was a public defense attorney in King County from 1987 to 1999. From 1996 to 1999 he served as the Dependency Unit Coordinator for the Society of Counsel Representing Accused Persons. Mr. Dowd is a graduate of Seattle University, and received his law degree from the University of Oregon Law School.

Ombudsman
Colleen Hinton is a social worker with broad experience working with children and families. Prior to joining the Ombudsman in January 2000, Ms. Hinton performed clinical assessments of children in foster care and worked at Children's Response Center (part of Harborview Center for Sexual Assault & Traumatic Stress), providing education and training on child maltreatment in East King County. She helped establish the clinical program at Children's Advocacy Center of Manhattan in New York City, and worked as a therapist for the Homebuilders intensive family preservation program in King County. Ms. Hinton is a graduate of the University of Natal in South Africa, and received her MSW from the University of North Carolina at Chapel Hill. She is a Licensed Independent Clinical Social Worker and member of the Academy of Certified Social Workers.

Senior Office Administrator
Lyn Winfield is experienced in data management systems. Prior to joining the Ombudsman, she worked in several departments at the King County Housing Authority (KCHA). She worked in the Section 8 Department, processing and maintaining applications for housing assistance and managed a caseload of program participants. She also served four years as the Administrative Assistant to the Director of Resident Services, working on policy, training, and Americans with Disabilities Act compliance issues, and managing the Resident Advisory Board.

Information and Referral Specialist
Corey Fitzpatrick is a recent graduate of George Washington University, where she received a B.A. in Human Services. Prior to joining the Ombudsman, she was actively involved in the child advocacy community in Washington, DC. She served as both a Court Appointed Special Advocate and an AmeriCorps volunteer, working in low-income preschool classrooms implementing language and literacy-based programs. Ms. Fitzpatrick also worked as an administrative assistant at the Children's Defense Fund.

Work Activities

The Ombudsman performs its statutory duties through its work in four areas.

- **Listening to Families and Citizens.** Families and citizens who contact the Ombudsman with an inquiry or complaint often feel that DSHS or another agency is not listening to their concerns. By listening carefully to families and citizens, the Ombudsman can effectively assess and respond to individual concerns and also identify recurring problems faced by families and children throughout the system.

- **Responding to Complaints.** The Ombudsman spends more time investigating complaints than on any other activity. The Ombudsman impartially investigates and analyzes complaints against DSHS and other agencies. Thorough complaint investigations and analyses enable the Ombudsman to respond effectively when action must be taken to change an agency's decision and to accurately identify problematic policy and practice issues that warrant further examination. They also enable the Ombudsman to back up the agency when it is unfairly criticized for properly carrying out its duties.

- **Taking Action on Behalf of Children and Families.** The Ombudsman takes action when it has determined that intervention is necessary to avert or correct a harmful oversight or mistake by DSHS or another agency. The Ombudsman's actions include: prompting the agency to take a "closer look" at a concern; facilitating information sharing; mediating professional disagreements; and sharing the Ombudsman's investigation findings and analysis with the agency to correct a problematic decision. Through these actions, the Ombudsman is often successful in resolving legitimate concerns.

- **Improving the System.** The Ombudsman is responsible for facilitating improvements to the child protection and child welfare system. The Ombudsman works to identify and investigate system-wide problems, and it publishes its findings and recommendations in public reports to agency officials and state policymakers. Through these efforts, the Ombudsman helps to generate better services for children and families.

The Ombudsman utilizes virtually all of its resources – 6 full-time staff and a biennial budget of nearly 1 million dollars – to perform these activities. The Ombudsman's work activities are described in more detail in the sections that follow.

LISTENING TO FAMILIES AND CITIZENS

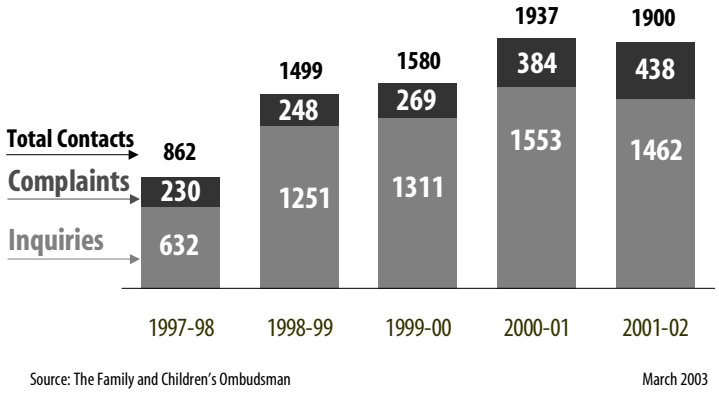
The Ombudsman listens to families and citizens who contact the office with questions or concerns about services provided through the child protection and child welfare system. By listening carefully, the Ombudsman can respond effectively to inquiries and complaints, and can identify recurring problems faced by families and children receiving services. Families and citizens who contact the Ombudsman with their questions and concerns strengthen the office's ability to uncover systemic problems and to facilitate improvements that will generate better services for children and families.

This section describes the contacts made by families and citizens to the Ombudsman during the reporting period of September 1, 2001 through August 31, 2002. It also highlights significant five-year trends in the contacts received by the Ombudsman between 1997-98 and 2001-02.[1]

Contacts to the Ombudsman

The total number of contacts made by families and citizens to the Ombudsman has increased dramatically since 1998. While the number of staff assigned to the Ombudsman (6 FTE) has remained constant over the past five years, the number of inquiries to the office has more than doubled. The number of complaints filed with the Ombudsman has increased **90 percent**.

Contacts to the Ombudsman have Doubled in Five Years.



Source: The Family and Children's Ombudsman March 2003

Contacts. When families and citizens contact the Ombudsman, the contact is documented either as an inquiry or a complaint.

1. Inquiries. Persons call or write to the Ombudsman wanting basic information on how the office can help them with a concern, or they have questions about the child protection and child welfare system.

The Ombudsman responds directly to these inquiries, some of which require additional research. The office refers other questions to the appropriate agency.

2. Complaints. Persons file a complaint with the Ombudsman when they have a specific complaint against the Department of Social and Health Services (DSHS) or other agency that they want the office to investigate.

The Ombudsman investigates every complaint that it receives within its jurisdiction.

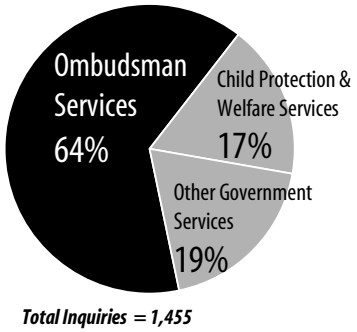
[1] After the Ombudsman began operations in 1997, it established an automated database. Using this database, the office has been able to track inquiry and complaint trends since 1998. Nineteen ninety-eight was the first year in which the Ombudsman was able to obtain data over a 12-month period.

From September 1, 2001 to August 31, 2002, families and citizens contacted the Ombudsman 1,900 times. These contacts were primarily **inquiries** made by persons in search of information and assistance. Nearly a fourth of these contacts were formal **complaints** seeking an Ombudsman investigation.

Fielding Inquiries

The Ombudsman received 1462 inquiries from families and citizens who needed information at an average rate of **28 inquiries per week** between September 1, 2001 and August 31, 2002.

Most inquiries seek information about the Ombudsman.



Total Inquiries = 1,455

Source: The Family and Children's Ombudsman March 2003

- **Sixty-four percent** of those making an inquiry wanted basic information on how the Ombudsman could help, how to file a complaint, and how to get a complaint form. If their concern involved the DSHS Children's Administration, the right to contact the Office of Constituent Relations was explained.
- **About 17 percent** concerned laws, policies, and procedures for child protection and child welfare services. The Ombudsman does not provide legal advice; however, legal rights and responsibilities were explained.
- **About 19 percent** concerned other government services. The Ombudsman found out who to contact, and referred callers to agencies that could help.

Receiving Complaints

Complaints provide the mechanism through which the Ombudsman is able to identify children and families at risk of harm due to an agency's action or inaction and pinpoint recurring and systemic problems that adversely affect children and families.

A complaint to the Ombudsman must involve an act or inaction by the Department of Social and Health Services (DSHS) or other agency that affects:

- A child potentially at risk of abuse, neglect or other harm by a parent or caretaker.
- A child or parent that has been the subject of a report or finding of child abuse or neglect, or parental incapacity.

A complaint form is required to initiate an Ombudsman investigation. It requests the name, address, and phone number of the person making the complaint. It asks the relationship of the person to the child and includes questions about: the family; custody or supervision of the child; steps taken to resolve the problem; a statement of the facts; and the action requested. It also asks how the person heard about the Ombudsman.

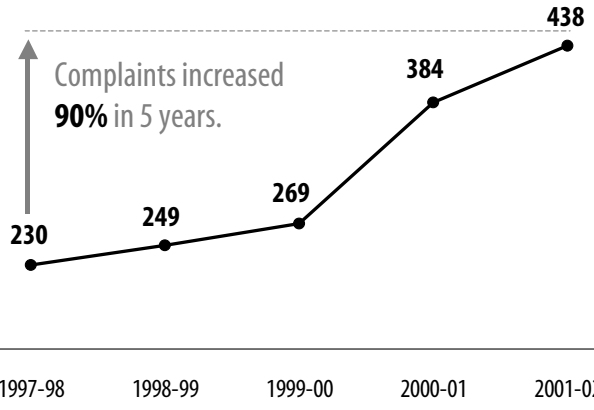
Complaint forms are available in English, Spanish, Russian, Vietnamese, and Braille. Forms are also available on the Ombudsman's web site, www.governor.wa.gov/ofco.

Complaint Trends

Over the past five years, data collected by the Ombudsman have revealed the following trends:

- Complaints to the Ombudsman most often are filed by parents, grandparents and other family members.
- Complaints most often are directed against the DSHS Division of Children and Family Services (DCFS).
- Complaints most often identify the Department of Social and Health Services' allegedly inappropriate response to reported child maltreatment as an issue of concern.
- Complaints most often involve a child age seven or younger.

Annual Complaints to the Ombudsman:

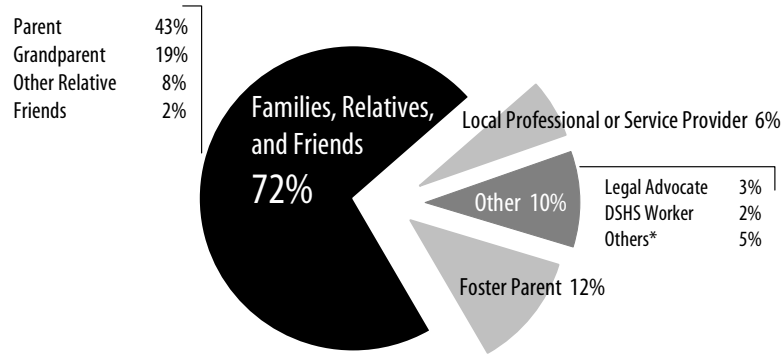


Source: The Family and Children's Ombudsman March 2003

There has been a significant upward trend in the number of complaints filed with the Ombudsman. In the current reporting period alone, the Ombudsman received 438 complaints from families and citizens seeking an investigation – an all-time high.[2]

Persons Who Complained to the Ombudsman

From September 1, 2001 to August 31, 2002



Others include children, law enforcement officials, legal guardians, parents whose parental rights have been terminated, and unknown.

Source: The Family and Children's Ombudsman March 2003

As in previous years, parents, grandparents and other relatives of the child whose family is involved with DSHS filed the majority of the complaints with the Ombudsman.

[2] Prior to 2000-01 the Ombudsman counted complaints filed together by a couple as single complaints. Starting that year, in an effort to improve the tracking of complainants, the office began counting complaints filed together by a couple as separate complaints. In 2000-01, 12 couples filed a complaint together; these were counted as 24 complaints. In 2001-02, 18 couples filed a complaint together; these were counted as 36 complaints. If complaints received from couples in 2001-02 had been counted as single complaints, (as in previous years) the percentage increase in complaints received by the Ombudsman between 1997-98 and 2001-02 would be 83 percent, instead of 90 percent.

Upward Trend in Referrals by DSHS Workers and Local Service Providers. The number of complainants referred to the Ombudsman by a Department of Social and Health Services (DSHS) worker or by a local service provider (e.g., teacher, counselor, child care provider, doctor, mental health counselor, private agency social worker or other service provider) increased substantially over the past five years.

Since 1998, the number of Ombudsman complainants who said they had learned about the office from a DSHS worker has increased 20 percent.

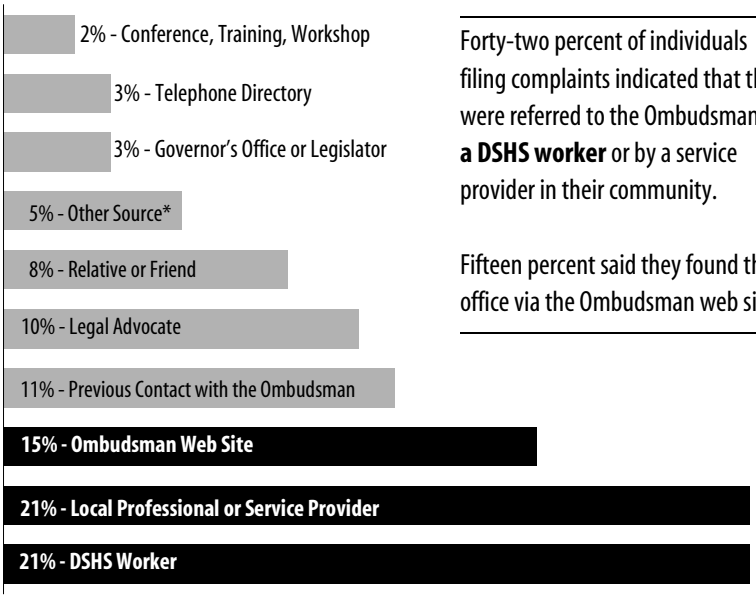
This increase may have been due in part to DSHS's affirmative response in 1999 to the Ombudsman's request that the department incorporate information about the office into the Children's Administration Training Academy program (which new social workers are required to attend) and in DSHS's complaint brochure and "Client's Rights" poster.

Since 1998, the number of Ombudsman complainants that said they heard about the office from a local service provider has increased 19 percent.

This increase may have been due in part to the Ombudsman's vigorous efforts to increase awareness among local service providers through participation in professional conferences and by broad dissemination of information about the office.

Who Referred Families and Citizens to the Ombudsman

Source of Referrals from September 1, 2001 to August 31, 2002



Forty-two percent of individuals filing complaints indicated that they were referred to the Ombudsman **by a DSHS worker** or by a service provider in their community.

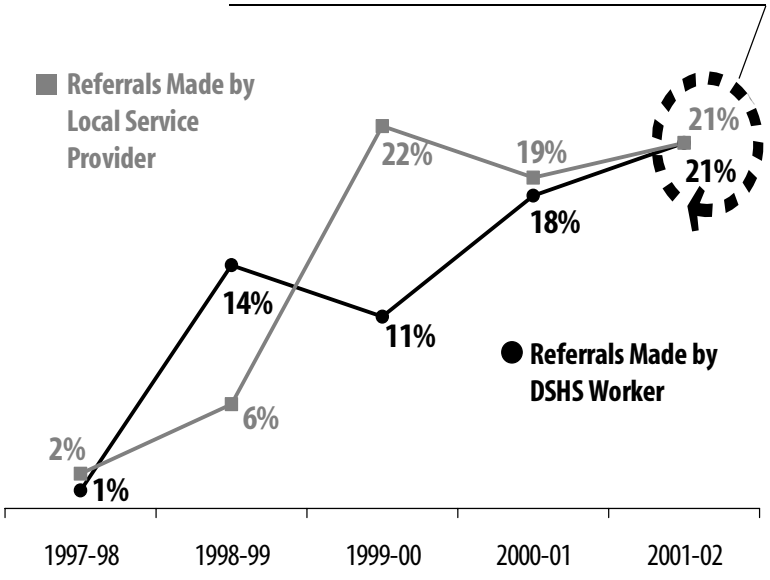
Fifteen percent said they found the office via the Ombudsman web site.

***Other source includes: law enforcement; media; and unknown.**

Source: The Family and Children's Ombudsman March 2003

Since 1998, the percent of referrals made by DSHS workers and local service providers has grown substantially.

In 2002, referrals by DSHS workers and local service providers together accounted for 42 percent of complaints.



Source: The Family and Children's Ombudsman March 2003

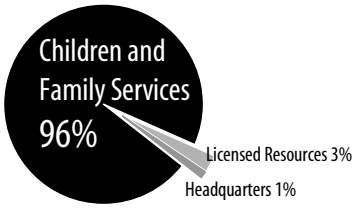
Complaints Involving DSHS

The Department of Social and Health Services (DSHS) Children's Administration is the state's largest provider of child protection and child welfare services. It is therefore not surprising that the Children's Administration was the subject of 96 percent of complaints to the Ombudsman.[3]

Of these, 96 percent were directed at the Division of Children and Family Services (DCFS), which includes Child Protective Services, Child Welfare and Adoption Services, and Family Reconciliation Services. A small percentage involved the Children's Administration headquarters and the Division of Licensed Resources (DLR), which licenses and investigates alleged child maltreatment in foster homes, group homes, and other residential facilities for children.

Complaints against DSHS Children's Administration by Division

From September 1, 2001 to August 31, 2002



Total Children's Administration Complaints=420

Source: The Family and Children's Ombudsman March 2003

Complaints against the Children's Administration by DSHS region:

DSHS Regions

	Children and Family Services	Licensed Resources
Region 1 Totals	**74**	**1**
Regional Office-Spokane	49	
Moses Lake	13	
Newport	2	
Colville	1	
Colfax	1	
Omak	4	
Wenatchee	4	1
Region 2 Totals	**48**	**2**
Regional Office-Yakima	1	1
Yakima	19	1
Richland/TriCities	10	
Sunnyside	1	
Toppenish	1	
Walla Walla	11	
Clarkston	4	
Ellensburg	1	
Region 3 Totals	**70**	**2**
Regional Office-Everett	2	
Alderwood/Lynnwood	15	
Oak Harbor	9	
Bellingham	8	
Monroe/Sky Valley	1	
Mount Vernon	8	
Arlington/Smokey Point	6	
Everett	20	2
Friday Harbor	1	

	Children and Family Services	Licensed Resources
Region 4 Totals	**81**	**4**
Regional Office-Seattle	6	
Kent/King South	23	
Bellevue/King Eastside	21	1
Seattle Central	9	
Seattle South	14	2
Seattle North	8	1
Region 5 Totals	**65**	**2**
Regional Office-Tacoma	46	1
Bremerton/Kitsap	19	1
Region 6 Totals	**67**	**1**
Regional Office - Lacey/Olympia	5	1
Vancouver	14	
Aberdeen	6	
Shelton	1	
Centralia	6	
South Bend	2	
Tumwater	5	
Kelso	7	
Port Angeles	4	
Port Townsend	6	
Stevenson	1	

Source: The Family and Children's Ombudsman March 2003

[3] The remaining four percent were directed against: Other DSHS divisions, Division of Child Support and Division of Developmental Disabilities; Family Court; local CASA program; and tribal child welfare services.

Most Frequently Identified Complaint Issues:
From September 1, 2001 to August 31, 2002 *(Some complaints identified more than one issue)*

Child Safety_____ 203 complaints
- ✓ Failure to protect child from parental abuse or neglect
- ✓ Failure to address safety concerns involving child in foster care or other substitute care
- ✓ Failure to address safety concerns involving child being returned to parental care
- ✓ Failure to provide appropriate services to child at risk of harming self or others

Family Separation and Reunification _____ 190 complaints
- ✓ Unnecessary removal of child from parental care
- ✓ Failure to provide appropriate contact between child and family
- ✓ Failure to reunite families despite parental compliance with court-ordered services
- ✓ Failure to place child with relatives
- ✓ Inappropriate termination of parental rights

Dependent Child Health, Well-Being, Permanency_ 95 complaints
- ✓ Inappropriate change of child's foster or other substitute placement
- ✓ Inadequate development or implementation of plan to transition child to new placement
- ✓ Failure to provide child with appropriate medical, mental health or educational services
- ✓ Unreasonable delay or opposition to adoption

Source: The Family and Children's Ombudsman March 2003

Complaint Issues

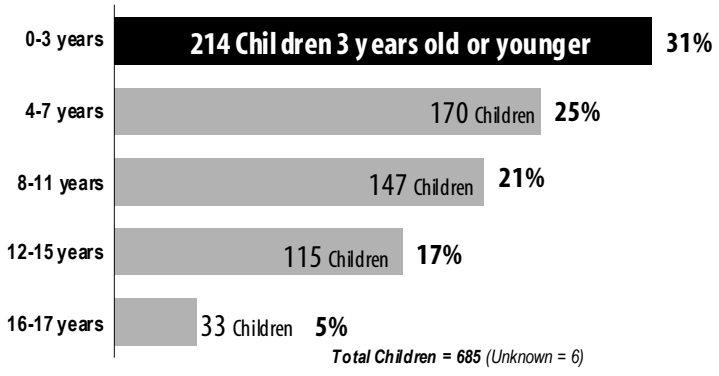
As in previous years, **safety of children** was the issue most frequently identified in complaints to the Ombudsman.

Of concern was DSHS's allegedly inadequate response to the reported maltreatment of children living in their parents' care, as well as children living in foster care or in other substitute care.

Many of the children identified in complaints to the Ombudsman were especially **vulnerable due to their young age**.

Almost **one third** of the children identified in complaints during the reporting year were **age three or younger.** Fifty-six percent were age seven or younger.

Ages of children identified in complaints:



Source: The Family and Children's Ombudsman March 2003

RESPONDING TO COMPLAINTS

One primary way in which the Ombudsman responds to families and citizens is by impartially investigating and analyzing complaints against the Department of Social and Health Services (DSHS) and other agencies that provide services through the child protection and child welfare system. The Ombudsman investigates and analyzes every complaint it receives. Sound investigations and analyses enable the Ombudsman to respond effectively when action must be taken to change an agency's conduct and accurately identify problematic policy and practice issues that require further study. They also allow the Ombudsman to effectively back up DSHS or another agency when it is unfairly criticized for properly carrying out its statutorily mandated duties.

This section describes how the Ombudsman conducts investigations and analyzes complaints. It also summarizes the characteristics and results of investigations that the Ombudsman completed during the reporting period of September 1, 2001 through August 31, 2002.

Complaints are investigated in a confidential manner.

The Ombudsman will not disclose the identity of a person filing a complaint without his or her permission. The Ombudsman also is required to maintain the confidentiality of its investigative records, along with confidential agency records and information that the office reviews, and is prohibited from disclosing confidential records or information outside the office. The Ombudsman's investigative records are not subject to subpoena, nor are they admissible as evidence in legal proceedings.

Investigating Complaints

Investigations generally begin when a completed complaint form is received. After receiving a completed form, Ombudsman staff enter specified complaint information into an automated database. The Ombudsman director then reviews the complaint to determine whether it meets Ombudsman criteria for an immediate investigation.[1]

If a complaint warrants an immediate investigation, the Ombudsman director will assign the complaint to a lead ombudsman and instruct him or her to initiate an emergent investigation. If it does not meet emergent criteria, the complaint will be assigned to a lead ombudsman for a standard investigation.

Standard Investigations

The lead ombudsman begins his or her investigation within 15 working days of the office's receipt of the complaint. Initially, the ombudsman will contact the person who filed the complaint and discuss specific issues in detail. The ombudsman then reviews information on CAMIS (DSHS's computerized case-management system), including the caseworker's narratives, Child Protective Services referral history, legal history and other relevant information.

[1] Ombudsman criteria for initiating an emergent investigation are: If true, the alleged agency action or inaction places the safety or well being of a child or family at imminent risk of serious harm.

The ombudsman also interviews DSHS caseworkers, supervisors and other individuals involved with the case, such as guardians ad litem and other service providers. If appropriate, the ombudsman may conduct a complete review of the hard file or request faxed copies of pertinent documents, such as community Child Protection Team reports or independent professional evaluations. In some instances, to obtain a more complete perspective of the case, the ombudsman will attend and observe (but not participate in) key meetings and court hearings.

After gathering sufficient factual information and researching applicable laws, policies and procedures, the ombudsman writes a report describing the complaint issues and case background. This investigative report also contains analysis and findings on key issues pertaining to the alleged conduct of DSHS or another agency. The report is provided to the Ombudsman director and other ombudsmen for a team review.

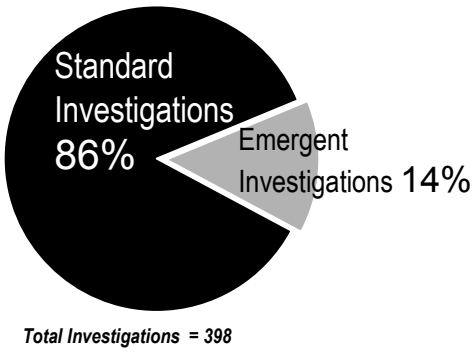
Emergent Investigations

The Ombudsman periodically receives phone calls alleging that DSHS's action or inaction has placed the safety or well being of a child or family at imminent risk of harm. Sometimes these allegations are contained in a written complaint. In either case, if the allegations meet the specified criteria for an emergent investigation, the complaint is immediately brought to the director's attention. The assigned ombudsman begins investigating the emergent complaint immediately and suspends other work.

The ombudsman expedites the standard investigation process and must report his or her preliminary or final findings to the director within 48 hours after receiving the complaint.

Type of Investigations Completed

September 1, 2001 to August 31, 2002



Total Investigations = 398

Source: The Family and Children's Ombudsman March 2003

Completed Investigations

Between September 1, 2001 and August 31, 2002, the Ombudsman **completed nearly 400 complaint investigations** – an all-time high.[2] This accomplishment was achieved even though the office was not ever fully staffed during the reporting period.

The vast majority of completed investigations were standard non-emergent investigations. One out of seven completed investigations met the Ombudsman's criteria for initiating an emergent investigation. Emergent investigations most often involved complaints about a child's safety.

[2] Of the 398 complaint investigations completed by the Ombudsman, 81 percent were investigations of complaints received during the reporting year, while 19 percent were of complaints received in a previous year.

Analyzing Complaints

The objective of a complaint investigation is to determine whether DSHS or another agency should be induced to change a decision because the Ombudsman has concluded that the agency has violated law, policy or procedure and/or unreasonably exercised its authority.

The Ombudsman's analysis begins when the lead ombudsman presents his or her written investigative report at a weekly team review meeting.

Team Review

Team review includes the Ombudsman director and the office's other ombudsman staff, who have extensive professional experience in law and social work.

The ombudsman's report provides a detailed background of the case and sets forth specific complaint issues, the ombudsman's analysis of each issue, and his or her recommendation about how the Ombudsman should respond. These confidential reports are for internal use only and are not released to the complainant or the agency.

After reading the report and listening to the ombudsman's summary, the team members may pose questions, test assumptions, identify information gaps, identify problematic policy or practice issues, raise additional issues for investigation or analysis, offer an alternative analysis or recommendation, and/or play "devil's advocate."

The Ombudsman acts as an impartial fact finder and not as an advocate, so the review team's focus is on determining whether the issues raised in the complaint meet the following objective criteria:

- The alleged agency conduct is within the Ombudsman's jurisdiction.
- The alleged agency action or inaction did occur.
- The agency action or inaction violated law, policy or procedure or was clearly inappropriate or unreasonable under the circumstances.
- The agency's action or inaction was harmful to a child's safety, health, well-being, or right to a permanent family. Or it was harmful to appropriate family preservation, contact or reunification.

While the Ombudsman review team generally reaches a consensus when determining the merits of each complaint, the director has ultimate decision-making authority.

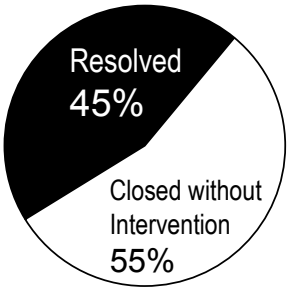
If the Ombudsman determines that a complaint does not meet the applicable criteria (see sidebar), the lead ombudsman personally notifies the complainant and explains the office's rationale for not taking further action. Additionally, the ombudsman refers the complainant to an agency or resource that may be of assistance. The investigation is then closed.

If the Ombudsman determines that a complaint meets the criteria, the lead ombudsman brings the matter to the attention of appropriate agency officials. The specific action taken by the Ombudsman will depend on the facts and circumstances of the individual complaint. *(See "Taking Action on Behalf of Children and Families" section for a selection of case studies illustrating how the Ombudsman resolves complaints.)*

When the Ombudsman takes action on a complaint, the person who filed the complaint is informed of the progress and final resolution of the case. Complaints are often resolved during the course of the Ombudsman's investigation – even before the Ombudsman has made a determination on whether the criteria were met. When this occurs, the lead ombudsman presents the complaint to the Ombudsman review team, documents any problematic policy or practice issues, and then closes the investigation.

Emergent Investigation Results

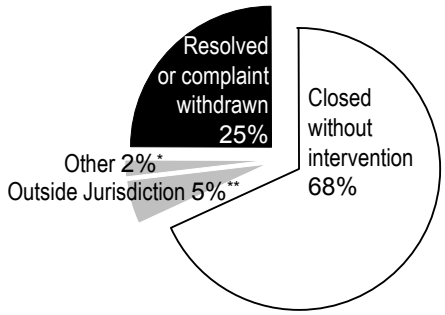
September 1, 2001 to August 31, 2002



Total Emergent Investigations = 56

Standard Investigation Results

September 1, 2001 to August 31, 2002



Total Standard Investigations = 342

* Other includes investigations that were closed because the complaint issue became moot or for some other reason could not be fully investigated.

** Once the Ombudsman determines that a complaint is outside of the office's jurisdiction, the investigator closes the investigation and refers the complainant to the appropriate agency for assistance.

Source: The Family and Children's Ombudsman March 2003

Results

Between September 1, 2001 and August 31, 2002, the Ombudsman resolved 45 percent of complaints that were the subject of an **emergent investigation.** As mentioned earlier, these investigations most often involve complaints about a child's safety.

During the same period, the Ombudsman closed about two thirds of its **standard complaint investigations,** after the office determined that an intervention to induce a change in the agency's course of action was not warranted. About one quarter of the investigations ended with the complaint being resolved after the agency agreed to change its course of action.

Policy and Practice Issues

Ombudsman investigations occasionally reveal problematic policy or agency practice issues. These may or may not be related to the central issue of the complaint.

For example, while investigating a complaint about the adoption of a child in foster care, the lead investigator noted that the child was taken into state custody only after DSHS had received 15 credible reports of suspected neglect against the child's mother.

Or, while discussing a complaint about DSHS's refusal to place a foster child with a relative, a review team member noted that the department did not, as required by law, conduct a search for potential relative placements at the time the child was initially removed from his parents and placed with his current, non-relative foster family.

Issues like these are documented by the lead ombudsman and entered into the Ombudsman database. The Ombudsman uses this information to identify patterns or trends that may warrant a systemic investigation resulting in recommendations for changes in policy or practice. *(See "Improving the System" section.)*

TAKING ACTION ON BEHALF OF CHILDREN AND FAMILIES

The Ombudsman takes action when it has determined that intervention is necessary to avert or correct a harmful oversight or mistake by the Department of Social and Health Services (DSHS) or another agency.

If the Ombudsman concludes that DSHS or another agency is acting in a manner that is outside of the agency's authority or clearly unreasonable, and the act could result in foreseeable harm to a child or parent, the Ombudsman induces the agency to address the problem.

This section describes cases that were handled by the Ombudsman in the last two years. It illustrates how the office works to help DSHS avert and correct avoidable errors.

The Ombudsman's actions often consist of the following:

- Prompting DSHS to take a "closer look" at a concern by having the agency collect additional information so it can reasonably evaluate the situation.
- Facilitating information sharing among DSHS caseworkers, family members, and service professionals to ensure that the agency considers all of the pertinent information available to it before making a critical decision.
- Mediating professional disagreements among DSHS workers and between DSHS workers and other service providers to prevent the disagreement from delaying a critical DSHS decision and to ensure that the final decision is reasonably consistent with acceptable standards and practices.
- Sharing the Ombudsman's investigation findings and analysis with DSHS supervisors or higher-level agency officials to persuade them to correct a decision or course of action that the Ombudsman has determined is problematic.

The Ombudsman is often successful in resolving legitimate concerns by taking action.

The Ombudsman acts to:

- Prompt DSHS to take a "closer look."
- Facilitate information sharing to ensure all pertinent information is considered before critical decisions are made.
- Mediate professional disagreements to avoid delay.
- Share the Ombudsman's investigation findings and analysis with DSHS to correct a decision or course of action.

Through these actions, the Ombudsman is often successful in resolving legitimate concerns about the safety of a child or the well being of a parent or child.

Prompting DSHS to Take a Closer Look

In the course of a complaint investigation, the Ombudsman may identify a concern that has not been fully investigated or addressed by DSHS. When this occurs, the Ombudsman brings the concern to DSHS's attention so that it may receive further investigation and evaluation.

Child Protective Services Initiates Child-Safety Check

A public health nurse contacted the Ombudsman, expressing concern that DSHS Child Protective Services (CPS) was not taking sufficient steps to protect four children living at home, ranging in age from nine months to 11 years.

The nurse told the Ombudsman that the children's mother had been arrested and incarcerated on an alcohol-related offense, and that the children had been left in the care of three teenagers.

She expressed concern that the teens were not responsible caregivers, as they had reportedly been kicked out of their own homes and were not attending school.

The nurse described the children's home as filthy, and reported that the children had head lice and the 11-year old girl was sharing a bedroom with a 16-year old male.

She said that CPS had investigated her report, but was refusing to take protective action because the children did not appear to be at imminent risk. The Ombudsman initiated an emergent investigation.

During this process, the Ombudsman confirmed the nurse's account and found that both CPS and the police had investigated the situation several days earlier, but decided not to take protective action.

At that time, the mother had been out of the home for 48 hours. The Ombudsman contacted the CPS caseworker and her supervisor to discuss the report.

During the discussion, the Ombudsman suggested that CPS contact the police to request a child-safety check to determine whether the mother had returned home and to re-assess the children's situation.
The CPS caseworker agreed and went to the home the next day with a police officer.

They found that the mother had still not returned and there had not been any improvement in the children's circumstances.

The children were placed in protective custody, and CPS filed a dependency petition seeking legal custody.

Prompting DSHS to Take a Closer Look *(continued)*

The Ombudsman's ability to prompt DSHS to more closely scrutinize issues of concern has helped the agency avoid potentially harmful oversights and errors.

Child Welfare Services Initiates Child-Safety Check

An aunt filed a complaint with the Ombudsman alleging that DSHS Child Welfare Services (CWS) was refusing to reunite the aunt's three-year-old niece with her mother, despite the fact that the girl's six-year-old brother had been reunited with their mother several months earlier.

The aunt objected to the inconsistencies in CWS's case plans for each child and believed there was no good reason for the three-year-old girl not to be returned home, as her mother had complied with all court-ordered services, the girl was having unsupervised weekend overnight visits with her mother, and the six-year-old boy appeared to be doing well in his mother's care while under CWS supervision.

After investigating the aunt's complaint, the Ombudsman determined that CWS's refusal to reunite the three-year-old girl with her mother was authorized and reasonable.

The Ombudsman found that the child had recently returned from weekend visits home with bruises and injuries (including black eyes), and she reported seeing the mother's previous boyfriend at her mother's home and attributed the bruises to him.

The mother's previous boyfriend had a criminal conviction for manslaughter, as well as an untreated history of domestic violence against the mother, and there was a restraining order in place that prohibited contact between him and the children.

Based on these findings, the Ombudsman became concerned about whether CWS was providing adequate protection to the children.

Although the family was receiving family preservation services in the mother's home, providing some level of monitoring, the Ombudsman believed that the agency needed more detailed information about the children's situation, including whether the mother's previous boyfriend was in her home.

The Ombudsman asked CWS to request the police to conduct a child-safety check during the girl's next weekend visit home.

That weekend, the CWS caseworker and the police together made an unannounced visit to the mother's home and found the boyfriend there in violation of the restraining order and the mother's agreement with CWS. The children were returned to their previous foster homes.

Prompting DSHS to Take a Closer Look *(continued)*

Division of Licensed Resources Interviews Group Home Residents about Possible Abuse

A foster parent filed a complaint with the Ombudsman alleging that a six-year-old child had been sexually abused by another foster parent.

According to the foster parent, although the DSHS Division of Licensed Resources (DLR), Child Protective Services (CPS), had received a report that the foster child's foster father had victimized another child, CPS did not interview the child while she was living in the foster father's home to determine whether she may have been abused also.

The Ombudsman investigated and found that DLR/CPS had in fact failed to investigate whether this foster child had also been abused by the foster father, after another child reported being abused by him.

After the six-year-old child left the foster father and was living in a new foster home, she reported that her former foster father had sexually abused her. Her allegations were confirmed by a subsequent DLR/CPS investigation.

The Ombudsman concluded that DLR/CPS's failure to interview the child at the time of receiving the third-party abuse report was a violation of agency policy and procedure.

The Ombudsman found that the agency had actually identified a total of three children who had previously lived in that foster home (including this child), after receiving the report, and had unsuccessfully attempted to contact the other two children.

Instead of interviewing the six-year old, however, DLR/CPS contacted her new foster parent and inquired whether she had noticed any concerns related to the child's possible sexual abuse, and upon hearing no concerns, left it at that. Had the child not later disclosed the abuse, she may never have received the support and treatment she needed (the abuse was quite severe).

The Ombudsman verified that the child was now receiving treatment. In addition, the Ombudsman informed agency officials of DLR's failure to interview the children, so they could take appropriate corrective action, and documented the failure in the Ombudsman's database as a possible systemic problem.

The Ombudsman's investigation also found that the private placement agency that licensed the foster father failed to report to DLR that the foster father had been fired from his job with a children's group home for sexually harassing staff. The Ombudsman verified that DLR had taken appropriate corrective action with the licensing agency for failing to report this information.

In addition, the Ombudsman followed up with DLR/CPS to find out if children who were at the group home at the time the foster father was employed there, had been interviewed to ascertain whether any of them might have been victimized also.

The DLR/CPS supervisor acknowledged that these possible victims had not been interviewed, and agreed to generate a new report for investigation. The agency then interviewed all the young people they were able to locate.

Facilitating Communication and Mediating Professional Disagreements

In the course of investigating a complaint, the Ombudsman may find that the DSHS decision maker lacks pertinent information that is known to other agency workers, family members or local service professionals working with the family. Or the Ombudsman may find that professional disagreement among DSHS workers, or between DSHS and a local service professional, is preventing the agency from taking timely and effective action. *(continued on next page)*

CWS Learns that Mother Favors Grandmother's Visits with Children

A grandmother contacted the Ombudsman with her complaint that DSHS Child Welfare Services (CWS) was refusing to allow her to have contact with her three granddaughters, ages 6, 4 and 3, who were in state custody.

She told the Ombudsman she had called the CWS worker several times to request visits, leaving messages and not receiving any response.

She had not had any contact with the children for over four months. The children had lived with her on and off for long periods in the past, and she stated she and the children had a close relationship.

The Ombudsman informed the grandmother that CWS is under no legal obligation to provide visits between foster children and their grandparents; however, given the close contact the children previously had with their grandmother, the Ombudsman was uncertain whether the agency's actions were reasonable.

The Ombudsman's investigation found that CWS had not documented or returned the grandmother's calls, and also found that agency records indicated that the grandmother appeared to pose no safety risks to the children.

The CWS worker told the Ombudsman she had not discussed the grandmother's request with the children's mother, but believed the mother would not approve based on the mother's troubled relationship with the grandmother.

However, at the Ombudsman's suggestion, the CWS worker contacted the mother to tell her about the grandmother's request. The mother told the CWS worker that the children had in fact been asking about their grandmother and were missing her, and she would be in favor of having occasional supervised visits.

The agency facilitated arrangements for a brief visit with the grandmother as part of a pre-arranged family holiday party, which the children enjoyed.

CWS agreed to consider requests from the grandmother for future visits.

Facilitating Communication and Mediating Professional Disagreements *(continued)*

When this occurs, the Ombudsman acts to ensure that critical information is being shared appropriately and, when necessary, works to mediate professional disagreements. The Ombudsman's ability to impartially facilitate communication and mediate disagreements has enabled DSHS to avoid potentially harmful delays and mistakes.

CWS Abandons Plan to Change Child's Placement

A community service professional contacted the Ombudsman to express concerns about a plan by Child Welfare Services (CWS) to move a 2-year old special-needs Native American child from her placement with out-of-state relative caregivers to a non-relative foster care placement in Washington State.

CWS had placed the child with her out-of-state relatives shortly after she was born, based on allegations of prenatal drug exposure, and the mother's admitted history of drug abuse.

Soon after the child was born, the mother expressed interest in relinquishing her parental rights, and a relinquishment and order terminating parental rights was approved by the court. After the child became legally free, the relative caregivers filed for adoption.

Before the adoption could be finalized, however, the mother successfully petitioned the court to restore her parental rights. The mother also requested that, while she engaged in the process of regaining legal custody, the child be placed in her care, or alternatively that the child be placed in Washington State.

In order to meet its legal obligation to make "reasonable efforts" to reunite the child with her mother, CWS determined that the child must be returned to Washington State and be available to the mother, even if this required removing the child from the only home and caregivers she had known.

Accordingly, CWS developed a plan to return the child to Washington State for an extended visit. During the visit, the child would be placed with a non-relative foster parent, who would assess the extent of the child's special needs and her ability to adjust to a change in her placement. The visit would also provide an opportunity for contact between the mother and child.

The out-of-state relatives opposed the placement change, asserting that the child had been diagnosed with gross motor delay and behavioral problems, including disordered sleep, and sensory integration dysfunction, and that a sudden change in her environment would be traumatic and harmful.

Upon investigation, the Ombudsman found that the child's treatment providers had in fact made this diagnosis and were greatly concerned about the child's ability to tolerate any change in her placement.

The Ombudsman shared this information with the CWS. Because the agency did not possess any information contradicting these concerns, the Ombudsman suggested that CWS either seek a second evaluation of the child (while in her current placement) to verify her condition or pursue reunification in a manner that would avoid the concerns expressed by her treatment providers.

After further discussion with the Ombudsman and other service professionals involved in the case, CWS abandoned its plan to remove the child from her caregivers for an extended visit, and instead provided the mother with extended out-of-state visits, where the child and her relative caregivers reside.

The court decision restoring the mother's parental rights was later over turned, and the child's adoption with her relative caregivers has since been finalized.

Facilitating Communication and Mediating Professional Disagreements *(continued)*

The Ombudsman Takes Steps to Ensure that Disagreement Between DSHS Regions Does not Jeopardize Children's Safety

The uncle of three children, ages 4, 3 and 2, contacted the Ombudsman with concerns about the children's safety and well-being.

Three months earlier, the court had reunited the children with their parents, after the children had spent two years in foster care due to their parents' chronic substance abuse and consequent neglect of their basic needs. The youngest child was born testing positive for methamphetamine.

After the family was reunited, in DSHS Region "A", the parents moved to another area of the state, in DSHS Region "B," where Child Protective Services (CPS) began receiving reports that the parents had relapsed. When CPS contacted the parents to investigate, the parents moved back to Region A, temporarily leaving the children with a distant relative in still another part of the state, in DSHS Region "C".

At this point, the uncle contacted CPS in Region C to express grave concerns, explaining that the distant relative caring for the children had an extensive CPS history.

Region C CPS went to the relative's home and, finding no immediate safety concerns, closed the case. The uncle then contacted the Ombudsman. The Ombudsman immediately contacted Region C. Though aware of the relative's CPS history, Region C did not assess the current risk to the children to be high, and believed that the parents had a right to place their children with a relative.

The Region C supervisor told the Ombudsman that Region B had been consulted and did not have concerns about the children's current situation. This conflicted with information the Ombudsman found documented by Region B in CAMIS (CPS's automated case management system.)

The Ombudsman contacted CPS supervisors in Regions A and B to obtain their assessment. Both expressed extreme concern about the children's safety, based on the parents' and the current relative caregiver's history.

The Ombudsman was puzzled by Region C's non-emergent response, especially since Regions A and B indicated they would respond immediately if the children were residing in their catchment areas.

When the Ombudsman again contacted the Region C supervisor to share the concerns expressed by the other regions, the supervisor said she would request the family's file from Region A and conduct her own case review.

The Ombudsman believed this delay would create unnecessary risk of harm to the children, having determined there was sufficient information documented on CAMIS to warrant immediate protective action. The Ombudsman therefore began contacting higher-level DSHS officials in an effort to mediate the disagreement between the regions regarding the level of safety risk to the children.

At the same time, the Ombudsman was informed by the uncle that the parents had discovered that the extended family was trying to gain custody of the children through family court, and had abruptly taken the children from Region C to an undisclosed location in Region A.

The Ombudsman encouraged the uncle to report this development to CPS. The Ombudsman then contacted the CPS supervisor in Region A to make sure she was aware of the uncle's report. Region A assessed the uncle's report as warranting an emergent response, based on the parents' CPS and police history and their moving of the children from one region to another apparently to avoid CPS or other outside intervention. Region A made immediate efforts to locate the family.

Shortly afterward, the children's father was arrested when the police found a mobile methamphetamine lab in his car. The children were taken into protective custody and placed with their extended family.

Inducing DSHS to Correct Mistakes

Upon completing an investigation and analysis, the Ombudsman may determine that DSHS has acted in a manner that is outside of the agency's authority or clearly unreasonable, and that the act is harmful to a child or parent. When this occurs, the Ombudsman contacts high-level agency officials to share its findings and analysis and prompt them to review and correct the error.

CPS Returns Children to Mother's Care

A mother contacted the Ombudsman with concerns regarding a stalemate she had reached with Child Protective Services (CPS) regarding the voluntary placement of her children with their grandparents.

The mother had entered into a voluntary placement agreement (VPA) with the agency six months previously, whereby her two children, ages 13 and 11, would be cared for by their grandparents while she completed substance abuse treatment. Per law and policy, VPAs are valid for 90 days, and can be extended for another 90 days by agreement of both parties; the VPA in this case had therefore expired.

After successfully completing a three-month in-patient treatment program, the mother was asked by CPS to leave the children with their grandparents while she continued to attend out-patient treatment to maintain her sobriety. CPS wanted her to demonstrate two months of sobriety and continued treatment.

The mother had complied with this request, and now wanted her children returned. She told the Ombudsman that CPS was resisting this, and that the CPS caseworker was not informing her of her rights, given that no new agreement had been entered into. She was afraid of veiled threats she perceived that CPS would remove her children from her if she took them back home without their approval.

The Ombudsman's investigation of her case validated the information she provided. CPS told the Ombudsman that it had concerns about the children returning to live with their mother due to the chronic nature of her substance abuse history; however, the agency also acknowledged that it did not have a sufficient basis upon which to file a dependency petition on the children.

The Ombudsman determined that the agency was violating law and policy by delaying reunification of the children with their mother despite expiration of the VPA, by failing to inform the mother of her legal rights, and by not allowing her to address CPS's concerns through the legal process of a dependency hearing.

The Ombudsman contacted the CPS supervisor and shared these findings. The agency subsequently allowed the mother to take her children back into her care, and she agreed to enter into a voluntary service agreement with CPS, which required the mother to continue participation in outpatient treatment services for 90 days.

This agreement helped to allay the agency's concerns about the children's welfare. CPS continued to monitor the children's safety and the mother's progress, and closed the CPS case four months later.

Inducing DSHS to Correct Mistakes *(continued)*

The Ombudsman's ability to induce DSHS to correct errors has helped the agency to avoid or mitigate any harm to children and families resulting from its mistakes. It has also led to improvements in agency practices.

CPS Reverses Decision to Leave Children in Parents' Care

A program director for a preschool program contacted the Ombudsman, requesting an immediate investigation of her concerns about the safety of two siblings, ages two and three years. The three-year old had recently alleged incidents of serious physical abuse at home.

Child Protective Services (CPS) was already involved with the children's family due to a previous report alleging neglect/lack of supervision, and a more recent report alleging physical abuse of the three-year-old by the step-father and failure to protect by the mother.

At a Child Protection Team (CPT) staffing, several local service professionals involved with the family expressed concerns for the children's safety in this home, citing the children's young age, the step-father's history of violence, lack of impulse control, and anger issues, as well as the mother's and step-father's alleged prior methamphetamine use.

The CPT recommended that CPS file a dependency petition in court seeking to place the children in protective custody outside of their parents' home. However, CPS did not remove the children from the home, as recommended by the CPT.

Instead CPS entered into a voluntary service agreement with the parents, which required the parents to participate in services while the children remained in the home.

When the Ombudsman contacted CPS, the supervisor explained that the agency was satisfied that the children were not at imminent risk of harm.

However, a short time later, the CPS supervisor informed the Ombudsman that the mother and step-father had violated the terms of the service agreement and that CPS was now planning to file a dependency petition.

However, CPS was considering an *in-home* dependency, which would provide court authority and oversight for required services, but would allow the children to continue living with their parents.

The Ombudsman determined that the CPS supervisor was in violation of agency policy and procedure, as he had failed to seek review or approval from the DSHS area manager or regional administrator of his decision to disregard the CPT's recommendation to remove the children from their home.

Additionally, the Ombudsman determined that in light of the seriousness of the physical abuse described by the child and the presence of other risk factors , CPS's decision to leave the children in their home was not reasonable.

The Ombudsman contacted the DSHS area manager to express concern about the ongoing risk to the children if they remained in the home, and shared its conclusion that CPS was violating agency policy and procedure by failing to implement or formally reverse the CPT's recommendations. The area manager concurred with the Ombudsman's findings.

Without further delay, CPS obtained a court order to place the children in foster care and filed a dependency petition, in accordance with the CPT's recommendations.

Inducing DSHS to Correct Mistakes *(continued)*

CPS Reverses Finding of Parental Child Neglect

A parent contacted the Ombudsman after losing her job at a child care center, when the center learned that she had a finding of child neglect on her Child Protective Services (CPS) record.

This came as a rude shock to the parent, who stated she was unaware of the finding, although she was aware of the CPS investigation that had been conducted over three years ago.

The parent wished to appeal the findings, as she felt they were unreasonable. She had talked to several DSHS workers to explore what her options might be, as the time period in which a parent must appeal CPS findings once notified, was long gone. She was unable to obtain the answers she needed, or any suggestions for resolution of her situation.

The Ombudsman investigated her concerns and found that CPS had sent a certified findings notification letter to the parent, as required by law and policy. However, it seemed plausible that the parent might not have received the letter, given her situation at the time.

But more important, after reviewing the CPS investigation, the Ombudsman determined that the finding of neglect was clearly unreasonable, based upon the facts established during the investigation.

Furthermore, there was no prior CPS history on the family except for an "information only" report in 1991, which did not suggest any abuse or neglect on the part of the parent. For these reasons, the Ombudsman requested a review of the findings by the DSHS Area Administrator.

This review resulted in the administrator's decision to change the finding. The parent no longer has a founded record of child neglect, and can resume her work in the child care field.

After Acknowledging Error, DSHS Takes Positive Steps to Prevent Future Mistakes

An administrator for a county juvenile court and detention facility contacted the Ombudsman, complaining that CPS's Central Intake Unit had failed to respond appropriately to a youth in need of placement.

Despite several hours of effort, detention staff was unable to locate a parent or responsible adult for a 16 year-old youth who was to be released from detention.

The detention supervisor then contacted CPS Central Intake, as the facility could not hold the youth in a secure facility, nor could it simply release him without a parent or guardian. The CPS intake worker refused to respond and told the detention supervisor to call the police.

The Ombudsman's investigation confirmed the court administrator's account. The Ombudsman determined that CPS Central Intake had violated state law and agency policy by not investigating an allegation that no parent was available to care for a child. The Ombudsman then contacted DSHS officials in Olympia to share the office's findings and analysis.

The officials agreed that CPS Central Intake should have accepted this report, and a CPS worker should have been assigned to interview the youth and determine an appropriate CPS response.

The officials also contacted the administrator for the county juvenile court and detention facility and offered to meet to further discuss the issue and clarify CPS's role in cases in which a youth being released from detention does not have a parent or responsible adult to live with. The DSHS officials also agreed to clarify with CPS Central Intake staff that such reports should be accepted and assigned to a CPS investigator.

Inducing DSHS to Correct Mistakes *(continued)*

DSHS Uses Mishandled Case as a Teaching Tool

By way of a news report, the Ombudsman became aware of a family involved in a serious domestic violence incident involving the discharge of a firearm near the family's young children.

The Ombudsman initiated an investigation to determine whether Child Protective Services (CPS) was made aware of the incident by the police and had responded appropriately. The Ombudsman learned that following the domestic violence incident, the police placed the family's children into protective custody and then made a report to CPS.

After a preliminary assessment of the situation, CPS returned the children to the non-offending parent, after having establishing a safety plan with that parent. At the end of its investigation, CPS closed the case.

Through a review of CAMIS (DSHS's automated case-management system), the Ombudsman also learned that the family had been the subject of 16 CPS reports in the previous 21 months. These reports had all either been categorized by CPS as "information only" (because CPS determined that the allegations in the report did not meet the legal definition of child abuse or neglect) or assessed as being a low-risk, meaning that no CPS investigation was required.

Allegations screened out as "information only" included reports of a black eye observed on a three-year-old, choking and hitting an 8-year-old on the head, leaving a bruise, the parents not protecting the children from sibling abuse, domestic violence in the home, the mother hitting the children, and the mother having a CPS record in three other states.

Allegations assessed as low risk and referred for preventive services included reports of lack of supervision by the mother and the father's firing of weapons inside the home. Only the last report of domestic violence and the use of a firearm was assessed as warranting a full CPS investigation.

Upon reviewing CPS's assessment decisions, the Ombudsman became concerned about the agency's decision to release the children to the non-offending parent prior to the completion of the CPS investigation, and without a more structured and comprehensive safety plan for the family. These concerns were based upon:

- The agency's awareness that the parents had a CPS history in other states and had fled one state apparently to avoid removal of the children due to findings of physical abuse.
- The nature and extent of the parents' CPS history in this state in the past two years, including allegations of physical abuse by the non-offending parent.
- The level of violence the children witnessed in the latest domestic violence incident.
- Reported substance abuse by the offending parent.
- The young ages of the children, and the fact that at least three of them were identified as developmentally delayed, increasing their vulnerability.
- Ongoing concerns regarding the children's safety that had been reported by multiple local service professionals in contact with the family.

The offending parent had already been released from jail when the children were returned to the non-offending parent. The family immediately left the state.

Because of the concerns about the management of this case, the Ombudsman contacted DSHS Children's Administration (CA) headquarters with a request for the agency to conduct a full case review and address the practice concerns identified.

The Children's Administration agreed and assigned two senior staff to review the file and interview workers involved in the case. The review was broad in scope and specific in its identification of both strengths and problems in the management of the case.

The final report, which was shared with the Ombudsman, was thorough and informative, and presented several recommendations for practice changes based upon the six major findings of the review. The Ombudsman was informed that this review would be used by the DSHS Child Welfare Training Academy to educate caseworkers and strengthen caseworker practice.

IMPROVING THE SYSTEM

The Legislature charged the Ombudsman with facilitating improvements to the child protection and child welfare system. After complaint investigations, the activity the Ombudsman spends the most time on is identifying and investigating system-wide problems. The Ombudsman's findings and system-improvement recommendations are published in public reports to agency officials and state policymakers.

To avoid duplicating other system-improvement efforts and target its limited resources to the issues of most importance to parents and children, the Ombudsman has developed specific criteria for selecting systemic issues for investigation. The Ombudsman employs these criteria when determining what kind of investigations to undertake.

The Ombudsman gives priority to systemic issues that impact a child or family's

- **Safety;**
- **Well-being; or**
- **Permanence.**

The Ombudsman criteria give priority to systemic issues that appear to have a significant impact on the safety, well-being or permanence of children and/or their families, and have been:

- Identified as a pattern or trend in complaints filed with the Ombudsman, and have not been adequately addressed by another agency;
- Identified as a concern, but have not been adequately investigated or addressed by another agency, and the Ombudsman's unique features (independence, neutrality, access to confidential information, cross-system perspective) would make it effective in evaluating the issue and/or;
- Assessed as being "invisible" because they are unlikely to be raised in complaints or concerns brought to the Ombudsman's attention (e.g., inadequate child fatality reviews).

This section summarizes the systemic investigations conducted by the Ombudsman since the office became operational in 1997. It describes the Ombudsman's findings and recommendations and how they were used by agency officials and state policymakers to improve the child protection and child welfare system.

Promoting Access to DSHS's Complaint Resolution Process and the Ombudsman

In 1997, the Ombudsman determined that the DSHS Children's Administration was not complying with state law requirements directing it to inform clients about the agency's complaint resolution process and how to access it. The Ombudsman found that DSHS caseworkers did not receive training on the agency's complaint resolution process and rarely informed clients about their rights or the procedures for pursuing a complaint against the agency, including their right to contact the Ombudsman.

The Ombudsman recommended that DSHS:

1) Provide clients (including young people age 12 and older) with concise written information outlining their rights and the procedures for filing a complaint under the agency's complaint resolution process, and their right to contact the Ombudsman, and;

2) Train workers on their duty to inform clients about the agency's complaint resolution process.

In response, DSHS:

1) Developed a new complaint brochure and "Clients Rights" poster that describes the agency's complaint process and how to contact the Ombudsman;
2) Developed an informational brochure for foster youth age 12 and older that includes information on their rights as a foster child and how to contact the Ombudsman and;
3) Incorporated information on the agency's complaint process, including the role of the Ombudsman, into the Child Welfare Academy's basic training curriculum.

Since these steps were implemented in 1999, the number of individuals filing complaints who said they were referred to the Ombudsman by a DSHS worker has increased by 20 percent.

Tightening School District Compliance with Mandatory Reporting Law

In 1998, the Ombudsman surveyed 130 school districts on their policies and procedures for reporting suspected child abuse and neglect. State law requires professional school personnel who have reasonable cause to believe that a child has suffered abuse or neglect to report the incident, or cause a report to be made, to the police or Child Protective Services (CPS). Failure to make a mandated report is a criminal offense.

The Ombudsman's survey was prompted by the confusion it encountered among teachers and other professional school personnel about their legal duty to report suspected child abuse and neglect. Many school personnel told the Ombudsman that school district policy required them to report abuse and neglect concerns to the principal, and not to the police or CPS. In addition, in the course of several complaint investigations, the Ombudsman had noted instances where a teacher's reasonable concern about a child's possible abuse had not been reported to the police or CPS.

The Ombudsman found that the policies of 47 of the 130 school districts surveyed did, in fact, require school personnel to report their concerns to the principal or other school official, who was then authorized to decide whether a report should be made to the police or CPS. The Ombudsman concluded that the policies not only were inconsistent with state law, but they also subjected school personnel to potential criminal liability if a mandated report was not made.

The Ombudsman recommended that 1) local school districts review their reporting policies to ensure that they are in compliance with the state's mandatory reporting law, and 2) school districts adopt the model reporting policy and procedure developed by the Washington State School Directors Association (WSSDA). In response, the WSSDA published the Ombudsman's findings in the WSSDA *Policy News* for school board members and advised that school districts modify problematic policies. The WSSDA also provided school districts with the model reporting policy recommended by the Ombudsman for adoption.

Improving CPS Child Sexual Abuse Interviews and Investigations

In December 1998, the Ombudsman completed its review of the involvement of DSHS case workers in the 1994-95 Wenatchee child sexual abuse investigations.

The Ombudsman's review was prompted by concerns that alleged child sexual abuse perpetrators and victims had been improperly questioned in joint interviews with Child Protective Services (CPS) and the police. The techniques allegedly employed by CPS and the police in eliciting statements from suspects and alleged child victims had become the focus of intense and enduring controversy.

The Ombudsman's review was the first full-scale independent review of the Wenatchee investigations by a government agency. It was undertaken to determine whether new or stronger safeguards were needed to protect children who are the subject of CPS investigative interviews and to ensure that possible child victims are provided with appropriate mental health services.

The Ombudsman's 6-month investigation encompassed the review of thousands of pages of documents and scores of interviews. In its final report, the Ombudsman noted that the sexual abuse allegations made by children had progressed over time from allegations commonly made in sexual abuse cases (e.g., abuse of a child by a single family member or friend) to allegations that are uncommon in sexual abuse cases (e.g., organized and systemic abuse of many children by community members).

Because the CPS interviews were not well enough documented, the Ombudsman could not determine whether the uncommon allegations occurred, as some of the children alleged, or something went wrong during the investigative process, resulting in factual distortions. The report described documented and alleged events that illustrate investigative errors that experts agree can increase the possibility of factual distortion.

The Ombudsman made three major recommendations for improving CPS child sexual abuse investigations. They were incorporated into state law by the 1999 Washington Legislature.

Interview Documentation. The Ombudsman recommended that CPS caseworkers be required to document child interviews in a verbatim or near-verbatim manner that captures which questions are asked, in what order, and the exact answers given to the questions. The Legislature placed this requirement in state law and also directed the Children's Administration to establish three pilot sites that rely on different methods and techniques for conducting and preserving the interviews of child sexual abuse victims. An independent evaluation of the three sites concluded that audio-taping was the most practical interview documentation method. DSHS plans to begin audio-taping child interviews this year.

Specialized Sexual Abuse Investigator Training. The Ombudsman recommended that DSHS be required to provide CPS caseworkers with specialized training in interviewing techniques. The Legislature extended the Ombudsman's recommendation to require that all persons responsible for investigating child sexual abuse allegations, including the police, prosecutors and CPS workers, receive ongoing specialized investigative training, including training on child interviewing techniques. State law now requires child sexual abuse investigators to receive specialized training.

Protocols for Child Sexual Abuse Investigations. The Ombudsman recommended that local jurisdictions be required to establish collaborative cross-discipline protocols to coordinate and guide the activities of law enforcement and other professionals involved in criminal child abuse investigations. The Legislature placed this requirement in state law and directed that each county have its protocol in place by July 1, 2000 and that each protocol must be consistent with state guidelines.

The Ombudsman found that approximately one third of Washington children involved in child abuse and neglect proceedings did not have a guardian ad litem.

Increasing Guardian ad Litem (GAL) Representation

In 1999, the Ombudsman issued a report on the lack of guardian ad litem representation for children in child abuse and neglect court proceedings.

The Ombudsman's report was prompted by the significant number of complaints received by the office in which the affected child was reported as having no one to represent his or her best interests in court.

The federal Child Abuse Prevention and Treatment Act (CAPTA) requires states that receive CAPTA grants to certify that the state has in effect, and is enforcing, a state law providing the appointment of a GAL to represent the child's best interest in judicial proceedings involving issues of child abuse or neglect.

The Ombudsman found that Washington State was receiving about $1.25 million per biennium in CAPTA grants and had made the required certification.

However, in a state-wide study, the Ombudsman found that approximately one-third of Washington children involved in child abuse and neglect proceedings did not have a GAL to represent them in court.

Over one-half of the children involved in proceedings in King, Snohomish and Spokane counties did not have a GAL during the time period under study. The Ombudsman also found that children in three counties were being served by GALs with individual caseloads ranging from 90 to 400 children.

Based on these findings, the Ombudsman recommended that the number of GALs be increased to a level that is sufficient to ensure appointment for all children who are involved in a child abuse and neglect proceeding.

The Ombudsman also recommended that state law be amended to clarify that a GAL shall be appointed to represent the best interest of every child involved in a child abuse and neglect court proceeding.

In response, the 1999 Legislature appropriated $1 million for the FY 1999-2001 biennium for additional volunteer court-appointed special advocate (CASA)/GAL representation.

This appropriation was the state's first major expenditure for volunteer CASAs/GALs for children, which it has continued to maintain.

The Ombudsman found that Washington is one of only five states in which the statutory definition of child neglect specifies that the risk of harm to a child must be imminent.

Highlighting Chronic Child Neglect

In 2000, the Ombudsman issued a report recommending that the Legislature modify the state law definition of child neglect. The recommendation was based on earlier Ombudsman reports, which identified DSHS's failure to timely intervene in chronic child neglect cases as a major concern.

While reviewing case files in the course of investigating complaints on other issues, the Ombudsman found that Child Protective Services (CPS) often screened out reports of child neglect without an investigation.

The problem was illustrated by the tragic death of a 7-year-old boy in a lake while he was playing unsupervised with his brother and several other children. The boy and his brother had been the subject of 19 reports to CPS, many from local service professionals expressing concern about the boys' speech delays, the mother's mental instability, and her persistent failure to provide the boys with appropriate care and supervision. CPS screened out 14 of the 19 reports without an investigation.

According to CPS, reports of child neglect were often screened out because the specific parental act or omission alleged in the report did not meet the state law definition of neglect, i.e., did not constitute a "clear and present" danger. Thus CPS often did not investigate a neglect report despite being aware of a documented pattern of neglectful conduct indicating that a child could be at risk.

In addition, the Ombudsman learned that CPS workers were being advised by assistant attorneys general that clear evidence of a neglectful act resulting in imminent danger was required to justify the filing of a petition in court to compel parental participation in services or remove the child. Consequently, CPS workers felt that until they had such evidence, they had no option but to pursue less aggressive interventions.

Further, the Ombudsman found that Washington is one of only five states in which the statutory definition of child neglect specifies that the risk of harm to a child must be imminent.

Based on these findings, the Ombudsman recommended that the statutory definition of child neglect be modified to clarify that neglect may result from an act or omission, *or pattern of conduct*, that constitutes a *substantial* danger to the child's health, welfare or safety. The Ombudsman also recommended that courts be allowed to consider the cumulative harm suffered by a child in determining whether a child shall be deemed a dependent of the state.

(Continued on next page)

In response, the House of Representatives established an interim Child Neglect Workgroup to study the issue further and develop policy and practice recommendations. The Workgroup was comprised of legislators, agency officials, child and family advocates, local service professionals, guardians ad litem, attorneys, and judges.

The Workgroup made several recommendations, including one to modify the definition of child neglect. Prominent newspapers, including the *Tacoma News Tribune* and the *Seattle Post-Intelligencer*, editorialized in favor of the change, citing the Ombudsman's report. Subsequently, the House approved legislation modifying the definition of child neglect. When the Senate failed to approve the legislation, House legislators indicated they would continue to push for its passage.

In addition, DSHS implemented changes in the agency's practices as part of its *Kids Come First Action Agenda.* The agency implemented a new risk assessment tool to identify serious risk for child abuse and neglect in families, adopted new practices to assist families on public assistance with chronic neglect issues, and established criteria for an automatic review of chronic neglect cases when a certain number of reports have been received by CPS. Further, the Office of the Attorney General provided assistant attorneys general in the Juvenile Practice Section with intensive training on chronic child neglect issues.

Addressing Biased Decision-making

In 2000, the Ombudsman reviewed the confidential DSHS case records of three-year-old Zy'Nyia Nobles and her family. Zy'Nyia died at home the previous month. Her mother was subsequently convicted of homicide by abuse. Zy'Nyia and her older brother were dependent and had been living in foster care since February 1997. DSHS Child Welfare Services (CWS) returned the children to their mother in February 2000, and the family remained under CWS supervision.

The Ombudsman conducted the case review to learn why the children had been returned to their mother and to determine what services had been in place to support the family and monitor the children's safety. Zy'Nyia's death was also reviewed by a Community Fatality Review Team convened by DSHS. The Team included community professionals, legislators and others.

At the Team's first meeting, the Ombudsman presented its completed investigation summary and identified several issues of concern. The Ombudsman asked the Community Fatality Review Team to consider the identified issues during its review of Zy'Nyia's death.

An issue of major concern identified by the Ombudsman was that of "decision maker bias." Decision maker bias occurs when a case worker develops an initial belief about a person or event and then becomes resistant to altering that belief, even in the face of conflicting information.

The Ombudsman found that the CWS case worker who made the decision to return the children to their mother appeared to have developed a strong bias in favor of the mother. At critical times, the worker appeared to assume the role of the mother's advocate.

This was demonstrated by the worker's decision to return the children to the mother's care without first addressing documented concerns about her mental health and parenting capacity or her repeated failure to comply with court-ordered services. It was also demonstrated by the inaccurate and incomplete information presented by the worker to the Child Protection Team (CPT) and the court.

The information presented by the worker tended to omit and minimize troubling concerns about the mother's mental health and parenting capacity. This undermined the CPT and court's oversight function. The Ombudsman highlighted this dynamic in its investigation summary and asked the Fatality Review Team to consider how the system can better protect against case worker bias.

When the Community Fatality Review Team issued its report, case worker bias was the central feature. The Fatality Review Team made several recommendations aimed at strengthening objectivity in case work decision making and improving the use and effectiveness of CPTs. Several of the Team's recommendations were subsequently included in the DSHS *Kids Come First Action Agenda.*

The Agenda provided new statewide training designed to strengthen "objective decision making" by case workers and supervisors. It also included new requirements for documenting decisions, which were intended to promote and support objective decision-making.

In addition, the Agenda included a provision to improve the use of CPTs by training case workers and CPT members on the use of CPTs, clarifying expectations, providing new tools to enhance CPT effectiveness, and tracking CPT performance.

Discovering What Young People Say is Working Best in Foster Care

In 2000, the Ombudsman initiated an innovative project aimed at learning what is working best in the foster care system. The state's foster care problems are well known. In contrast, the system's strengths have received little attention or study.

The project was greatly influenced by a system-change approach called Appreciative Inquiry. This approach is based on the premise that positive systemic change can be achieved by identifying what works and focusing energy on doing more of it. It was also based on the belief that young people in foster care have the most to teach adults about what in the system is working well and matters most to them.

The Ombudsman interviewed 32 young people, ages 11 to 17 years old, residing in licensed family foster homes. The young people were asked several open-ended questions about their most positive experiences in foster care. (See side bar.) They were also asked for their ideas on how to make their experiences in foster care the best they could be.

After synthesizing all of the stories and ideas elicited through the interviews, the Ombudsman identified three prominent themes that reflected the participants' collective perspective on what is working well and matters most to them.

The Ombudsman asked foster youth these questions:

1. During your time in foster care, you have probably had some tougher times and some better times. For now, I'd like you to remember one of the really good times you've had. It might be a particularly good day or week, or any time when things were going really well for you. Of it might have been a great talk you had with someone; or any time you remember being really special – a time when you felt really good and happy.

2. Think about a time while you've been in foster care when you felt really taken care by an adult. This could have been a time when someone was really kind or caring, or a time when someone listened to you or helped you get what you wanted.

3. Think about a time while you've been in foster care when you felt really taken care of by an adult, who seemed to just understand what you wanted or needed without you even asking.

4. This next question is an important question for most people and you may need a moment to think about it. It can be a great feeling to be accepted, included in things. Think of a time during your foster care experience when you felt a part of things. This could be a person who made you feel accepted or a part of a group where you felt included.

5. Now I would like you to think for a moment about your own strengths and gifts. Specifically, I'd like you to remember a time that you went after something you wanted. It might have been something big or something quite small. Anyway, there was something that you realized was important to you, and you said to yourself, "Go for it," and as a result, you made something good happen for yourself.

Feeling like a regular part of the family.

"When I got here it felt … like a normal family. There were four kids and two adults. I feel very accepted and included now in my foster home. I am treated like a member of the family. They don't treat me different.

For example, if I do something special, like I was in a play last summer, they didn't all show up to come and see me in the play. Whoever could make it came to see me, and I liked it that way because that's the way it would be for any other family member."

"Holidays, Christmas, birthdays – my foster family always includes me. ***Even if I'm in a bad mood I get included.*** *I am included and part of everything. When we have a family picnic, I don't know everyone, but everyone acknowledges that I'm part of the whole scheme. All the relatives just accept me as family."*

Feeling cared about.

"I grew up taking care of myself. ***The most I've ever felt taken care of by an adult is here****. Just little things make a difference, like [my foster mom] noticed my new pants and asked if I wanted to get my pants hemmed."*

"My foster mother had six foster kids in her home. She would buy us all our own toiletries, shampoo and deodorant and things, and she would put our name on the things so it was just for us.

It's the only foster home I've been in where we didn't have to share things like that…"

"My foster mother walked me to my class the first day of school and introduced me to my teacher. She talked to him for awhile and made it easier than I thought it would be. New schools are always hard. I was worried, but things turned out OK."

"I wanted to be in football, and my [foster] dad helped me so I could do it. He said anything I needed, he would help me with it. I knew I would have to practice a lot. I told myself to just do my best and try to get it. I had a lot of help. My PE teacher let me run laps during PE, so I could catch up on my speed. My coach let me stay after practice, and he helped me with my passing, blocking and my speed. My [foster] dad picks me up because I miss the bus since I stay so late after school. He picks me up, and he helps coach me, and just helps me."

Feeling like my opinions matter.

"[My guardian] really helped me to get off my meds. I was on a bunch of different meds since I was about four years old, for ADD, ADHD, and the meds had lots of side effects. Like I would get migraines and an upset stomach.

I had been asking for years to go off the meds, and no one listened to me. They would just change my prescription. But the side effects never went away. At first, [my guardian] told me I had to take meds, but then ***he supported me*** *and told the case worker and everyone else to take me off my meds, which they did. It was kind of cool that he stood up for me. I've been off my meds now for six or seven months."*

"My foster parents have a second house in Ocean Shores, and they thought about moving there. [My foster mom] asked me if it was okay with me if we moved and, if it was, she told me to give her five reasons why it would be good to move. Before, my mom moved all the time, and I never had any input. I had to change schools every year. [My foster mom] wanted everyone on board if we decided to move."

The appreciative interviews were a powerfully rewarding experience for the Ombudsman interviewers.

The interviewers came out of the process with a renewed sense of the individuality, vulnerability, resilience and awareness of the young people in foster care.

In addition, the interviewers were moved by the ***utter simplicity of their best experiences and wishes*** and by the unexpected commonalities and coherence in what young people said matters most to them.

The Ombudsman recommended that the DSHS Children's Administration convene a large cross-section of key participants in the foster care system, including young people, in an "Appreciative Summit." The purpose of the summit would be to engage participants in a mutual discovery of what's working best in the foster care system and to design specific ways to replicate and amplify these successes throughout the system.

DSHS did not convene a summit, as the Ombudsman recommended. However, since publishing its report on the project, the Ombudsman has been contacted by DSHS, along with several child welfare advocates across the country, who wanted to learn more about this positive approach to large-scale change and discuss other potential applications in the child welfare system. In addition, DSHS expressed interest in using the Ombudsman report as a component of its foster parent recruitment and training efforts.

Strengthening Student Safety at the Washington School for the Deaf

In 2001, the Ombudsman completed an investigation of student-on-student sexual abuse at the residential Washington School for the Deaf (WSD). The Ombudsman's review was prompted by student safety concerns raised by WSD parents at a special legislative hearing.

The purpose of the Ombudsman's review was to develop an accurate understanding of the nature and extent of sex-related incidents that had been reported to school authorities and to identify systemic or practice issues regarding the response to these incidents by WSD, Child Protective Services (CPS) and law enforcement.

The Ombudsman's investigation encompassed documented reports of sex-related incidents involving WSD students during the 1995-96 through 2000-01 school years. Ombudsman investigators reviewed written incidents reports and tracked the responses of WSD, CPS, and the police.

The Ombudsman's final report noted that WSD's incident documentation and record-keeping system was inadequate to allow Ombudsman investigators to reliably identify every report of alleged student-on-student misconduct at WSD.

However, working with the records available to it, the Ombudsman counted 121 reports of serious incidents of student sexual misconduct during the six-year period under review. Further, the Ombudsman determined that 11 "repeat perpetrators" were responsible for 62 percent of the reports.

All of the repeat perpetrators had severe behavioral and/or mental health issues. Despite their serious and chronic behaviors WSD continued to enroll and serve these students.

Because the school lacked the resources necessary to meet the needs of these students, their sexual aggression continued and led to the ongoing victimization of other students. The Ombudsman found that WSD's responses appeared to result in a culture that tolerated sexual aggression and victimization.

Finally, the Ombudsman determined that Child Protective Services (CPS) was unable to facilitate necessary safety improvement at WSD in part because it lacked formal authority to compel the school to address identified safety deficiencies and concerns. The Ombudsman made several recommendations for strengthening student safety at WSD.

One of these called for the WSD to obtain expert consultation on sexual aggression and victimization issues to assist the school in identifying sexually aggressive students, improving staff awareness and understanding of sexual aggression and victimization, and developing a protocol for assessing and addressing the needs of student victims.

The school implemented this recommendation in the process of implementing Governor Gary Locke's safety directive (The Governor's directive included a provision directing the school not to admit sexually aggressive students.)

The Ombudsman also recommended a change in state law to formalize and strengthen CPS's oversight role at WSD. The 2002 Washington Legislature responded by providing CPS with statutory authority to investigate and follow up on safety-related deficiencies and concerns at WSD.

Supporting Relative Placements for Children

In 2002, the Ombudsman participated in a work group established by the Legislature to develop policy options for strengthening and supporting relative and kinship placements for children under the state's care.

The Kinship Care Workgroup was convened by DSHS and met over a period of several months. The Workgroup examined a variety of barriers faced by relative and kinship caregivers, including caregivers' financial needs, legal issues, and ability to access social services.

The Ombudsman provided the Kinship Care Workgroup with the perspectives and needs of relative and kinship caregivers who had contacted the office with an inquiry or complaint. The Ombudsman identified common issues and concerns, as well as its own observations about the barriers that appeared to prevent or undermine children's placement with relatives.

The Ombudsman encouraged the Kinship Care Workgroup to address several key issues:

1) Ensuring that DSHS case workers conduct timely and thorough relative searches when placing children outside of their home;
2) Providing relative caregivers with access to the court system to provide information on the child's well being;
3) Improving inter-state communication between agencies when dependent children are placed in a relative's home outside of the child's home state and;
4) Establishing safeguards to ensure that neither child safety nor family preservation is jeopardized in efforts to promote relative placements.

The Kinship Workgroup's final report included several recommendations, including:

1) Development of a standardized, statewide protocol for DSHS case workers to identify possible relative and kinship placements;
2) Establishment of a program to assist relative and kinship caregivers with understanding and navigating the service system for children in out-of-home care; and
3) Implementation of a "Kinship Caregiver's Authorization Affidavit" that would allow caregivers to access appropriate medical and education services.

The Workgroup's recommendations were incorporated into legislative proposals and presented to the 2003 Legislature for consideration.

Strengthening Family Reunification Efforts

The Ombudsman is currently participating on the Dependency and Termination Equal Justice Project.

The 2001 Legislature directed the Washington State Office of Public Defense to initiate the Project in response to troubling statistics indicating that Washington State's family reunification rate is over 30 percent lower than in 1997.

The Project's purpose is to enhance family reunification and permanency for children in state care by designing a statewide program to improve the representation of parents in dependency and termination of parental rights proceedings.

A major portion of the Project's work is being carried out by three subcommittees. Each subcommittee is concentrating on an area that greatly affects the reunification process.

The Legal Representation subcommittee is reviewing the impact of continuances in dependency and termination proceedings, and the correlation between reductions in continuances and achieving earlier permanent plans for children in state care.

The Expert Services subcommittee is examining the provision of expert services, as well as the effectiveness of drug courts, in dependency and termination proceedings.

Under the current system, the majority of expert witnesses in dependency and termination proceedings are obtained through state-contracted providers, and parents rarely have the ability to seek their own expert assessment.

The Ombudsman is participating on the Access to Services subcommittee. State and federal law provide that parents are entitled to receive remedial services, such as drug treatment and parenting classes, to assist them in reuniting with their children.

These laws also require that either family reunification or an alternative permanent placement plan for the child must be established within specific timelines.

This subcommittee is examining parents' ability to access effective remedial services in a timely manner, while also maintaining regular parent-child visitation. As a subcommittee participant, the Ombudsman is highlighting legitimate concerns brought to its attention by parents.

These include DSHS's inability or failure to implement appropriate remedial services in a timely manner and the agency's sometimes unrealistic case plans that fail to prioritize services or allow a reasonable time period for completion.

The Ombudsman is also highlighting the inconsistent efforts by the agency to facilitate meaningful visitation between parents and their children in state care.

The Equal Justice Project will culminate in a published report with its findings and recommendations to judicial leaders and state policy makers.