Activities and Recommendations

Covering the period
through December 31, 2003

Office of the Family & Children's Ombudsman

2003 annual report

STATE OF WASHINGTON

OFFICE OF THE FAMILY AND CHILDREN'S OMBUDSMAN

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November 2004

To the Residents of Washington State:

I am pleased to present to you the 2003 Annual Report of the Office of the Family and Children's Ombudsman. In this year's report we provide recommendations for reforms in the areas of evidence-based assessment and treatment, adolescent services and placement, residential placement options for children with developmental disabilities, relative/kinship care and child protective teams.

Events of the past year dramatically highlight the need for system-wide improvements in our state's child welfare system. Three-year-old Rafael Gomez died after being removed from foster care and returned to the care of his parents while still under the supervision of DSHS. We reviewed the record of DSHS' work with Rafael's family and presented our findings to the Community Fatality Review Team. The review team concluded the most significant factors contributing to his death were the same factors identified in child fatality reviews conducted in 1995 and 2000. This sobering conclusion is that previously recommended safeguards, and system improvements, which could have prevented this tragic death, were not sufficiently implemented.

This year we responded to a record number of complaints. From the myriad of issues presented in these complaints, it is clear there is a need for accountability at all levels of the child welfare system. Only by identifying and challenging failures by the child welfare system to meet its responsibilities will the system measurably improve.

An ongoing mission for our office is to respond to citizens in a meaningful and timely manner while ensuring that we still have the opportunity to consider system-wide concerns. Given sufficient resources in the year ahead, we plan to undertake a study of the process that triggers external child fatality reviews. We also expect increased contact from foster parents as a result of new legislation directing the Ombudsman to respond to complaints from foster parents who believe they have been retaliated against by DSHS.

I want to welcome Uma Ahluwalia, Assistant Secretary of DSHS. In her first year, she has been faced with many challenges. Among these were the results of the Child and Family Services Review (CFSR) by the federal government. This audit concluded that DSHS failed to substantially conform to several standards or outcomes that promote safety and permanence for children. Many of the issues identified by the CFSR have previously been noted by OFCO. The Children's Administration has crafted an initial response to the Federal review. We look forward to our oversight role in monitoring the development and implementation of these reforms and foresee an increase in our workload as we monitor these changes.

On behalf of all of us at the Office of Family and Children's Ombudsman, I want to thank you for your interest in our work. I am grateful for the leadership of our advisory board members, the oversight of the Legislature, and the input of many outside professionals and citizens dedicated to improving the welfare of children and families. We greatly appreciate the opportunity to serve the families, children and citizens of Washington State.

Sincerely,

Mary Meinig

Mary Meinig
Director Ombudsman

Advisory Committee

Western Washington Committee

John Neff, M.D.
Children's Hospital and Regional Medical Center, Seattle

Edith Owen
Relatives Raising Children Program, Tacoma

Gary Preble
Private Attorney, Olympia

Jim Theofelis
The Mockingbird Society, Seattle

Jane Boyajian
WORKETHICS, Seattle

Martha Bird, M.D.
Child, Adolescent, and Adult Psychiatrist, Silverdale

Robert Lipke
Lummi Nation Child Protection Project, Bellingham

Shirley Caldwell
Therapeutic Health Services, Seattle

Lori Garvin
Parents Coping with Child Protective Services, Tacoma

Susan Kemp
University of Washington School of Social Work, Seattle

Marie Jamieson
Catalyst for Kids, Seattle

Teresa Berg
Pierce County Sheriff's Office, Tacoma

Lois Schipper
Seattle & King County Public Health, Seattle

Darlene Flowers
Foster Parents Association of Washington, Renton

Central Washington Committee

Sue Baker,
Chelan/Douglas County Court Appointed Special Advocate, Wenatchee

Dan Fessler
Yakima County Department of Assigned Counsel, Yakima

Mary Ann Warren
Catholic Family And Child Service, Wenatchee

Laurie Leaverton
Yakima County Court Appointed Special Advocate, Yakima

Sherrie Mashburn
Parents Are Vital in Education, Sunnyside

Patty Orona
Yakima County School District, Yakima

Dean Mitchell
Moses Lake Police Department, Moses Lake

Nila Whiteshirt-Sears
Casey Family Program NAKCP, Toppenish

Robin Jones
NCW Child & Family Advocacy Center, Wenatchee

Eastern Washington Committee

Ellen Cady
Northwood Middle School, Spokane

Scott Stevens
Spokane County Court Appointed Special Advocate, Spokane

Art Harper
Foster Parent Liaison, Spokane

Windy Tevlin
Whitman County Court Appointed Special Advocate, Colfax

Joyce and Miles Stookey
Relatives Raising Relatives, Spokane

Rosey Thurman
Team Child, Spokane

Dave Williams
Partners with Families and Children, Spokane

Greg Casey
Private Attorney, Spokane

Rand O. Young
Spokane County Juvenile Court Services, Spokane

Barb Feyh
Community and Family Services, Spokane Regional Health Division, Spokane

Kelly Busse
Spokane Police Department, Spokane

Legislative Children's Oversight Committee

Senator Jim Hargrove, Chair
24th District

Senator Jeanne Kohl-Welles
36th District

Senator Val Stevens
39th District

Representative Marc Boldt
17th District

Representative Judy Clibborn
41st District

Representative Ruth Kagi
32nd District

EXECUTIVE SUMMARY

The Office of the Family and Children's Ombudsman was established by the Washington State Legislature in 1996[1]. The Ombudsman investigates complaints involving children and families receiving child protection and child welfare services, or any child reported to be at risk of abuse, neglect or other harm. In addition, the Legislature directed the Ombudsman to recommend system-wide improvements that benefit children and families.

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 welfare system.

The Ombudsman's Role:

- **Listen** to Families and Citizens
- **Respond** to Complaints
- **Act** on Behalf of Children and Families
- **Improve** the System

This report provides an account of the Ombudsman's activities through August 31, 2003. It also describes cases handled by the Ombudsman that illustrate how the office works to help the Department of Social and Health Services (DSHS) avert and correct avoidable errors. In addition, the report sets forth the Ombudsman's recommendations for system-wide improvements.

The Role of the Ombudsman

The Ombudsman operates as an independent agency under the Office of the Governor. Acting as an impartial fact finder, the Ombudsman provides families and citizens an avenue through which they can obtain an independent and impartial review of the decisions made by DSHS and other state agencies.

The Ombudsman performs its duties by focusing its resources – five full-time staff and a biennial budget of nearly one million dollars – on complaint investigations, complaint intervention and resolution, and system investigations and improvements.

Inquiries and Complaints

A fundamental aspect of the Ombudsman's work is to respond to the needs of citizens by listening to their concerns, educating them about the child welfare process and referring them to appropriate resources to assist them with their particular issue.

By responding effectively to citizens' questions and concerns, the Ombudsman determines if their concern falls within the scope of the Ombudsman to investigate, or if there is another resource available to better assist them.

[1] RCW 43.06A

Between September 1, 2002 and August 31, 2003, the Ombudsman received over 1400 inquiries from families and citizens who needed information. During this period, the Ombudsman also received 463 complaints - an all-time high and a 17 percent increase from 2000-01. The steep upward trend of complaints filed with the Ombudsman in recent years shows no signs of slowing.

Most complaints to the Ombudsman were filed by parents and other family members. Complaints most frequently identified DSHS' allegedly inadequate response to a report of child abuse or neglect as the issue of concern. A majority (58 percent) of individuals filing complaints with the Ombudsman indicated that they were referred to the office by someone else. Over half of these individuals reported that they were referred by a community professional, local service provider or DSHS worker.

Complaint Investigation and Ombudsman In Action

The Ombudsman spends more time investigating and evaluating complaints than on any other activity. Impartial investigation and analysis enable the office to respond effectively when action is necessary to facilitate resolution of a concern or induce corrective action by the agency.

Between September 1, 2002 and August 31, 2003, the Ombudsman completed 460 complaint investigations – an increase of nearly 13 percent from the previous year. The Ombudsman resolved 31 percent of complaints during this period that were the subject of an emergent investigation. Emergent investigations most often involved concerns about a child's safety or well-being. Nearly one-quarter of emergent investigations were closed after direct intervention by the Ombudsman to induce the agency to correct an unauthorized or unreasonable course of action.

During the same period, the Ombudsman facilitated resolution of nearly 25 percent of complaints that were the subject of a standard investigation. Almost two-thirds of standard investigations were closed after the office determined that further action was not warranted.

Fatality Review

The Ombudsman receives notification from DSHS' Division of Children and Family Services (DCFS) on every fatality known to DCFS. This information sharing is a critical step in the Ombudsman's review of cases in which child abuse or neglect was identified as a factor in the child's death.

Two-year-old Rafael Gomez died on September 10, 2003, six months after the DCFS returned him to the care of his parents. The Ombudsman reviewed DCFS case records to learn more about DCFS' activities in Rafael's case, including the agency's efforts to return the child to his parents despite the serious injuries he sustained previously while in their care.

The Ombudsman found that caseworker bias was a key contributing factor to DCFS' flawed decision to advocate for Rafael's return home. Despite a series of significant injuries incurred by Rafael at home and the presence of other red flags indicating that he was at risk of physical abuse, the DCFS worker maintained his erroneous perception that the child's parents posed no safety risk to the child. The Ombudsman presented its completed investigation summary, which identified caseworker bias and several other issues of concern, to the Community Fatality Review Team convened by the DSHS

Children's Administration (CA). The Ombudsman asked the Review Team to consider the Ombudsman's findings as part of its comprehensive review of Rafael's death.

Child Protection Teams

Child Protection Teams, or CPTs, are made up of community professionals with a wide range of expertise whose role is to assess child protection and welfare cases and advise DCFS on risky and/or complex decisions. Because CPTs represent such a vital component of the system's cross-check on caseworker bias, and due to recurring concerns expressed in the past two community child fatality review reports and in complaints to the Ombudsman, the office initiated an independent review of CPT practices. The death of Rafael Gomez was the second child fatality in three years to raise serious concerns about DCFS' use of Child Protection Teams.

There continues to be disagreement within DCFS as to the fundamental purpose and value of CPTs and virtually no uniformity in CPT practices among DCFS regions, or even among local offices within a region. The Ombudsman found that, despite recent efforts by DSHS to implement CPT improvements, there has been little overall positive change in their structure and use.

Based on these findings, the Ombudsman recommends that Children's Administration leadership work closely with DCFS staff and stakeholders to develop a collective understanding of the purpose and value of CPTs. The leadership should also communicate – and regularly reiterate – its expectations regarding the agency's use of CPTs. In addition, Children's Administration should fully endorse and support the development and implementation of a uniform statewide CPT system by addressing key issues. These issues include: clarifying policy and practice guidelines; establishing a system of accountability; providing training to DCFS staff and CPT members; and clarifying and supporting the role of CPT coordinators.

Issues and Recommendations

After complaint investigations, the Ombudsman spends most time on identifying and investigating system-wide problems. The Ombudsman has identified and investigated four systemic issues that are the subject of findings and recommendations in this report. These issues are discussed in greater detail in the section titled *Issues and Recommendations*. They include:

1. **Evidence-based Assessment and Treatment.** In reviewing child fatality reports and complaints in 2003, the Ombudsman identified a major deficit in the consistency and quality of assessments and services typically used in the child welfare system. Fortunately, assessment tools and treatment services exist whose validity and effectiveness are supported by scientific evidence. An independent state entity should convene a multi-disciplinary Evidence-Based Services Summit to examine a broad range of evidence-based assessment and service models[2] for children and families in the child welfare system and make recommendations to DSHS.

[2] Evidence-based assessments and treatment refers to tools and methodologies whose validity and effectiveness are supported by scientific evidence.

2. **Protecting Adolescents.** The Ombudsman found that in some cases, CPS screens out reports of child maltreatment involving adolescents without an investigation. CPS characterizes such reports as a "family in conflict" and refers them to a DCFS unit called Family Reconciliation Services. This practice appears to be based on the assumption that the adolescent's age alone enables the youth to protect him or herself from abuse or neglect. However, not all adolescents are, in fact, capable of protecting themselves from parental maltreatment, and CPS' failure to respond means that legitimate reports of child maltreatment are not being addressed. The Ombudsman recommends that state law be amended to clarify that DSHS may not refuse to provide adolescents with child protective services based solely on their age.

3. **Children with Disabilities.** The Ombudsman found that DSHS is not able to meet the needs of families requesting an out-of-home placement for children with developmental disabilities, or physical or mental handicaps. DSHS acknowledges that the Voluntary Placement program, which was created to serve this population, has no funding to serve additional children. The Ombudsman recommends that the state provide an adequate supply and range of residential placement options for children with developmental disabilities or other serious handicaps.

4. **Relative and Kinship Care.** The Ombudsman found that DCFS often has difficulty in timely identifying and assessing the suitability of relatives who are willing to care for a child in state custody. The Ombudsman recommends that, as part of its current improvement activities, Children's Administration develop:

    1) a statewide protocol for identifying relative/kinship placement resources, and

    2) an objective assessment process for evaluating the suitability of relative/kinship caregivers.

    CA should also promote family involvement in the agency's case planning process. In addition, the Ombudsman recommends that CA develop criteria to assist workers in assessing and prioritizing their responsibilities and competing policy goals when making critical placement decisions.

Terms and Acronyms:

Dependent Child.....A child for whom the state is acting as the legal parent.
CA.....Children's Administration
CPS .....Child Protective Services
CPT .....Child Protection Team
DSHS.....Department of Social and Health Services
DCFS .....Division of Children and Family Services
CWS .....Child Welfare Services

ROLE OF THE OMBUDSMAN

The Ombudsman was established by the Washington State Legislature in 1996, following the death of three-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' participation in the Wenatchee child sexual abuse investigations. In each instance, families and citizens who previously had reported concerns about DSHS' 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 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

Director/Ombudsman
Mary Meinig, Director of the Office of Family and Children's Ombudsman (OFCO), has served as an ombudsman with the office since it opened in 1997. Prior to joining OFCO, Ms. Meinig maintained a successful clinical and consulting practice specializing in treating abused and traumatized children and their families. Her previous experience 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. She is frequently asked to present her work at national conferences, and has authored several professional publications on this topic. 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 OFCO, Mr. Dowd was a public defense attorney in King County from 1987 to 1999. A significant part of Mr. Dowd's practice involved dependency proceedings and 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. Mr. Dowd joined OFCO in December 1999.

Ombudsman
Linda Mason Wilgis is a former Assistant Attorney General for the State of Washington, where from 1991 to 2001 she gained extensive experience in dependency and guardianship cases involving both children and vulnerable adults. Before joining the Office of the Attorney General, Ms. Mason Wilgis was in private practice with a Seattle firm. She is a graduate of Skidmore College and received her law degree from the University of Virginia. Prior to attending law school, Ms. Mason Wilgis served under Senator Henry M. Jackson as a professional staff member on the U.S. Senate Committee on Energy and Natural Resources.

Special Projects Assistant
Doris Stevens came to OFCO in 2003 as Assistant to the Director for Special Projects. Ms. Stevens has had extensive experience as a social worker, supervisor, program manager and teacher. She retired from Harborview Medical Center after 27 years creating and building programs in the social work department--pioneering counseling services for abused and traumatized patients. Formerly, Stevens spent five years as a child welfare worker for a private adoption agency. She graduated from Valparaiso University (Indiana), received a Master's degree in social work from the University of Chicago's School of Social Service Administration, and is a Licensed Independent Clinical Social Worker (LICSW) in the state of Washington.

Information Specialist/Office Administrator
Megan Palchak is a recent graduate of the University of Vermont. Prior to joining OFCO, Ms. Palchak was a Program Assistant for the Washington Association of Criminal Defense Lawyers, and member of their legislative committee. She was also a Program Coordinator for a drop-in Boys and Girls Club located in a low-income housing neighborhood where she collaborated with local families, community professionals, and youth on various youth development projects. Ms. Palchak also interned with environmental advocacy group Save the River in Clayton, New York. Ms. Palchak has been with OFCO since August 2003.

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 – five full-time staff and a biennial budget of nearly one million dollars – to perform these activities. The Ombudsman's work activities are described in more detail in the sections that follow.

INQUIRY AND COMPLAINT PROFILES

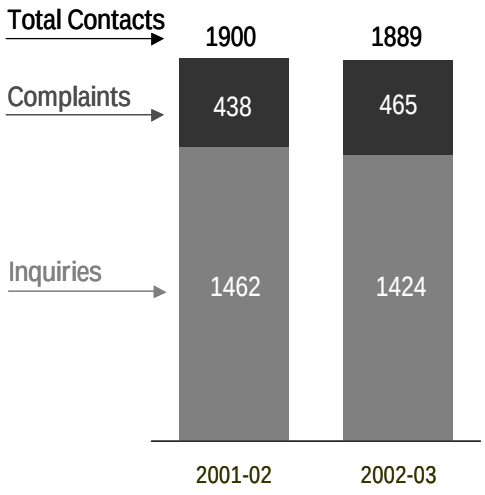
The Ombudsman listens to families and citizens who **contact** the office with questions or concerns about services provided through the child protection and child welfare system. By listening carefully, the Ombudsman is able to respond effectively to their **inquiries** and **complaints**.

This section describes contacts made by families and citizens during the reporting period of September 1, 2002 to August 31, 2003.

Contacts to the Ombudsman

From September 1, 2002 to August 31, 2003, families and citizens contacted the Ombudsman 1,889 times. These contacts were primarily **inquiries** made by persons in search of information and assistance. Nearly one-third of these contacts were formal **complaints** seeking an Ombudsman investigation, a significant increase from 2001-02.

Contacts to the Ombudsman



Source: The Family and Children's Ombudsman, August 2004

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

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.

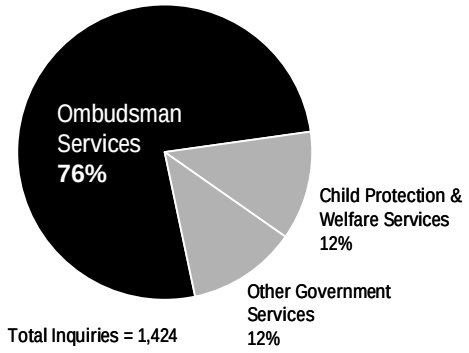
Complaints. Persons file a complaint with the Ombudsman when they have a specific complaint against the Department of Social and Health Services (DSHS) or other agency that they want the office to investigate.

The Ombudsman investigates every complaint that is within its jurisdiction.

Fielding Inquiries

The Ombudsman received 1424 inquiries from families and citizens who needed information at an average rate of 27 **inquiries per week**.

Most inquiries seek information about the Ombudsman



Source: The Family and Children's Ombudsman, August 2004

- **76% 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 Department of Social and Health Services (DSHS) Children's Administration, OFCO explained that they have the right to contact the Office of Constituent Relations.
- **About 12% concerned laws, policies,** and procedures for child protection and child welfare services. Ombudsman does not provide legal advice, explains legal rights and responsibilities.
- **About 12% concerned other government services.** The Ombudsman found out who to contact and referred these people to agencies that could help.

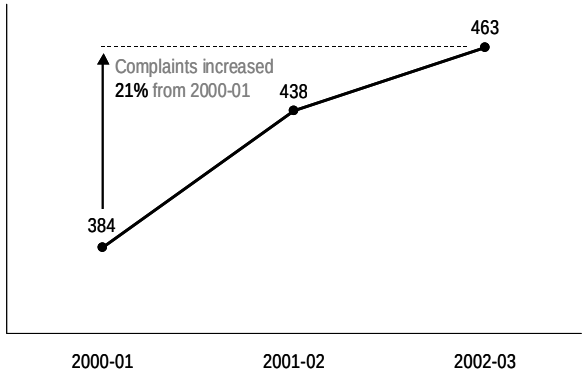
Receiving Complaints

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

- A child 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 of child abuse or neglect, or parental incapacity.

The Ombudsman received 463 complaints in 2003, an all-time high and an increase of 17 percent from 2000-01. The historic upward trend in the number of complaints filed with the Ombudsman shows no signs of slowing.

Annual Complaints to the Ombudsman



Source: The Family and Children's Ombudsman, August 2004

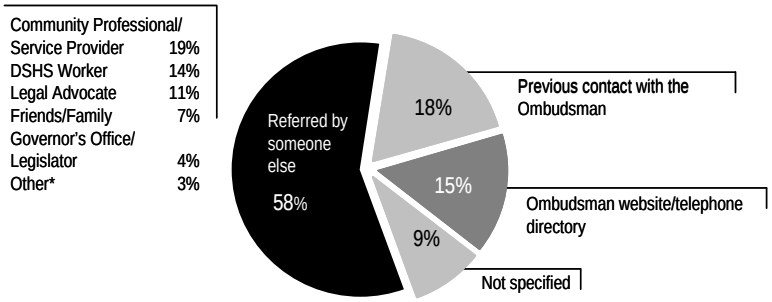
How they heard about the Ombudsman

The majority (58%) of individuals filing complaints with the Ombudsman indicated that they were referred to the office by someone else. Over half of these individuals reported that they were referred by a community professional/service provider (e.g., teacher, counselor, child care provider, doctor, private agency social worker, mental health professional) or DSHS worker.

Eighteen percent knew about the office from a previous contact, while 15 percent said they found the office via the Ombudsman website or telephone directory.

Persons Who Complained to the Ombudsman

From September 1, 2002 to August 31, 2003



**Assistant attorney general, law enforcement official, media and judge.*

Source: The Family and Children's Ombudsman, August 2004

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.

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 93 percent of complaints to the Ombudsman.[1]

Of these, 93 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

[1] The remaining seven percent were directed against: Other DSHS divisions, Washington Courts, Division of Developmental Disabilities; local CASA/GAL program; and tribal child welfare services.

Complaints against the Children's Administration by DSHS region

DSHS Regions

	Children and Family Services	Licensed Resources
Region 1 Totals	**67**	**1**
Clarkston*	3	
Colfax		
Colville	8	
Moses Lake	10	
Newport	1	
Omak	2	
Regional Office Spokane	36	
Wenatchee	5	
Republic	2	
Region 2 Totals	**50**	**0**
Clarkston*	1	
Ellensburg	1	
Regional Office-Yakima	3	
Richland/Tri-Cities	11	
Sunnyside		
Toppenish	5	
Walla Walla	8	
Yakima	20	
White Salmon**		
Goldendale**	1	
Region 3 Totals	**81**	**0**
Alderwood/Lynnwood	9	
Arlington/Smokey Point	11	
Bellingham	6	
Everett	23	
Friday Harbor	1	
Monroe/Sky Valley	6	
Mount Vernon	8	
Oak Harbor	8	
Regional Office-Everett	9	

	Children and Family Services	Licensed Resources
Region 4 Totals	**81**	**1**
Bellevue/King Eastside	21	
Kent/King South	29	
Regional Office-Seattle	3	1
Seattle Central (include NA unit)	2	
Seattle North	3	
Seattle South	9	
African-American Children's Services	4	
King West	18	
Region 5 Totals	**74**	**0**
Bremerton/Kitsap	21	
Regional Office-Tacoma	53	
Region 6 Totals	**60**	**0**
Aberdeen	8	
Centralia	6	
Kelso	6	
Port Angeles	2	
Port Townsend	2	
Regional Office-Lacey/Olympia	4	
Shelton	7	
South Bend	1	
Stevenson	2	
Tumwater	2	
Vancouver	18	
Forks	1	
Long Beach	1	
STATEWIDE		
Central Intake Unit	6	
Children's Administration HQ, Olympia		

*Moved from Region 2 to Region 1 effective July 1, 2003

**Moved from Region 6 to Region 2 effective July 1, 2004

Source: The Office of the Family and Children's Ombudsman, August 2004

Most Frequently Identified Complaint Issues:
From September 1, 2002 to August 31, 2003 *(Many complaints identified more than one issue)*

Child Safety _____ 220 complaints

- ✓ Failure to protect child from parental abuse or neglect
  - Neglect/Lack of Supervision
  - Physical abuse
  - Sexual abuse
  - Emotional abuse
  - Developmentally disabled child in need of protection
  - Children with no parent willing or capable of providing care
  - Other abuse
- ✓ 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 placement or services to children at risk of harming themselves or others

Family Separation and Reunification _____ 210 complaints

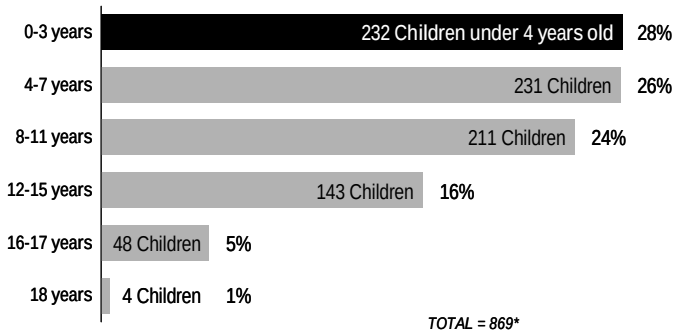
- ✓ Failure to reunite family
- ✓ Failure to place child with relative (including siblings)
- ✓ Unnecessary removal of child from parental care
- ✓ Failure to provide appropriate contact between child and family
- ✓ Other inappropriate placement of child
- ✓ Inappropriate removal of child from relative placement
- ✓ Inappropriate termination of parental rights
- ✓ Concerns regarding voluntary placement agreements for non-dependent children
- ✓ Other family separation concerns

Dependent Child Health, Well-Being, Permanency ___ 84 complaints

- ✓ Inappropriate change of child's foster or other placement/inadequate transition t new placement
- ✓ Failure to provide child with appropriate medical, mental health, educational or other services, or inadequate service plan
- ✓ Inappropriate permanency plan or unreasonable delay in achieving permanency
- ✓ Failure to provide appropriate adoption support services/other adoption issues
- ✓ Inappropriate placement/inadequate services to children in institutions/facilities

Source: The Family and Children's Ombudsman, August 2004

Ages of children identified in complaints



**Some individual children were counted more than once because they were identified in more than one complaint.*

Source: The Family and Children's Ombudsman, August 2004

Complaint Issues

As in previous years, **safety of children** was the issue most frequently identified in complaints to the Ombudsman. Complainants were concerned with the allegedly inadequate response by the Department of Social and Health Services (DSHS) to the reported maltreatment of children living in their parents' care, as well as children living in foster care or in other substitute care. Concerns about **family separation and reunification** and the **health, well-being and permanency** of children under state supervision were also frequently identified issues in complaints to the office.

Most of the children identified in complaints to the Ombudsman were age seven or younger.

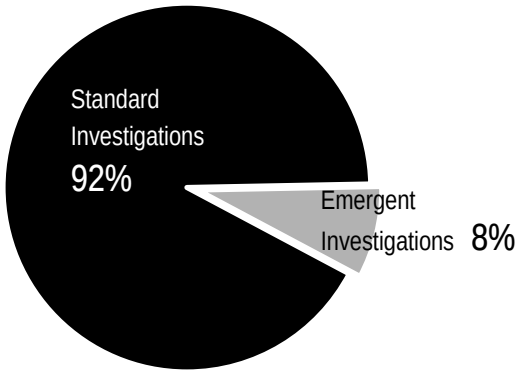
The table at left shows the breakdown of complaints received in the three most frequently identified complaint categories.

RESPONDING TO COMPLAINTS

The Ombudsman investigates and analyzes every complaint that it receives.[1] Through impartial investigation and analysis, the office determines what response is appropriate. The Ombudsman may respond by working to change a decision by the Department of Social and Health Services (DSHS) or another agency, or the office may take no further action because it has determined that the agency has properly carried out its duties.

Type of Investigations Completed

September 1, 2002 to August 31, 2003



Total Investigations = 460

Source: Office of the Family and Children's Ombudsman, August 2004

Completed Investigations

Between September 1, 2002 and August 31, 2003, the Ombudsman completed 460 complaint investigations – an increase of nearly 13 percent from the previous year.[2]

This accomplishment was achieved despite the loss of Ombudsman staff due to reductions in the state operating budget. Following the reduction, the Ombudsman implemented substantial operational efficiencies, including streamlining its investigative process and prioritizing investigations of complaints involving current issues, rather than past actions.

The vast majority of completed investigations were standard non-emergent investigations. One out of every thirteen investigations met the Ombudsman's criteria for initiating an emergent investigation, most often involving complaints about a child's safety, or where timely intervention by the Ombudsman could make a significant difference to a child or family's immediate well-being.

[1] The Ombudsman may also initiate an investigation without a complaint. During the reporting year, the office initiated nine investigations as a result of independent information obtained by way of news reports or by a call of concern where the caller did not wish to file a formal complaint, but provided sufficient information to warrant follow-up by the Ombudsman. Two thirds of these investigations were closed after the Ombudsman's concerns were resolved, and one third were closed without further action.

[2] Of the 460 completed investigations, 83 percent were investigations of complaints received during the reporting year, while 17 percent were of complaints received in a previous year. Eighteen percent of complaint investigations were still open at the end of the reporting year. For the purposes of this section, investigations of complaints raising identical issues are counted only once.

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."

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

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.

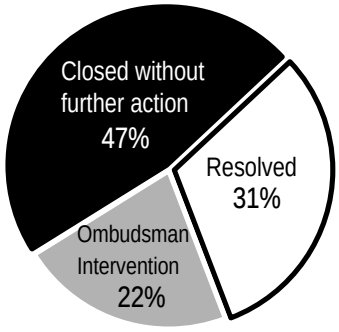
If the Ombudsman determines that a complaint does not meet the applicable criteria (see sidebar), the lead ombudsman personally notifies the complainant and explains the office's rationale for not taking further action. Additionally, the Ombudsman refers the complainant to an agency or resource that 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 "Responding to Complaints" 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

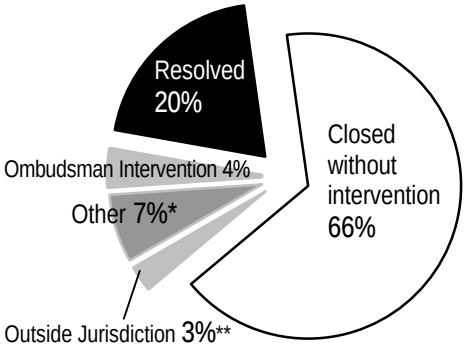
September 1, 2002 to August 31, 2003



Total Emergent Investigations = 36

Standard Investigation Results

September 1, 2002 to August 31, 2003



Total Standard Investigations = 424

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

** After an investigation is closed because it is outside of the Ombudsman's jurisdiction, the complainant is referred to appropriate resources for assistance.

Source: Office of the Family & Children's Ombudsman, August 2004

Emergent Investigations

The Ombudsman criterion for initiating an emergent investigation:

If true, the alleged agency action or inaction places the safety or well-being of a child or family at imminent risk of harm.

Results

Between September 1, 2002 and August 31, 2003, the Ombudsman **resolved 31 percent** of complaints that were the subject of an **emergent investigation**. As mentioned earlier, emergent investigations most often involved concerns about a child's safety or well-being. In many cases the Ombudsman's efforts to ensure that critical information was obtained and considered by the agency and to facilitate timely communication among the people involved resolved the concern.

Nearly **one-quarter** of emergent investigations were closed after direct intervention by the Ombudsman to induce the agency to correct an unauthorized or unreasonable decision or course of action.

During the same period, the Ombudsman **resolved nearly 25 percent** of complaints that were the subject of a **standard investigation**. Nearly two thirds of standard investigations were closed after the office determined that further action was not warranted.

OMBUDSMAN IN ACTION

The Ombudsman takes action on a complaint when it has determined that action is necessary to avert or correct a harmful oversight or avoidable 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 intervenes by persuading the agency to correct the problem. The office induces corrective action by sharing its investigation findings and analyses with supervisors and higher-level agency officials.

Frequently, a concern is resolved before corrective action is necessary. In these cases, the Ombudsman actively facilitates resolution by ensuring that critical information is obtained and considered by the agency and facilitating communication among the people involved.

On occasion, an agency error is brought to the Ombudsman's attention after the fact, and corrective action is not possible. When this occurs, the Ombudsman brings the error to the attention of high-level agency officials, so they can take steps to prevent such incidents from recurring in the future.

The Ombudsman is often successful in resolving legitimate concerns.

The Ombudsman facilitates resolution by:

- Prompting DSHS to take a "closer look."
- Facilitating information sharing to ensure all pertinent information is considered before critical decisions are made.
- Mediating professional disagreements to avoid delay of critical decisions.

The following sections provide brief descriptions of complaints in which the Ombudsman induced corrective action, facilitated resolution, or prevented future mistakes in the last reporting period. It illustrates how the office works to help DSHS avert and correct avoidable errors.

Inducing Corrective Action

When necessary, the Ombudsman induces DSHS or another agency to correct a mistake by sharing its investigation findings and analyses with supervisors and higher-level agency officials.

Finding: A Child Protective Services (CPS) worker entered into an agreed order of dependency with a mother that allowed liberal unsupervised visits between the mother and her child. The worker did this even though his supervisor had directed him to place restrictions on the mother's contact with the child due to safety concerns. As a result, the child was exposed to unauthorized contact with her dangerous father, and was driven in a vehicle by her mother while the mother's license was suspended.

Outcome: After the Ombudsman intervened, CPS took corrective action by setting a court hearing to address this issue, and the court amended the agreed order to require only supervised visits.

Finding: A CPS supervisor unreasonably changed a screening decision on a report alleging chronic neglect of a developmentally disabled youth, resulting in no investigation.

Outcome: The Ombudsman intervened and requested a review by the area manager, who agreed that the screening decision should not have been changed, and the report was assigned for a high standard investigation.

Finding: CPS did not investigate within the required timelines a report of child abuse that it had determined to be "emergent."

Outcome: The Ombudsman intervened with the CPS supervisor. As a result, the report was investigated two days later. The child disclosed recent physical abuse, and she was placed into protective custody.

Finding: CPS failed to provide services in a timely manner to protect young children, and preserve a family after the parent was expelled from an in-patient drug treatment program. CPS had an open case with this family at the time the parent was expelled from treatment, due to physical abuse and neglect allegations.

Outcome: The Ombudsman intervened and contacted the area manager, expressing concerns regarding services for this family. CPS established a safety plan and provided comprehensive services including family preservation services, mental health services, and outpatient drug treatment. The agency also convened a Child Protection Team (CPT), a group of knowledgeable professionals, to review the case and provide additional recommendations.

Finding: CPS failed to conduct an adequate investigation into allegations of sexual abuse of a child by a stepfather who had a prior conviction of a child sex offense. Specifically, CPS unreasonably relied upon the assessment of a mental health provider who was not a certified sex-offender treatment provider; had not reviewed records regarding the step-father's previous crimes against children; and had not established a safety plan to protect the children residing in the home.

Outcome: The Ombudsman intervened and contacted the area manager to express concerns regarding CPS' investigation. CPS then agreed to obtain an evaluation of the step-father by a certified sex offender treatment provider, review criminal court records, and establish a safety plan to limit contact between the step-father and children in the home.

Finding: CPS unreasonably screened out a report of sexual abuse of a child, after deciding that the report did not meet the criteria for investigation.

Outcome: After the Ombudsman intervened with the area manager, CPS reconsidered the screening decision, accepted the report for investigation and forwarded the report to law enforcement.

Finding: Child Welfare Services (CWS) failed to provide a dependent youth with an appropriate placement. Specifically, on numerous occasions, the youth's placement at a secure Crisis Residential Center (CRC) exceeded the five-day maximum set forth in law.

Outcome: After the Ombudsman intervened, CWS placed the youth in a therapeutic foster home.

Finding: CWS inappropriately used a substance abuse detoxification/ assessment center serving both adults and youths, as a short-term placement for dependent youths who were homeless or disenfranchised, but were not necessarily in need of detoxification or assessment for substance abuse treatment. While this center reportedly provided a high level of supervision, it did not separate the juvenile population from the adults.

Inducing Corrective Action *(continued)*

Outcome: After the Ombudsman intervened, the area manager acknowledged that the detoxification assessment center had been used inappropriately for short-term placement for youth, and issued a directive that this practice cease.

Finding: CWS failed to comply with Inter-state Child Placement Compact (ICPC) requirements prior to placing dependent children with an out-of-state relative. The purpose of the requirements is to ensure that the placements of children who are placed out of state are safe and appropriate.

Outcome: The Ombudsman intervened by notifying the area manager, who then initiated the ICPC process.

Finding: CPS failed to follow the recommendation of the Child Protection Team (CPT) to remove children from their parent's care based on allegations of physical abuse, nor did the agency obtain required approval from the regional administrator to disregard this recommendation.

Outcome: The Ombudsman intervened, notifying the area manager of its concerns that the recommendations of the CPT had been ignored. The area manager acknowledged that the decision to override the CPT recommendation should have been approved by the regional administrator. CPS subsequently placed the children in protective custody and filed a dependency petition.

Finding: CPS failed to appropriately assign a report of child neglect by a day care provider. The report had been assigned to the Office of Foster Care Licensing as a licensing complaint, and not referred to CPS as a child safety concern. As a result, CPS did not investigate the report.

Outcome: After the Ombudsman intervened, CPS corrected its error and conducted an investigation, including interviews with all children involved, their parents, and their day care providers.

Finding: Due to a dispute over jurisdiction between two DSHS regions, CPS failed to assign an emergent referral for investigation of allegations of child neglect.

Outcome: The Ombudsman intervened and contacted the area managers involved urging the agency to take appropriate action in response to this report. The case was then assigned within two days and the children were ultimately placed with a suitable relative.

Finding: CPS failed to investigate allegations of child abuse and neglect in a timely manner. Specifically, the worker did not conduct parent and child interviews within required timelines.

Outcome: The Ombudsman intervened by contacting the CPS supervisor with concerns. A CPS worker went to the home and interviewed the mother the next day. The mother admitted illegal drug use. CPS provided chemical dependency assessment and treatment services to the mother and established a safety plan that included both scheduled and unannounced home visits.

Finding: CPS Central Intake failed to send a report requiring an emergent response to the local investigative CPS unit within 24 hours. This prevented the local unit from responding within 24 hours, as required by law and policy.

Outcome: After the Ombudsman brought the omission to the agency's attention, CPS Central Intake sent the report to the local CPS unit for immediate investigation.

Finding: CWS failed to adequately address mental health issues regarding a grandparent, prior to placing a dependent child with him. The grandparent had failed to maintain placement of the grandchild in the past. Furthermore, the grandparent had a history of abuse and neglect as a parent.

Outcome: By the time the Ombudsman received this complaint, the child had already been placed with the grandparent. The Ombudsman intervened by contacting the CWS supervisor to request that these concerns be thoroughly investigated as part of the adoption home study. Prior to completion of the home study, the child was removed following the grandparent's mental health crisis.

Facilitating Resolution

The Ombudsman frequently is able to resolve a concern before corrective action is necessary. The office accomplishes this by ensuring that critical information is obtained and considered by the agency and facilitating communication among the people involved.

Finding: CWS failed to conduct a home visit or criminal background check before placing two foster children with relatives in a distant region of the state.

Outcome: At the Ombudsman 's urging, the worker conducted an assessment of the home, which uncovered the relatives' criminal history. This information, in addition to subsequent CPS reports alleging abuse and neglect of the children in the home, led CWS to determine that the placement was, in fact, unsuitable and the children were ultimately moved to another placement.

Finding: CWS failed to conduct any health and safety visits for over nine months, regarding a dependent child placed in a relative's care.

Outcome: After the Ombudsman flagged the omission, the case was reassigned to a new caseworker who, upon investigation, found multiple safety concerns. The child was subsequently removed from the relative's home due to reports of domestic violence, and the child was placed in foster care.

Finding: CPS failed to monitor a six-month Voluntary Service Agreement (VSA) with a parent that established a safety plan for the protection of a child from a registered sex offender.

Outcome: The omission was addressed when, at the Ombudsman's urging, the CPS worker conducted a home visit and interviewed the child. The parent signed a new safety plan, and the CPS case was ultimately successfully closed.

Finding: CPS failed to immediately notify a father when his two children were placed in protective custody and a dependency petition filed.

Outcome: At the Ombudsman's urging, CPS called the father, and faxed notice of the dependency proceeding to the father's attorney.

Finding: CWS failed to notify a father when a dependency guardianship of his child was vacated, even though he was paying child support and could have been located. As a result, the father was not being considered as a placement resource for the child.

Outcome: The father learned from relatives that the guardianship had been vacated, and he contacted the department. At the Ombudsman's urging, CWS agreed to conduct a home study and, if appropriate, consider the father as a placement resource.

Finding: CWS failed to follow the recommendation of a Child Protection Team (CPT) to remove a child from a foster home. Two years after the recommendation, the agency neither had taken steps to address the CPT's safety concerns nor to override the CPT recommendation.

Outcome: While this complaint was under investigation by the Ombudsman, CWS convened a new CPT to assess the child's safety and well-being.

Finding: CPS failed to complete an investigation into multiple allegations of child abuse and neglect in a timely manner. The CPS case remained open but inactive for several months after law enforcement and CPS completed their joint investigation of sexual abuse allegations.

Outcome: The CPS case was reassigned due to the urging of the Ombudsman, and the new caseworker entered into a voluntary service agreement with the family, which provided intensive family preservation services.

Finding: CPS failed to investigate a report alleging physical abuse and neglect of a child in a timely manner.

Outcome: At the Ombudsman's urging, CPS investigated the referral and entered into a safety plan/service contract with the parent.

Finding: CPS unreasonably decided to close a case because the mother refused to accept services, even though allegations of physical abuse of a child were founded.

Outcome: The situation was resolved when, at the Ombudsman's urging, CPS agreed to staff the case with a CPT. The parent agreed to the services and evaluations recommended by the CPT.

Facilitating Resolution *(continued)*

Finding: CPS failed to intervene in a timely manner to protect two children from chronic maltreatment by their parent. Over a period of almost four years, CPS received 25 reports, documenting physical neglect, emotional abuse, and physical abuse of the children, directly related to the parent's mental disabilities. Although CPS provided services, the parent's participation was marginal, no progress was identified, and the level of risk to the children was not reduced.

Outcome: While the situation was resolved, during the course of the Ombudsman's investigation, CPS received a new report of abuse and placed the children in protective custody with their relatives.

Finding: CWS failed to establish permanency in a timely manner for a 10-year-old legally free child placed with relatives out-of-state. The child had been placed with her relatives for over two-and-a-half years and the adoption had not been finalized due to ICPC compliance issues with both the sending and the receiving state.

Outcome: With the Ombudsman's assistance in facilitating communication, the ICPC delays were addressed, and the adoption was finalized.

Finding: CWS failed to provide appropriate out-of-home care as recommended by the treatment providers for an adolescent child with significant mental health and behavioral problems, after a Voluntary Placement Agreement (VPA) expired. The youth's reunification with his family failed after 17 days, and he was again placed voluntarily with another family. The youth had been the subject of a VPA for over one year, and had been in at least 13 different placements.

Outcome: At the Ombudsman's urging, CPS filed a dependency petition and found a therapeutic placement for this child.

Preventing Future Mistakes

When corrective action is not possible, the Ombudsman brings the error to the attention of high-level agency officials, so they can take steps to prevent such mistakes from recurring in the future.

Finding: The Ombudsman found that CPS unreasonably declined to investigate numerous referrals over a two-year period reporting chronic child maltreatment that included physical abuse, neglect, and exposure to domestic violence. The children were ultimately taken into protective custody by law enforcement, which finally resulted in CPS involvement.

Outcome: The Ombudsman requested a full review of the case by Children's Administration (CA), and the final CA report, with several recommendations for changes in CPS practice, is being used by the DSHS Child Welfare Training Academy.

Finding: A state-contracted therapist for a child failed to report that the child had been hit with a belt by his relative foster parent. CPS later determined that the act constituted physical abuse, and the child was moved to the care of another relative.

Outcome: The Ombudsman brought the therapist's omission to the attention of the area manager, who then reviewed the relevant laws and policies governing mandated reporters with the therapist.

Finding: CPS failed to conduct a timely investigation into allegations of physical abuse and neglect of a child by her parents. Specifically, the child was not seen by a CPS worker until three weeks after the report was made. Although bruises on the child had been reported, by the time the child was seen no bruises were observed. This resulted in an inconclusive finding. The investigation itself was not completed until six months later, well outside of the 90-day timeline for completion of CPS investigations.

Outcome: By the time the Ombudsman received this complaint, CPS had completed its investigation. The Ombudsman brought concerns regarding the delay in seeing the child and completing the investigation to the attention of CA officials. A subsequent CPS referral alleging medical neglect of the child was investigated in a timely manner.

Finding: CPS failed to take appropriate steps to protect young children, after an infant in the home suffered serious head injuries as a result of physical abuse. The parents initially did not identify the perpetrator, and after he confessed, the parents refused to cooperate with law enforcement's efforts to locate the perpetrator, did not obtain a restraining order against him, and refused services offered by CPS.

Outcome: By the time the Ombudsman received this complaint, the perpetrator had been arrested. However, the Ombudsman concluded that based on the severity of the child's injury, and questions as to the parents' willingness and ability to protect, it was clearly unreasonable for CPS to have allowed the children to remain in the home. The Ombudsman requested an internal review of the case by CA headquarters. The review concluded that the uninjured children should have been removed from the home during the CPS investigation, due to the high risk factors posed by the children's age, the fact that the identity of the perpetrator remained unclear for some time, and the family's failure to cooperate with CPS.

Finding: CWS failed to do a relative search until a dependent infant had been in a non-relative foster home for seven months. CWS also failed to conduct required 90-day health and safety visits to the child, for over five months, and failed to provide the foster parents with five days' notice of the child being moved.

Outcome: By the time the Ombudsman received this complaint, the child had been removed from foster care and placed with a relative.

Preventing Future Mistakes *(continued)*

Ombudsman brought these findings to the attention of Children's Administration headquarters.

Finding: CPS unreasonably screened out a referral from a youth detention facility reporting that a youth was in need of placement as no parent could be located, and the youth was due for immediate release.

Outcome: CPS Central Intake Unit acknowledged to the Ombudsman that this referral should have been accepted, and stated it would take corrective action with supervisors and workers regarding proper response to these types of referrals.

Finding: CPS Central Intake Unit failed to answer incoming calls in a timely manner. Specifically, a medical professional attempting to report suspected child abuse/neglect was kept on hold for 27 minutes.

Outcome: By the time this complaint was received by the Ombudsman, the medical professional had succeeded in reporting safety concerns to CPS. The Ombudsman notified Children's Administration headquarters of systemic concerns regarding Central Intake, which were ultimately addressed by returning CPS Intake daytime to local CPS offices.

The Ombudsman is Often Successful at Resolving Legitimate Concerns

The Ombudsman actively facilitates resolution by ensuring that important information is obtained and considered and by mediating professional disagreements so that critical decisions can be made.

The Ombudsman assists a relative caregiver maintain guardianship of a child

A grandparent contacted the Ombudsman with concerns about DCFS' decision to remove her 16-year-old granddaughter from her care. The youth had been in her care since she was five years old, and a dependency guardianship was established eight years ago. The youth was recently removed from her care due to findings of medical neglect. The grandparent believed the allegations had not been investigated adequately and that the agency's findings were unreasonable.

The Ombudsman determined that DCFS' decision was primarily based on concerns of a treating emergency room physician, alleging that the grandparent failed to administer the youth's seizure medication as prescribed. The Ombudsman questioned whether DCFS had considered a letter of support from the youth's primary care physician, as well as other letters from the school, the church, extended family and friends all supporting the grandparent's ability to care for this youth. At the Ombudsman's urging, the caseworker interviewed the physician and requested a copy of his letter. The caseworker further found that the youth, though placed with another relative, still very much wanted to live with her grandparent. After interviewing the primary physician and reviewing all available information, the new caseworker agreed to return the youth to her grandparent's care and withdrew the motion to terminate the guardianship.

The Ombudsman assists CWS in gathering complete information to ensure suitable permanent placement

A foster parent contacted the Ombudsman with concerns about DCFS' plan to place her 11-year-old foster child with his half-sibling, who was in the care of the sibling's parent. Safety concerns centered on allegations that the parent's spouse had a criminal record; the sibling had behavior problems; and the parent would not be able to provide the 11 year old child with appropriate attention and supervision due to the number of children in the home. The Ombudsman found other issues not raised by the complainant. Although parental rights to the child had been terminated for the past four years, a permanent placement had not yet been identified. He had been in approximately 18 different placements, including a failed relative placement, a failed reunification, and a failed pre-adoptive placement. While reviewing DCFS records, the Ombudsman discovered CPS history listed under a different spelling of the parent's last name, which had previously not been considered by DCFS staff. These records included a CPS finding of physical abuse of a child by the parent, and a referral alleging sexual assault of two adolescent youths. The Ombudsman also found that the parent's spouse had an extensive CPS history regarding her own children, as well as a criminal history.

After consideration of the records that the Ombudsman brought to the agency's attention, the sibling's parent did not pass an adoption home study. Because there had been significant delays in achieving permanency for this child, the DCFS Area Manager directed that all work on the case be expedited. A suitable adoptive family who had known the child was explored, and the child was placed in this home five months after the case came to the Ombudsman's attention.

A FATALITY REVIEW: RAFAEL GOMEZ

Two-year-old Rafael Gomez died on September 10, 2003, six months after the DSHS Division of Children and Family Services (DCFS) returned him to the care of his biological parents. An autopsy determined that Rafael died of "blunt-force trauma" to his head.

DCFS was involved in Rafael's life since his birth. The agency filed a dependency petition in court and placed Rafael in foster care a few days after he was reportedly born with drugs in his system. At 10 months of age, he was returned to his parents, while they participated in services. While in his parents' care, Rafael suffered serious physical injuries including broken bones, skull fractures and burns. Following these injuries, Rafael was again placed in foster care. In March 2003, at the recommendation of DCFS, the court ordered that Rafael again be returned to his parents' care. Rafael and his family remained under DCFS supervision until his death.

The Ombudsman asked the review team to focus on several key issues:

- **Performance Issues**
  - ✓ Screening and Investigation
  - ✓ Risk Assessment
  - ✓ Child Protection Team
  - ✓ Support Services
  - ✓ Non-Compliance
- **System Issues**
  - ✓ CPT Staffings
  - ✓ In-home Service Providers

The Ombudsman reviewed DCFS case records to learn more about the history of the agency's involvement with Rafael's family, including the circumstances that led to his placement in foster care, the services offered and provided to the family, and the agency's March 2003 recommendation to the court that Rafael again be returned to his parents' custody. The Ombudsman also wanted to examine the issues and concerns that arose on both occasions after the child was returned home, together with DCFS' response.

Rafael's death was also reviewed by a Community Fatality Review Team convened by DCFS. The Team included community professionals and legislators. At the Team's first meeting on December 17, 2003, the Ombudsman presented its completed investigation summary and identified several issues and areas of concern.

The Ombudsman found that caseworker bias was a key contributing factor to the agency's erroneous decision to advocate for Rafael's return home. The case record reflects that the DCFS worker assigned to this case believed that the parental deficiencies of Rafael's parents were limited to substance abuse, and that once this issue was addressed, the parents were capable of providing Rafael with safe and appropriate care. The worker appeared reluctant to reassess his belief despite the frequency and severity of the child's injuries while in his parents' care, abuse concerns raised by medical professionals and Rafael's foster parent, and the mother's complaints regarding the child's behavior. Instead, these incidents and concerns were minimized or discounted. The worker's failure to objectively test or reassess his perceptions about Rafael's parents and their potential for physical abuse led him to unreasonably advocate for the child's return home.

Caseworker bias was also a prominent factor in the death of three-year-old Zy'Nyia Nobles in 2000. Zy'Nyia was killed by her mother several months after DCFS returned her to her mother's care. In that case, the CWS worker appeared to act as the mother's advocate and pushed for Zy'Nyia's return home despite the mother's violent history, documented concerns about her mental health and parenting capacity, and her failure to complete or make progress in court-ordered services.[1]

Despite previous efforts by the DSHS Children's Administration to address this issue, biased decision-making by caseworkers persists and continues to place children at risk of serious harm.

Considering the Issues

The Ombudsman asked the Community Fatality Team to consider the following issues in a review of Rafael's death.

Performance Issues

- **Screening and Investigation**—Shortly after Rafael was returned the first time to his parents' care, DCFS Child Protective Services (CPS) received several reports clearly indicating that he was at risk of physical abuse. In fact, the child suffered several severe injuries while living with his parents. Case records indicate that many of these reports either were not investigated or determined to be inconclusive or invalid by CPS workers. Moreover, on one occasion, a DCFS Child Welfare Services (CWS) worker documented a service provider's concern about the suspicious nature of one of Rafael's injuries, but did not forward the concern to CPS for screening and investigation.
- **Risk Assessment**—The severity and chronicity of Rafael's injuries alone suggested the strong possibility of physical abuse. However, the CWS worker did not assess his parents' risk for physical abuse – even though assessment tools specifically designed to identify this risk were available. The worker did obtain a "psycho-social" evaluation of both parents. However, this assessment was inadequate as assessment tools designed to measure the risk for physical abuse were not. Moreover, the worker failed to provide sufficient background information on the parents to the psycho-social evaluator.
- **Child Protection Team**—The DCFS worker failed to provide complete information to the Child Protection Team (CPT) as it was deciding whether to support the worker's plan to return Rafael home.[2] Specifically, the Ombudsman questioned whether the CPT was provided with all medical reports and findings regarding the child's injuries, as well as reports of maltreatment after the child was returned home. Additionally, the Ombudsman raised concerns that information to the CPT accentuated the parents' progress and minimized any deficiencies.[3]

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[1] Ombudsman July 2000 Review of Zy'Nyia Nobles Fatality (edited to protect confidentiality): www.governor.wa.gov/ofco.

[2] RCW 74.14B.030 requires that DSHS "establish and maintain one or more multidisciplinary teams in each state region of the division of children and family services. The team shall consist of at least four persons, selected by the department, from professions which provide services to abused and neglected children and/or the parents of such children. The teams shall be available for consultation on all cases where a risk exists of serious harm to the child and where there is dispute over whether out-of-home placement is appropriate."

[3] Issues and recommendations regarding the use of Child Protection Teams are discussed in greater detail in the section titled "Exploring the Purpose and Value of Child Protection Teams" of this report.

- **Support Services**—The CWS worker did not ensure that critical in-home support services, such as of a public health nurse, were provided to Rafael's family upon his return home. Also, the worker did not ensure that Rafael was provided with therapeutic day-care services to help address his reported behavioral problems and further assess his treatment needs.
- **Non-Compliance**—Case records showed that Rafael's mother did not fully comply with substance abuse treatment services. Moreover, on more than one occasion she insisted on changing treatment providers whom she perceived as being critical of her progress. There is no evidence that this caused the DCFS worker to reassess his support for returning Rafael to parent's care.

System Issues

- **CPT Staffings**—The Ombudsman asked the Review Team to consider how the structure and operation of CPTs could be improved to enable them more effectively to fulfill their role. Specifically, the Ombudsman identified CPT membership, the decision making process, and the timing of CPT meetings as issues of concern.
- **In-home Service Providers**—The Team was asked to consider whether Family Preservation Service (FPS) and Home Support Service (HSS) providers were sufficiently able to address the issues identified in the psycho-social evaluation of Rafael's parents and whether FPS or HSS providers were adequately trained to identify and assess child safety issues and/or parents' potential for physical abuse.

The Community Fatality Review Team released its report on May 28, 2004. The report addressed many of the issues identified in the Ombudsman's review.[4]

[4] Rafael Gomez Fatality Review - Report of the Fatality Review Committee, May 28, 2004, http://www1.dshs.wa.gov/ca/pdf/Gomez.pdf

EXPLORING THE PURPOSE AND VALUE OF CHILD PROTECTION TEAMS

The death of Rafael Gomez is the second child fatality in the past three years to raise serious concerns about the DSHS Division of Children and Family Services' (DCFS) use of Child Protection Teams (CPTs). Despite a consensus among state policymakers and previous fatality review committees regarding the value of CPTs in assisting DCFS with risky and/or complex decisions, the agency thus far has failed to ensure their proper implementation and use.

This section outlines the history of CPTs and describes the Ombudsman's recent review of CPT practices. It also sets forth the Ombudsman's findings and recommendations.

The Ombudsman Review of Child Protection Teams Resulted in Recommendations:

- Clarify policy and practice guidelines.
- Create a system of accountability.
- Require training for DCFS staff and CPT members.
- Provide support, authority, sufficient time for coordinators.

Background

Child Protection Teams consist of volunteer community professionals with a wide range of expertise who assess child protection/welfare cases and provide advice and consultation to DCFS on critical decisions. There are currently 76 CPTs throughout the state.

The Legislature first established CPTs in 1987, following the death of three-year-old Eli Creekmore after DCFS returned him to his parents' care. In an effort to improve critical case decision making, the Legislature required DCFS to make CPTs available for consultation on cases involving serious child safety issues and disputes over whether to remove a child from home.[1] In 1995, following the death of three-year-old Lauria Grace after she was returned to her mother by DCFS without a CPT consultation, Governor Mike Lowry, acting upon a recommendation by a community fatality review team, issued an Executive Order mandating CPT consultation by DCFS workers in particular child protection cases.[2]

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[1] RCW 74.14B.030 provides: "[t]he department shall establish and maintain one or more multidisciplinary teams in each state region of the division of children and family services. The team shall consist of at least four persons, selected by the department, from professions which provide services to abused and neglected children and/or the parents of such children. The teams shall be available for consultation on all cases where a risk exists of serious harm to the child and where there is dispute over whether out-of-home placement is appropriate."

[2] Executive Order 95-04 states: "The Department of Social and Health Services shall utilize the multidisciplinary community protection teams established pursuant to RCW 74.14B.030 as follows: A. In all child protection cases in which the risk assessment results in a "moderately high" or "high" risk classification, and the child is age six years or younger; B. In all child protection cases where serious professional disagreement exists about a risk of death or serious injury; C. In all child protection cases that are opened on the basis of "imminent harm"; and D. In all complex child protection cases where such consultation will help improve outcomes for children. The Department of Social and Health Services shall establish, maintain, and staff multidisciplinary community protection teams sufficient to review these cases as soon as feasible and shall continue to develop a broad array of team members who will work with the department to make the best decisions possible to protect and improve the lives of the children in our state."

In 2000, in the course of reviewing the tragic death of three-year-old Zy'Nyia Nobles, the Ombudsman and a community fatality review team identified serious concerns regarding the agency's utilization of the CPT. Specifically, it was noted that information provided by the DCFS worker to the CPT was inaccurate and incomplete, and "presented in a manner to support [the worker's] belief that the child[…] should be returned to [her] mother."[3] The worker's selective presentation of information led the CPT to support her flawed plan to return Zy'Nyia to her mother, who was subsequently convicted of murdering the girl.

Following Zy'Nyia's death, DSHS Secretary Dennis Braddock released the *Kids Come First Action Agenda*, which included a provision to improve the use of CPTs by "clarifying expectations," "tracking performance," and "providing training and new tools to improve their effectiveness." The Ombudsman applauded the *Agenda's* CPT component, noting that the use and effectiveness of CPTs varied widely across the state. The Ombudsman observed that while CPTs are often used as intended – to assist workers with risky or complex decisions – CPT members report that they are also often used by workers to "rubber stamp" critical decisions that workers have reached on their own.

A little over three years later, following the death of two-year-old Rafael Gomez after DCFS returned him to his parents' care, serious concerns about the agency's use of CPTs arose once again.[4] In this case, the community fatality review committee stated that it was troubled by the "serious flaws" in the CPT system that appeared to have led the CPT to support the worker's plan to return Rafael home. The fatality committee recommended a statewide review of the CPT process, specifically including the following items:

- Clarification of the role of CPT members
- Appointment of designated "devil's advocate"
- CPT membership composition
- Variability of participation by CPT members
- Invitation and inclusion of service providers, foster parents, guardians ad litem
- Case staffing and continuity of teams
- Case presentation and sharing of source documents with CPTs
- Time allocation and format of case staffings
- Resolution of dissent and disagreement by CPT members on recommendations to DCFS

Following Rafael's death, as part of *Kids Come First: Phase II,* Uma Ahluwaila, Assistant Secretary for the DSHS Children's Administration, proposed to "review and revise the CPT model to improve consistency and effectiveness."[5]

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[3] Zy'Nia Nobles Community Fatality Review Report, November 2000; see also, Ombudsman July 2000 Review of Zy'Nia Nobles Fatality (edited to protect confidentiality): www.governor.wa.gov/ofco. The Ombudsman noted: "[T]he […] independent evaluation and oversight functions of the CPT […] appeared to have been undermined as a result of having received information from the caseworker that was not entirely accurate or complete . . . ."

[4] Rafael Gomez Community Fatality Review Report, May 2004; see also, section titled "A Fatality Review: Rafael Gomez" of this report.

[5] Children's Administration Program Improvement Plan/Kids Come First: Phase II, section 4.4 (draft).

Ombudsman Review

The Ombudsman's review of CPT practices was prompted by concerns brought to the Ombudsman's attention by parents, relatives, community professionals, and occasionally, by CPT members themselves.

These concerns include:

- Failure to schedule CPT reviews in appropriate cases or in a timely manner
- Failure of DCFS workers to provide current, complete case information to team members
- CPT decision-making process
- DCFS' failure to follow CPT recommendations[6]
- Whether and how parents, foster parents and other relatives are included (or excluded) and treated in the CPT review

Because CPTs represent such a vital component of the system's cross check on caseworker bias, and due to the recurring concerns expressed in the past two community fatality review reports and in complaints to the Ombudsman, the Ombudsman determined that an independent review of CPT practices was warranted.

Review Process

The Ombudsman's review included a review of: CPT-related complaints to the Ombudsman; pertinent statutes, executive orders, policies and procedures; relevant portions of the agency's strategic plans; monthly state Outcome Measures on CPTs; the CPT Volunteer Handbook; the Kids Come First CPT Curriculum; and materials developed by the statewide CPT coordinators group. In addition, the Ombudsman interviewed: a lead CPT coordinator from each region and 12 other current and former CPT coordinators (including facilitators who are not DCFS staff); a sampling of 20 current or former CPT members with a variety of professional perspectives and a range of experience; several family members who participated in a CPT staffing; agency staff involved in administration of CPTs; and other community professionals who have extensive experience providing services to families whose cases have been referred to a CPT for review.

Findings and Recommendations

Despite the agency's effort to implement CPT improvements outlined in Secretary Braddock's *Kids Come First Action Agenda*, the Ombudsman found there has been marginal overall change in their structure or use statewide. There continues to be disagreement within DCFS as to the essential purpose and value of CPTs and virtually no uniformity in CPT practices among DCFS regions, or even among local offices within regions.

A group of CPT coordinators from across the state has been meeting regularly to promote uniform policies and practices.[7] The group has attempted to clarify policy and developed a CPT volunteer

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[6] Section 2562 of the DSHS Children's Administration Practices and Procedures Guide states that CPT recommendations are advisory, but **must** be followed when deciding to place a child or return a child home.

[7] There are currently 45 CPT coordinators across the state. Coordinators may be either DCFS staff or contracted personnel.

training manual and a standardized CPT review form that also serves as a guide for CPT meetings. Notwithstanding these efforts, there continues to be a significant lack of clarity within DCFS and among the larger community as to the purpose and value of CPTs: why they exist, whether they're useful, and the types of cases that should receive a CPT review. This lack of clarity has resulted in inconsistent policy interpretations and practices across the state.

The following comments are illustrative of the current confusion:

> *"CPTs were created by Executive Order—that's never going to go away—so the department [DCFS] has to make the best of it." [Regional CPT coordinator]*
>
> *"The caseworker told our team that she was just bringing the case for review because she had to, even though the child had already been removed." [CPT member]*
>
> *"There is such a shallow level of information presented by the department, the coordinator is watching the clock and not listening; therefore outcomes are predetermined." [CPT member]*
>
> *"CPTs are a set-up for failure, usually used by the department to manipulate the placement decision. How can people who don't know the case be helpful in twenty minutes' time?" [CPT member]*
>
> *"The department is incapable or unwilling to make difficult placement decisions and are abrogating their lawful responsibility by passing it off to a CPT." [community professional]*
>
> *"We haven't been given the resources to handle the extra work created by CPT mandates." [DCFS CPT coordinator]*
>
> *"CPTs should be self-governing…when run by the department they are used to corral, limit, homogenize the decision-making." [volunteer CPT facilitator]*
>
> *"The department [DCFS] is responsible for placement decisions and therefore should not refer to CPTs as 'shared decision making" but rather "informed decision making." [community professional]*

Recommendations

- The Children's Administration (CA) leadership should work closely with DCFS staff, community professionals, and service providers across the state to develop a clear and shared understanding of the purpose and value of CPTs. The leadership should also clearly communicate, and regularly reiterate, its expectations regarding the agency's use of CPTs.
- The Children's Administration should place its full endorsement and sufficient resources towards supporting a CPT system that functions uniformly statewide, by addressing the following areas:

Clarify policy and practice guidelines for CPTs

Although CA policy has laid out guidelines for CPT practice, there is still ambiguity and room for widely varying interpretations. One respondent characterized the Executive Order requiring CPTs as "pie in the sky." Regional CPT policies vary from having none at all to being very specifically delineated. In response to the Ombudsman's request for regional policies, one region responded that it "follows the Executive Order"; another said it was "in the process of writing a regional policy"; three

regions submitted policies with varying detail although none had been updated since 1999. Only one region's policy provided detailed guidance for agency workers as to which cases are to be staffed, as well as scheduling, conducting, presenting at CPTs, and documenting and following through with recommendations.

The state CPT coordinators group has attempted to clarify ambiguous areas. A stronger leadership role by CA leaders in clarifying and enforcing CPT policies would effect more rapid and uniform change.

CA policy should further define:

Which cases must be referred to a CPT and at what point in case planning. A study of the CA policy leaves the reader with many questions as to specific case scenarios. The CPT coordinators group, described earlier, has spent considerable time discussing clarifications to address the ambiguities but does not have the authority to implement or enforce these clarifications.

Membership composition. Teams often fail to have a drug and alcohol expert as a regular participant. It is also difficult for many teams to secure a law enforcement specialist as a team member. These two areas of expertise, along with mental health, have been cited by child fatality reviews as significant omissions. Current CPT policy does not comment on whether or how to include these important perspectives.

Bias/conflict of interest. The Ombudsman found several instances of team membership including professionals who had generated the initial CPS report or who were simultaneously providing evaluative or therapeutic services to the subject child or family.

DCFS participation. CA policy provides no guidance on how many DCFS staff may attend a CPT or what is their appropriate role. One CPT member complained that there are usually three or four DCFS staff at the meeting, "trying to control the process and telling us what we can't decide." The Ombudsman found that DCFS staff usually do not vote on recommendations, but they do sometimes attempt to influence the team's recommendation by citing legal constraints or lack of agency resources to provide desired services.

Who may attend and present. Current CA policy states that the family shall be invited "if appropriate,"[8] but some teams never invite parents or foster parents as it is "not part of the culture". Other CPTs always invite parents, and in some instances, it is left to the discretion of the DCFS worker. Similar questions exist as to guardians ad litem and attorneys. One experienced CPT coordinator explained that parents and legal advocates are not invited to meetings because CPT reviews are "internal" and for the purpose of assisting the DCFS worker. That office does not want to duplicate the work on the case by re-interviewing family or having a quasi-legal staffing.

Recommendations. There were numerous complaints regarding the lack of sufficient time for the CPT to review materials and have meaningful discussions about recommendations. There are also problems when CPTs cannot come to agreement at an initial staffing and request

[8] Children's Administration Practices and Procedures Guide, Sec. 2562(B)(1)(b)(ii).

more information; and then they may not have the same members in attendance at a follow-up CPT.

Documentation. Some teams take minutes, documenting the discussion and recommendations, others do not. It is clear that not all teams are using the standardized forms developed by the CPT coordinators group.

Create a system of accountability for following CPT policy

Currently there is no system to ensure that DCFS holds a CPT review in all cases in which the policy mandates, such as an information system to track compliance and report on CPT results. The Ombudsman found that it is left to DCFS workers and supervisors to request a CPT when required. There seems to be more vigilant use of CPT reviews in a timely manner by Child Protective Service (CPS) workers, and Child Welfare Service (CWS) workers are less likely to prioritize CPTs in their case planning. One CPT coordinator reported that a recent quarterly regional "Central Case Review" found that 85 percent of CPS cases were in full compliance with CPT mandatory review requirements, while only 25 percent of CWS cases complied with this standard.

At a minimum, DCFS should document in the CAMIS-GUI [9]information management system whether a CPT review is required. Additionally, after each CPT meeting a summary of the review and the CPT's recommendations should be entered into CAMIS. Currently, CPT recommendations are usually not recorded in CAMIS. These entries could assist in case management and accountability and also provide data for quality assurance purposes.

Require training of DCFS staff

Ongoing training needs to communicate the purpose and usefulness of CPTs. Workers need support in making the best use of CPT recommendations in their case planning. The most frequently cited complaint was related to workers not providing full and accurate information to the CPT. In order for a CPT review to serve its intended purpose, the worker must be willing and able to provide complete information about the case and be open to receiving challenging questions from team members. There have been complaints that some workers find the CPT process creates unnecessary work, threatens their practice decisions, and is superfluous to case planning. Some workers receive no training about how to use and present at CPT meetings. There have also been complaints of workers coming unprepared to CPT reviews and—more seriously—deliberately withholding or slanting information in order to manipulate the team's recommendations. One community agency director no longer allows staff to vote at CPT meetings due to a lack of confidence that the team is being provided accurate information on which to base their recommendations.

Provide support, authority, sufficient time and specialized training for CPT coordinators/facilitators

CPT coordinators must be able to effectively recruit, train and facilitate the teams. In some offices, teams are coordinated and facilitated by a DCFS worker who has this as one of many job responsibilities. One region has contracted CPT facilitation to a for-profit group of professionals who work with a DCFS coordinator. Some teams are facilitated by volunteer community professionals. The roles and duties of coordinators and facilitators should be clearly defined. Many coordinators have

[9] CAMIS is the Children's Administration information system in which they document activity on each case, such as the social worker's contact with the children, family, and service providers..

not received the leadership training necessary to mediate difficult discussions among strong personalities. In small communities where there is little anonymity, the coordinator has an additional challenge of conducting a truly unbiased, critical decision-making process. CPT coordination and facilitation requires strong leadership and organizational skills, as well as dedicated time.

Require orientation and training for all volunteer CPT members

Currently, community volunteers are not required to receive training before serving on a CPT. The agency has produced a comprehensive manual - Child Protection Team: Volunteer Handbook (February 2003). However, its use varies widely. For example, the Ombudsman found that a few CPT coordinators were not aware of the Handbook, while other CPT members have received the Handbook but no follow up orientation or training. DCFS has also developed a CPT training curriculum, and there has been a push in some regions in the past year to provide training to CPT members. However, not all coordinators have been trained to use the curriculum, and those that have say they do not have adequate time to make use of this resource. This is highly unfortunate because, in addition to providing comprehensive information about Children's Administration mandates and CPT processes, the curriculum covers how to "apply the principles of critical thinking to the review process." Lack of critical thinking was cited as a CPT failure in the Gomez fatality review. Critical thinking is an essential part of optimal CPT decision-making and should be expected.

Although there is no data documenting how services have been enhanced and how many child injuries or deaths have been prevented due to CPT recommendations, the Ombudsman did find cases where CPTs operated in a manner helpful to the DCFS' decision-making. When Children's Administration conducts their review of the CPT system, the Ombudsman recommends that they make use of these best practices and products already developed, e.g. the Volunteer Handbook, the training curriculum, the work of the CPT coordinators group; build on these; and ensure they are used by all CPTs throughout the state. The Ombudsman will continue to monitor use of CPT reviews in ensuring child safety and family preservation.

ISSUES AND RECOMMENDATIONS

In addition to conducting investigations, the Ombudsman is required by state law to develop recommendations for improving the child protection/welfare system. The recommendations in this section are based on Ombudsman analysis of information derived from investigations, surveys, and research. They are aimed at strengthening the state's protection and care of vulnerable children.

The Ombudsman developed recommendations in the following four areas:

- Evidence-based assessment and treatment;
- Protecting adolescents;
- Children with developmental disabilities;
- Relative and kinship care.

Recommendation 1: Evidence-based Assessment and Treatment

Direct the Washington State Institute of Public Policy (WSIPP)[1] or another entity to convene a multi-disciplinary summit to examine a broad range of assessment and service models, identify programs found to be effective through rigorous research, and make recommendations to the Department of Social and Health Services (DSHS).[2] This will enable DSHS to implement assessment and treatment models with demonstrated research effectiveness, to help workers more accurately predict risk to children, and provide the most effective therapeutic services for families.

Background

In reviewing child fatality reports and complaints to the office, the Ombudsman identified major deficits in the consistency and effectiveness of assessments and services typically utilized by the DSHS Division of Children and Family Services (DCFS) in the provision of child protection and welfare services.

In some cases, the deficit lay in DCFS' reliance on inadequate assessment tools. For example, in many cases assessment models measuring risk of child abuse and neglect, or anger management evaluations of a caregiver, failed to provide workers and supervisors with the depth of knowledge required to make the best decisions to protect children.

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[1] WSIPP recently released a report on prevention and early intervention programs targeting a variety of outcomes including child maltreatment. This report summarizes evidence of a program's effectiveness and provides a cost-benefit analysis. Information contained in this report provides an excellent starting point for identifying effective programs. Benefits and Costs of Prevention and Early Intervention Programs for Youth (July, 2004) (hereinafter, WSIPP Report), Aos, Lieb, Mayfield, Miller and Pennucci, Washington State Institute for Public Policy, http://www.wsipp.wa.gov/

[2] This recommendation parallels one made in the WSIPP Report (page 5) that "legislation should designate an existing or new entity…to develop a list of approved research-based prevention and early intervention programs…to ensure that Washington taxpayers get a good return on the selected prevention and early intervention approaches."

In other cases, the deficit lay in the use of ineffective service models, such as traditional parenting classes, Family Preservation Services (FPS) and Family Reconciliation Services (FRS). These services are intended to help families address mental health, substance abuse, parenting deficiencies and other issues in order to strengthen positive family functioning. However, it is the Ombudsman's observation that they often do not produce successful outcomes. In fact, several research studies have indicated that these services are not effective.[3] Failure to provide effective services adversely impacts both family reunification and child safety. Fortunately, risk assessment and treatment tools exist whose validity and effectiveness are supported by scientific evidence. One example is the Child Abuse Potential Inventory (CAPI), a 160-question instrument that estimates the risk of a caregiver committing child physical abuse.[4] Cases reviewed by the Ombudsman indicate that although this tool is used by a few providers with whom DCFS contracts for assessment services, it is not utilized on a consistent basis either across the state or within regions.[5]

A number of treatment programs have also been found, through rigorous research, to be effective with child welfare populations. One such program is Parent-Child Interaction Therapy (PCIT). The PCIT is a 14-session program where parents learn specific skills to change coercive parenting styles and improve parent-child interactions through teaching parents how to interact positively with their children, reinforce good behavior, and consistently apply step-by-step non-violent alternatives to physical discipline. This intervention has been shown to improve parent child relationships, decrease child behavior problems and reduce re-referral to Child Protective Services (CPS) from almost 50 percent (for usual services) to about 20 percent in physically abusive families.[6] The PCIT is only one example of an evidence based intervention service worthy of examination.

Rationale

The goal of convening a multi-disciplinary summit to examine various assessment and service models targeting child abuse and neglect, is to identify assessment tools and treatment programs found to be effective through rigorous research, and make recommendations to DSHS. Implementation of evidence-based tools and services will enhance DSHS' ability to assess child safety, identify and address parental deficiencies, and improve outcomes for children and families. Moreover, utilizing assessment tools and services, that are proven effective, will help ensure that state funding is allocated in the most cost effective manner.

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[3] Westat, Inc., Chapin Hall Center for Children, and James Bell Associates. (2001) Evaluation of Family Preservation and Reunification Programs: Interim Report. Washington, DC: U.S. Department of Health and Human Services. (Study was unable to conclude that the family preservation programs achieved the objective of reducing placement of children in foster care, and also found little difference between the family preservation and control groups in the incidence of reports of maltreatment.); See also, Benefits and Costs of Prevention and Early Intervention Programs for Youth (2004), Aos, Lieb Mayfield, Miller and Pennucci, Washington State Institute for Public Policy

[4] Assessing Physical Child Abuse Risk: The Child Abuse Potential Inventory, Milner, J.S. Clinical Psychology Review, Vol. 14, No. 6, pp.547-583 (1994). Other examples of standardized assessment tools include the Parenting Stress Index (PSI) and the Achenbach Child Behavior Checklist (CBCL).

[5] DCFS Region 5 has established specific policy governing psychological and behavioral assessment services. This policy lists preferred assessment tools, including the CAPI, PSI and CBCL for psychological and parenting assessments. DCFS Region 5, Policy Memorandum #02-07.

[6] Physical Abuse Treatment Outcome Project: Application of Parent-Child Interaction Therapy (PCIT) to Physically Abusive Parents. Grant Number: 90CA1633, U.S. Department of Health and Human Services.

How Inadequate Assessments Harm Children

The Ombudsman initiated an investigation when a four-year-old child was removed from the foster parent's care after suffering numerous physical injuries. Two toddlers had previously been removed from the foster parent's care due in part to inappropriate discipline/anger management-related concerns. Although the children had already been removed from the foster home by the DSHS Division of Children and Family Services (DCFS), the Ombudsman reviewed the case to determine whether safety risk posed by this foster parent had been appropriately identified and addressed by the agency.

The agency first became aware of concerns regarding the foster parent shortly after two toddlers were placed in licensed care. Child Protective Services (CPS) received a referral reporting harsh and inappropriate discipline by the foster parent. A professional involved with the foster parent also noted concerns regarding unreasonable discipline of the toddlers. Furthermore, the foster parent told the children's social worker of several instances of physical injury to the children and attributed them to accidents. For example, within a two-month period, the foster parent reported that: the child fell and hurt his knee; the child pinches and bruises self; the child pulls hair out; the child fell out of car and has scrapes and bruises; the child twists own ear and they are black and blue; the child fell and scraped head; the child hit other child and left a red eye; and the child leaned against open car door leaving child with a bruise.

A thorough parenting assessment concluded the toddlers should be removed from the foster parent's care and that the foster parent should undergo an anger management assessment and treatment as recommended. Following the parenting assessment, the toddlers' DCFS social worker removed them from this home.

The foster parent agreed to an anger-management assessment. Although the written assessment states that it was conducted pursuant to the standards set forth through the State Certified Perpetrator Treatment Program, the Ombudsman found no indication that:

- Any assessment tools were used to evaluate the foster parent's propensity to act in anger or potentially abuse a child;
- The evaluator received or reviewed any background information such as, reports of multiple injuries to the child, concerns from professionals regarding inappropriate discipline by the foster parent, or a previous assessment identifying anger management as an issue that needed to be addressed;
- The evaluator made any collateral contacts in completing the assessment.

Based primarily, if not exclusively on information provided by the foster parent, the evaluator concluded that the foster parent would be a good teacher, caretaker and nurturer. The evaluator did not recommend any anger management classes, counseling, or treatment for the foster parent. Other than the parenting classes that the foster parent had already completed, no additional treatment services were deemed necessary.

Following this evaluation, DCFS placed two other young children with the foster parent. Shortly after the placement, the agency again became aware of concerns about the foster parent's rigid discipline and reports of physical injuries to the children. A referral to CPS also reported that the foster parent was being physically rough with one of the children to a degree that greatly disturbed the person making the report. Again, the foster parent characterized injuries to the children, including burns on the head and a split lip, as accidental.

The children were removed from the foster home after a medical professional contacted CPS to report serious bruising to the child's head, face and throat, burn marks on the face, and a fractured arm. Upon completing its investigation, the DSHS Division of Licensed Resources (DLR) concluded that the foster parent had physically abused the children. The Ombudsman contacted the DLR administrator and voiced concerns about the inadequate assessment and the agency's acceptance of it. The Ombudsman took no further action, as the children were removed from the home.

Recommendation 2: Protecting Adolescents

Require Children's Administration to mandate that older children and adolescents receive appropriate child protective services and that they not be treated differently solely because of their age. In particular, referrals alleging physical abuse against an older child or adolescent should be investigated and not screened out on the premise that youths can more adequately protect themselves.

CPS Fails to Screen for Investigation

A community professional contacted the Ombudsman expressing concerns about a 16-year-old alleged to be neglected and exploited by her parent. The professional stated that CPS was declining to investigate a recent report alleging that the girl had been on a "one week run of methamphetamine" and possible prostitution activity involving her and her parent. When the police picked up the youth she was with a 22-year-old man. Upon further investigation, the Ombudsman found that the girl had younger siblings, who were all dependent and in foster care, due to chronic neglect by the parent. The family's CPS history contains numerous referrals alleging chronic neglect, unsanitary conditions in the home, domestic violence, and substance abuse by the parents. The parent recently agreed to relinquish parental rights to the dependent children currently in foster care, as services to enable family reunification had been unsuccessful.

When the Ombudsman questioned DCFS' decision not to file dependency on the 16-year-old, DCFS replied it did not have a suitable placement for her, as she would likely run from a licensed care.

The Ombudsman determined that the latest referral was initially screened as "information only" by the after-hours supervisor at the CPS Central Intake (CI) Unit. The next day, the office-hours CI supervisor changed the screening decision and accepted the referral for investigation. When the referral reached the local CPS office, however, it was again screened out. The Ombudsman contacted a CI supervisor who concurred that the referral should have been screened in for investigation of sexual exploitation. The Ombudsman contacted the local supervisor and the area manager who agreed to have the ongoing CWS worker for the siblings interview the youth, obtain further information and try to engage the youth in services. Before the worker was able to meet with the youth, the youth was admitted to a 5-month in-patient drug treatment program in another region of the state. The DCFS worker offered to meet with the youth after her discharge from drug treatment, to explore services, including out-of-home placement.

Background

The Department of Social and Health Services is required to investigate allegations of child abuse and neglect.[7] As defined by statute, "child abuse and neglect" does not differentiate by the age of a child.[8] The child's age is a relevant factor in determining whether or not circumstances indicate that the child's health, welfare, and safety are harmed. However, all children under the age of 18 are entitled to Child Protective Services (CPS).[9] Complaints to the Ombudsman indicate that referrals to CPS are often screened out or assigned for a lower standard of investigation, based on the child's age, on the assumption that an adolescent is able to protect him or herself from abuse or neglect. In other cases, referrals alleging maltreatment are referred to Family Reconciliation Services and characterized as a "family in conflict" based on the youth's age, even though allegations of child abuse or neglect are present. As a result legitimate concerns of child abuse or neglect are not always adequately addressed.

Rationale

A child's age should be only one of multiple factors relevant in assessing risk of harm due to allegations of child abuse or neglect. By reiterating its responsibility and commitment to serve adolescents exposed to abuse or neglect, CA will strengthen CPS efforts to respond to allegations of abuse or neglect involving adolescents and ensure that this population receives protection, placement and services it deserves under the law.

[7] RCW 26.44.020; RCW 26.44.030; RCW 74.13.031(3); and RCW 74.15.030.

[8] RCW 26.44.020(12).

[9] RCW 26.44.020(6).

Recommendation 3: Children with Developmental Disabilities

- Require DSHS to provide an adequate supply and range of residential placement options for children with developmental disabilities or other serious handicaps.
- Require DSHS to develop and implement a coordinated protocol between Children's Administration, the Division of Developmental Disabilities and Mental Health Services addressing the placement and service needs of families with developmentally disabled children and children with serious handicaps.
- Require DSHS to submit to the Legislature a report setting forth protocol to coordinate placement and services for these children.

The Agency Grapples with the Shortage of Mental Health Treatment Resources During a Disruption in an Adoptive Placement

The adoptive parents of a 13-year-old with significant mental health and behavior problems requested out-of-home placement for the youth, due to violent behaviors, including self-injury and threatening to kill his adoptive parents. The youth was placed at a mental health hospital under a voluntary placement agreement. When the agreement expired, the hospital staff recommended that he not return home, as his problems were too serious for the family to handle. DCFS insisted that the youth return home with Family Reconciliation Services in place.

After 17 days, the youth again had to be placed in out-of-home care, and a new voluntary placement agreement was established. The youth experienced 24 placement episodes in 6 months, including several admissions to juvenile detention for running away. The youth was placed pursuant to a voluntary placement agreement for a year, while the family requested that a dependency petition be filed. Child in Need of Services and At-Risk-Youth petitions filed by the parents failed to successfully address the youth's placement and treatment needs. DCFS filed a dependency petition after obtaining a Children's Long-term In-patient Placement (CLIP) at a mental health facility. DCFS stated that the delay in filing a dependency petition was in part due to difficulty locating a CLIP placement for this youth. The Ombudsman noted the lack of mental health resources available for adolescents.

Background

Recognizing that the needs of developmentally disabled children or children with physical or mental handicaps may exceed their parents' ability to care for them at home, state law establishes a procedure by which parents may seek placement for the child in a licensed facility based solely on the child's disability.[10] However, complaints to the Ombudsman indicate that in many cases, the Division of Developmental Disabilities, the Division of Children and Family Services and the mental health system are not equipped to meet the needs of families requesting an out-of-home placement for their delayed/handicapped child. **As a result, services and placement resources are not provided in a uniform and consistent manner.** Often, the success of accessing such services has depended on an individual parent's ability to advocate for their child and to navigate the intricacies of the system. DSHS acknowledges that the Voluntary Placement Program, which was created to serve this population, "has no new funding at this time to serve additional children and is not currently accepting new entries."[11]

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[10] RCW 74.13.350 states: "The legislature recognizes that, because of the intense support required to care for a child with developmental disabilities, the help of an out-of-home placement may be needed. It is the intent of the legislature that, when the sole reason for the out-of-home placement is the child's developmental disability, such services be offered by the department to these children and their families through a voluntary placement agreement."; RCW 26.40.030 states: "The parents or parent of any child who is temporarily or permanently delayed in normal educational processes and/or normal social adjustment by reason of physical, sensory or mental handicap, or by reason of social or emotional maladjustment, or by reason of other handicap, may petition the superior court for the county in which such child resides for an order for the commitment of such child to [the co-custody of the state] as provided in RCW 26.40.040."

[11] DSHS website 04/05/04: www1.dshs.wa.gov/basicneeds/dis2vp.html "Voluntary Placement Program (DDD)." The website advises parents that they may make a "written request for out-of-home placement" and the child's name will be entered into a database. Lack of funding has had an adverse impact on existing residential treatment facilities. For example, officials for the Martin Center, one of the state's few treatment centers for severely mentally ill children, recently announced that the facility will close in June 2004. Officials stated that, state reimbursements have fallen far short of the real cost of care.

Rationale

Failure to meet the needs of this population places these children (often teens) at risk of harming themselves and/or others. Lack of voluntary residential treatment options leaves families to rely inappropriately on the child welfare system and/or the juvenile justice system for residential treatment. By the times this occurs, the child is often in acute crisis. Providing sufficient residential treatment resources through DDD and the mental health system will enable parents of children with developmental disabilities or mental handicaps to access needed services and treatment in a coordinated and effective manner.

Recommendation 4: Relative & Kinship Care

Recent efforts by the DSHS Children's Administration (CA) to improve the agency's ability to identify and support relative and kinship caregivers should include the following:

- Development of a statewide protocol for identifying relative/kinship placement resources.
- Development of an objective assessment process for evaluating the suitability of relative/kinship caregivers.
- Development of criteria to assist workers in making relative/kinship placement decisions.
- Promoting family involvement in the agency's case planning process.

Background

State law establishes a preference for relative care[12] for children legally removed from their parents and recognizes that "children who cannot be with their parents, guardians, or legal custodians are best cared for, whenever possible and appropriate by family members with whom they have a relationship."[13] Additionally, in 2003, the legislature required DSHS to design and implement strategies to prioritize the placement of children with willing and able kin when out-of-home placement is required.[14]

Moreover, The CA has identified enhancing relative/ kinship placements and engaging families in case plan development as major themes of its comprehensive reform plan.[15] CA efforts to strengthen and support relative placements include: a Title IV-E waiver proposal in order to "deliver enhanced, culturally competent and individually tailored kinship supports" that will engage relatives and fictive kin in the planning for and placement of their children;[16] revision of CA policy and procedures governing relative search and placement;[17] and the development of home-study guidelines to be used for assessing potential relative placements.[18]

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[12] RCW 13.34.060(1)(a); RCW 13.34.130(1)(b); RCW 13.34.130(2); and RCW 74.13.600.

[13] RCW 13.34.060 Notes: Finding 1999 c 17.

[14] RCW 74.13.600

[15] DSHS Kids Come First: Phase II Comprehensive Reform Plan (Draft) May 24, 2004.

[16] State of Washington Title IV-E Child Welfare Demonstration Waiver Proposal, January 23, 2004.

[17] CA Practices and Procedures Guide Section 4527- draft revision, December 1, 2003.

[18] DSHS memo: Relative Home Study- Social Worker Guide, April 16, 2004.

CWS determines that non-relative rather than relative placement is in child's best interests

The Ombudsman is frequently contacted when the DSHS Division of Children and Family Services (DCFS) is deciding on a permanent placement for a dependent child. Typically, emotions are charged as recently-located, sometimes estranged relatives vie with foster parents who have grown attached to the child after months or even years of foster care placement. Sometimes, the Ombudsman receives separate complaints from different parties involved in the case, each presenting their concerns about why they believe the agency is acting unfairly. In these cases, DCFS must grapple with competing policies governing placement of children: policies which state a clear preference for placing children with relatives, yet also dictate that the number of changes in placement should be minimized and the long-term "best interests" of the child maximized. Invariably, the best interests of the child are viewed differently by the various stakeholders involved.

One such complaint asked the Ombudsman to examine the reasonableness of DCFS' decision not to place a two-year-old dependent child with her relatives, even though the relatives had received an approved adoption home study and had adopted the child's older sibling. The two-year-old child was born drug-affected, and spent her first five months alternately with her mother, either at home or in a treatment center and in temporary foster care. At the age of five months, DCFS inquired if the relative was available to care for this child. However, due to a serious illness in the family, she was unable to take the child at that time. The relative also expressed ambivalence about her ability to take the child in the future, even if her husband's health improved. The child was then placed in a foster home with prospects for permanent placement if necessary.

When the child was almost a year old, the relative contacted the agency expressing interest in caring for the child. The agency provided an adoption home study, and according to the relative, encouraged her to obtain the parent's agreement to relinquish their rights and have her adopt the child. However, DCFS ultimately opposed moving the child from her current placement, based on the relative's earlier ambivalence and the child's healthy bonding with the foster parents. DCFS arranged for an evaluation to assess the child's relationship with the grandparents and with her foster-adopt parents and the capacity of both parties to parent this child long-term, which the court then ordered. This evaluation concluded that both parties would be capable caregivers, but recommended that given the level of bonding between the child and the foster parents, it would be in her best interests to remain with them and have ongoing, extensive contact with the relatives.

The Ombudsman reviewed the evaluation and the sequence of events in the case, and concluded that DCFS was not violating law or policy, that the relatives had been fairly considered for placement, and the agency's preference to maintain the child's placement with her foster parents was not unreasonable.

Rationale for Development of a statewide protocol for identifying relative/kinship placement resources

The Ombudsman has encountered numerous situations in which the DCFS failed to timely locate a relative who was willing and capable of caring for a child in state and also noted a lack of consistency in practice in conducting relative searches. CA's efforts to enhance relative/kinship placements must assure consistent, statewide compliance with policy and procedure governing relative searches. Whenever possible, efforts to locate relatives should begin prior to a child entering state care. For example, in a case of a family involved with CPS due to referrals for neglect, relatives should be identified before the actual need for out of home care arises. Relative search should continue throughout case management, until an appropriate permanent plan is implemented. Coordination between DCFS and other state agencies should expedite establishment of paternity, and engage paternal relatives. The results of DCFS' relative search activities must be consistently documented in the child welfare information management system.[19]

[19] Children's Administration Care Management Information Systems (CAMIS) is the Children's Administrations' information system in which they document activity on each case, such as the social worker's contact with the children, family, and service providers.

Rationale for the development of an objective assessment process for evaluating the suitability of relative/kinship caregivers

DCFS uses a less stringent assessment standard for temporary placements than for permanent placements.[20] However, uniform assessment standards should apply irrespective of whether the child's placement is considered to be temporary or permanent. This is essential for two reasons: first, children should not be subjected to a "lesser" standard simply because their placement may be temporary. Second, the nature of placements can change over time depending on the needs of a child. What started as a temporary placement may evolve to a permanent placement. The current difference in placement standards can result in delays in permanency and create multiple placements. An objective relative assessment process is essential to assure the safety and welfare of children placed in relative care. Assessments must also be completed in a timely manner so that a child may be placed with an available and appropriate relative as soon as possible. To this end, CA should make efforts to expedite relative home studies and coordinate with law enforcement to complete criminal history checks of relative caregivers and family members in a timely manner.

Rationale for the development of criteria to assist workers in making relative/kinship placement decisions

Placement decisions can be exceptionally difficult because they must be consistent with the agency's dual responsibilities to reunite families and act in the child's best interest. Additionally, placement decisions often encompass multiple policy goals that are often in conflict with each other, such as: consideration of parental preferences, limiting the number of out-of-home placements, maintaining sibling groups, preference for relative/kinship placements, and consideration of the child's bonding and attachment with a non-relative care provider. In order to make sound and consistent placement decisions in the context of multiple policy goals, CA should develop criteria to prioritize and balance competing policy goals. For example, criteria should address under what circumstances a child's attachment to a care provider might outweigh the preference for placement with an available relative.

Rationale for promoting family involvement in the agency's case planning process

In addition to providing placement and care, relatives can be a valuable asset in case planning. Efforts to engage relatives in a child's case should include improved communication between DCFS and relatives. For example, DCFS should notify relatives of the court process,[21] educate relatives regarding the child welfare system, and within confidentiality requirements, inform relatives of the status of the child's case. Procedures such as the case staffings including extended family, which engage relatives in the case planning process are valuable tools and should be utilized to address such issues such as placement, visitation, reunification, and permanency.

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[20] Children's Administration Practices and Procedures, Section 45273(C) only requires that the department determine that the home is minimally adequate for the care of children in order to initially place a child in a relative's care.

[21] In 2003, the Legislature took a significant step to involve relatives in a child's dependency proceeding, by allowing relatives to attend court hearings, even when the public is excluded, based on a finding of best interest of the child. RCW 13.34.115(3)(a).