Activities and Recommendations

# Office of the Family & Children's Ombudsman

2005 annual report

**STATE OF WASHINGTON**

# OFFICE OF THE FAMILY AND CHILDREN'S OMBUDSMAN

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April 2006

To the Residents of Washington State:

I am pleased to present to you the Annual Report of the Office of the Family and Children's Ombudsman, which summarizes the Ombudsman's activities for both 2004 and 2005. In these two years, the Ombudsman has witnessed the arrival of new leadership as well as an altered legal landscape. In this report, we recommend reducing caseworker and supervisor caseloads, strengthening the role that relative and foster care providers serve in the child welfare system, facilitating visitation between relatives and dependent children, and implementing reforms to prevent child fatalities.

This past year has brought new leadership to the Department of Social and Health Services (DSHS). We welcome Robin Arnold-Williams who has taken over the helm as Secretary of DSHS and Cheryl Stephani, Assistant Secretary of DSHS. We look forward to maintaining a collegial relationship in our work to ensure better outcomes for families and children.

The Legislature enacted several measures to strengthen the child protection system. We want to thank them deeply for their tireless efforts, particularly in the areas of ongoing concern to our office, such as improving CPS intervention in cases of chronic neglect, screening of referrals on abuse and neglect of adolescents, and addressing postpartum depression as it affects parenting.

Our new Governor, Christine Gregoire, set the stage for signing these measures into law. She provided immediate energy and initiative by articulating a "back to basics" approach to child welfare. We very much appreciate her interest and support of the work that we do.

In addition to this executive and legislative oversight, a group of experts from across the nation, the Braam panel, will be instrumental in improving our child protection and child welfare services. By ensuring that DSHS complies with a settlement agreement reached after litigation by a class of foster children, the panel will help DSHS realize internal reform. This has been a formidable undertaking and we wish to thank the Panel for its vital and conscientious work.

Tragically, child fatalities continued to demand a significant part of our focus. We reviewed the fatalities of 16 month-old Justice and six-week-old Raiden Robinson. This sobering process was repeated with the death of 4 year-old Sirita Sotelo. We continue to have grave concerns that the recommendations that arise from these and other fatality reviews, which could be life saving, are not being sufficiently and consistently implemented.

On behalf of all of us at the Office of Family and Children's Ombudsman, we appreciate your interest in our work. We greatly value our role as a voice for the families and children of Washington State and understand that we could not realize this role without the input of our advisory boards, oversight of the Legislature, and the input of citizens and professionals. Thank you for contributing to the welfare of children and families.

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

Teresa Berg
Pierce County Sheriff's Office,
Tacoma

Lois Schipper
Seattle & King County Public Health,
Seattle

Linda Katz
King County Superior Court,
Seattle

Daryl Daugs
Families for Kids,
Bremerton

### 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

Lauri 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

Dann Flesher
Relatives as Parents,
Benton City

### 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 Telvin
Whitman County
Court Appointed Special Advocate,
Colfax

Rosey Thurman
Team Child,
Spokane

Dave Williams
Partners with Families and Children,
Spokane

Greg Casey
Private Attorney,
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 Ruth Kagi
32nd District

# Table of Contents

# Executive Summary

In 1996, the Washington State Legislature, with the enactment of Chapter 43.06A RCW, created the Office of the Family and Children's Ombudsman. The Legislature charged the Ombudsman with investigating 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's Role:**

- Investigate and respond to complaints
- Recommend system-wide improvements
- Educate citizens about the child welfare process
- Act on behalf of children and families

## The Role of the Ombudsman

The Ombudsman operates under the Office of the Governor, independent of the Department of Social and Health Services (DSHS). Acting as a 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-and-a-half 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 a particular issue. To respond effectively to citizens' questions and concerns, the Ombudsman first determines if their concern falls within the scope of the Ombudsman to investigate, or if there is another resource available to better assist them.

Between September 1, 2003 and August 31, 2005, the Ombudsman received over 3,000 inquiries from families and citizens who needed information. During this same two-year period, the Ombudsman received over 900 complaints.

Most of the complaints filed with the Ombudsman were filed by parents and other family members. The top two issues citizens brought to the Ombudsman were 1) complaints about child safety, expressing concerns about the inadequate response by DSHS to reported maltreatment of children, and 2) complaints expressing concerns about family separations and reunification. In addition, a significant number of complaints involved the health, well-being and permanency of dependent children.

## 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, 2003 and August 31, 2004, the Ombudsman completed 425 complaint investigations and between September 1, 2004 and August 31, 2005, the Ombudsman completed 427 complaint investigations. For both reporting years, the majority of completed investigations were standard, non-emergent investigations (84%). Approximately one out of six complaints, however, met the Ombudsman criteria for an emergent complaint. These most often involved complaints about child safety or well-being.

In previous years, the annual report included three main categories of Ombudsman actions: inducing corrective action, facilitating resolution, and preventing future mistakes. This year the Ombudsman captures a previously unreported category: poor practice. These cases involve decisions by agency personnel that, although not violations of law, policy, or procedure, do not reflect best practice. In these cases, the Ombudsman intervened if the action complained of was current, or brought to the agency's attention the failure to achieve best practice if the complaint involved past action. The actions listed in this new category made up 33% of the total actions reported by the Ombudsman.

## Review of Fatalities

The Ombudsman receives notice from DSHS/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 is identified as a factor in the death of a child.

In the past two years, the Ombudsman conducted two investigations into high profile fatalities. Justice and Raiden Robinson died with a CPS referral still open after 9 months. Sirita Sotelo died two months after her dependency was closed. Based on these two investigations, the Ombudsman made a series of recommendations for DSHS including:

- Improving procedures for case reviews by CPS supervisors;
- Implementing caseload standards for CPS workers and supervisors;
- Modifying the statutory provisions governing CPS investigations and interventions;
- Requiring CPS to attempt to obtain mental health evaluations of a parent when mental health issues contribute to the alleged child abuse or neglect;
- Strengthening case supervision following a child's return to a parent's care;
- Assuring that appropriate services for successful reunification are provided; and
- Improving assessment of other adult caregivers in parent's home.

In view of the valuable information gathered from examining the Robinson and Sotelo child fatalities, the Ombudsman compiled and analyzed data on unexpected deaths of 87 children who died in 2004. These children had received services from DSHS Children's Administration within one year of their death, or had been in the care of the agency within this timeframe.

This analysis led to the development of several practice and systemic recommendations within this annual report, which we believe will substantially improve the child protection system. Among these, the Ombudsman recommends reinstating a coordinated statewide child fatality review process so that both the Department of Health and the Department of Social and Health Services Children's Administration can bring their joint expertise to the table. This will put back into place a solid framework to ensure that all sudden and unexpected deaths of children are reviewed and that such reviews reflect a multidisciplinary approach.

A proper review depends on getting accurate and reliable data. For that reason, among our recommendations you will find a suggestion that counties be audited to ensure that unexpected deaths of young children are being investigated in accordance with protocols that have been established pursuant to Washington's SIDS law, Chapter 43.103 RCW.

The Ombudsman believes it is critical there be a system in place to monitor implementation of recommendations that arise from child fatality reviews. Unless this is put into place, the value of child fatality reviews is undermined.

Our review of these 87 deaths confirmed what we already knew—that child fatalities represent the greatest failure of the child protection system, but also the most meaningful opportunity for reform. For the study of a child's death to result in improved practice, it must be based on complete, accurate, and impartial data; and a multidisciplinary group of professionals must evaluate these recommendations to prioritize them, and determine how they should be implemented. Without a concrete system for considering and implementing such changes based on the findings of these investigations, the reviews are an exercise in futility.

## Foster Parent Retaliation

In 2004, the Legislature gave foster parents the clear right to file a complaint with the Ombudsman if they believed they had been retaliated against for engaging in a protected activity, such as advocating for services on behalf of the foster child. In response to the 2004 legislation, the Ombudsman developed an analytical framework for determining whether retaliation had occurred. Retaliation complaints are complex because of vastly contradictory interpretations of events. As a result, making a determination of whether or not retaliation occurred can be a difficult, time consuming process. But if illegal retaliation occurred, then the Ombudsman will intervene.

In addition to the response to the retaliation legislation, the Ombudsman has conducted a series of meetings with foster parents, in organized groups and in other settings, to hear the concerns of foster parents regarding our current foster care system. Several of these concerns are listed in this report.

## Issues and Recommendations

After complaint investigations, the Ombudsman spends the most time on identifying and investigating system-wide problems. The Ombudsman has identified and investigated three systemic issues that are the subject of findings and recommendations in this report:

1. Reduce caseloads of caseworkers and supervisors;
2. Provide caregivers with a greater and more consistent opportunity to be heard; and
3. Provide relatives who have an established relationship with a child ongoing contact after the child has been placed out of home pursuant to a dependency action.

In addition, the Ombudsman has identified four areas of concern that the Ombudsman intends to review and investigate in the coming year. The systemic recommendations are to:

1. Inadequate recruitment, licensure, and retention of foster homes;
2. Inadequate screening of individuals who provide care to dependent children and youth under the supervision of the state as well as non-dependent children in licensed daycare;

3. Failure of DCFS to encourage the maximum parent and child and sibling contact possible, consistent with existing law; and
4. Removal of children from long-term care pre-adoptive placements.

## Response to the Ombudsman's Previous Systemic Recommendations

This section details the responses of the Children's Administration and the Legislature to systemic recommendations made by the Ombudsman in previous reports, including the 1999, 2000, 2003 Annual Reports, and the Justice and Raiden Robinson Fatalities Review Report. These responses include a number of policy changes on the part of the Children's Administration. These responses also include two bills passed by the Legislature that address recommendations made in part by the Ombudsman regarding the need for greater protection of adolescents and intervention in cases of chronic neglect.

## Ombudsman Activities

In addition to investigating complaints and investigating systemic problems, the Ombudsman is also charged with promoting public awareness and understanding of family and children services. The Ombudsman accomplishes this task by actively participating on committees established to critically examine child protection/welfare issues, presenting at conferences, reviewing and analyzing proposed legislation, testifying before the Legislature, and conducting site visits of state-licensed facilities. Included in this section is a list of such activities the Ombudsman has completed in the past two years.

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## 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
CWS .....Child Welfare Services
DSHS .....Department of Social and Health Services
DCFS.....Division of Children and Family Services
FRS.....Family Reconciliation Services

# The 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.

## 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.

## 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**
*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.

**Ombudsman**
*Steven Wolfson* is a social worker with extensive experience working with families and youth. Most recently, Mr. Wolfson served as a court appointed Guardian ad Litem, investigating and making recommendations to the court regarding child custody and visitation disputes. From 1990 to 2000, Mr. Wolfson served as Clinical Director at Kent Youth and Family Services. Mr. Wolfson is a graduate of Clark University in Worcester, Massachusetts and University of Washington School of Social Work. He is a Licensed Independent Clinical Social Worker.

**Ombudsman**
*Keith Talbot* is an attorney who before joining OFCO served as a law clerk to the Honorable William W. Baker at the Washington State Court of Appeals and served as a bailiff/law clerk to the Honorable Charles W. Mertel in King County Superior Court. He received a joint J.D./Master of Public Policy from Duke University. Before graduate school, he provided direct service to at-risk youth through experiential education/leadership training programs with the American Youth Foundation based in New Hampshire, and the Cornstalk Institute based in Albuquerque, NM. He also served two years as a volunteer in the United States Peace Corps working to reduce the infant mortality rate in the southwest of the Dominican Republic.

**Information Specialist/Office Administrator**
*Rachel Pigott* holds a Master's Degree in Social Work from Boston University. Before joining OFCO, she worked to improve attendance by working with families through the Boston Public Schools. She spent one year in the AmeriCorps working to strengthen families and to connect undergraduate students from Western Washington University to their community through coordinating service-learning projects. She was also a Program Specialist for the Boston Center for Adult Education.

**Research Analyst**
*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.

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

**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.

# Inquiry and Complaint Profiles

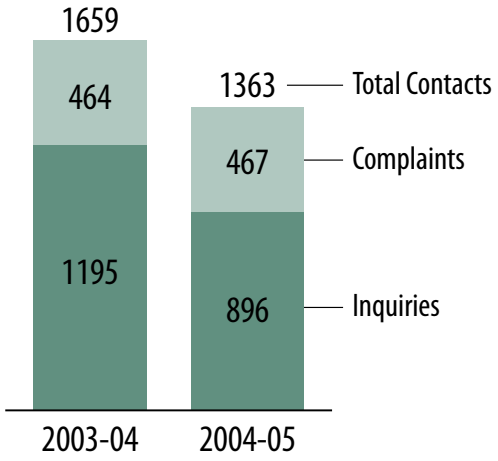
The Ombudsman listens to families and citizens who **contact** the office with questions or concerns about services provided through the child protection and child welfare system. By listening carefully, the Ombudsman is able to respond effectively to their **inquiries** and **complaints**.

This section describes contacts made by families and citizens during the reporting period of September 1, 2003 to August 31, 2004 and the reporting period of September 1, 2004 to August 31, 2005.

## Contacts to the Ombudsman

**From September 1, 2003 to August 31, 2004,** families and citizens contacted the Ombudsman **1659** times. **From September 1, 2004 to August 31, 2005**, families and citizens contacted the Ombudsman **1363** times[1]. These contacts were primarily **inquiries** made by persons in search of information and assistance. Approximately **one third** of these contacts were formal **complaints** seeking an Ombudsman investigation.

**Contacts to the Ombudsman**




Source: Office of the Family and Children's Ombudsman, February 2006

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

**Inquiries.** Persons call or write to the Ombudsman wanting basic information on how the office can help them with a concern, or with questions about the child protection or 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.

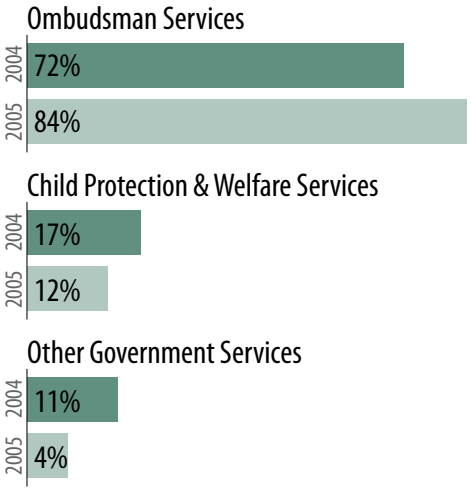
**Complaints.** Persons file a complaint with the Ombudsman when they have a specific complaint against the Department of Social and Health Services or other agency that they want the office to investigate. The Ombudsman investigates every complaint that is within its jurisdiction.

[1] The Ombudsman no longer documents non-OFCO inquiries, due to workload constraints. OFCO staff refer non-OFCO inquiries to the appropriate resource, such as other ombudsman, the landlord/tenant information line, or children and family ombudsman in other states.

## Fielding Inquiries

In 2004, the Ombudsman received **1,195** inquiries from families and citizens who needed information at an average rate of **23 inquiries per wee**k.

**Most Inquiries Seek Information on How the Ombudsman Can Help**




Source: Office of the Family and Children's Ombudsman, February 2006

- **About 72% 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 17% concerned laws, policies** and procedures for child protection and child welfare services. The Ombudsman does not provide legal advice or explain legal rights and responsibilities.
- **About 11% other government services.** The Ombudsman found out who to contact and referred these people to agencies that could help.

In 2005, the Ombudsman received **896 inquiries** from families and citizens who needed information at an average rate of **17 inquiries per week.**

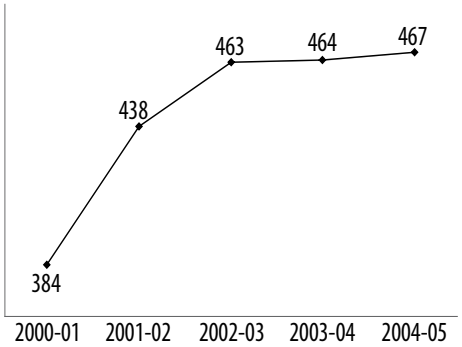
- **About 84% wanted basic information** on how the Ombudsman could help, how to file a complaint, and how to get a complaint form. If their concern involved the Department of Social and Health Services (DSHS) Children's Administration, OFCO explained that they have the right to contact the Office of Constituent Relations.
- **About 12% concerned laws, policies,** and procedures for child protection and child welfare services. Ombudsman does not provide legal advice or explain legal rights and responsibilities.
- **About 4% 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.

**Annual Complaints to the Ombudsman**




Source: Office of the Family and Children's Ombudsman, February 2006

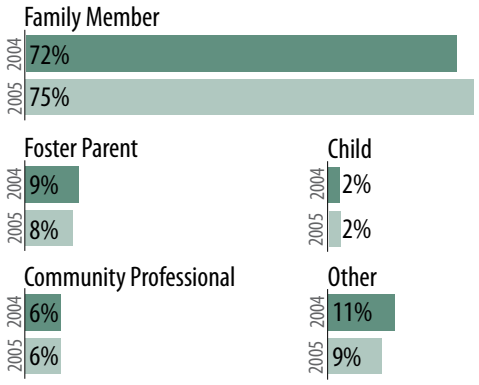
**The Ombudsman received 464 complaints in 2004 and 467 complaints in 2005.** The Ombudsman continues to receive a high number of complaints and the number of complaints filed with the Ombudsman shows no signs of slowing.

# Complainant Profiles[2]

## Persons Who Complained

As in previous years, parents, grandparents and other relatives of the child whose family is involved with DSHS filed the majority of the complaints to the Ombudsman. The graph below demonstrates how constant these numbers were over the past two reporting years.

**Persons Who Complained to the Ombudsman**



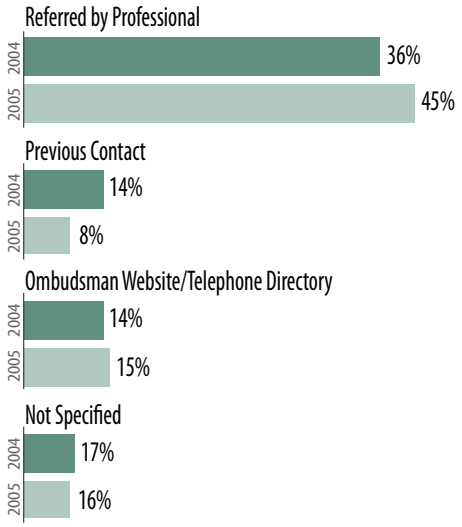

Source: Office of the Family and Children's Ombudsman, February 2006

## How they Heard about the Ombudsman

In 2004, 71 percent of individuals filing complaints with the Ombudsman indicated that they were referred to the office by someone else. Close to 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. Other individuals were referred by a friend or family member, the Governor's Office, an attorney, or a CASA/GAL. In 2004, 14 percent knew about the office from a previous contact, while 14 percent said they found the office via the Ombudsman web site or telephone directory.

In 2005, 77 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/service provider (e.g., teacher, counselor, child care provider, doctor, private agency social worker, mental health professional) or DSHS worker. Other individuals were referred by a friend or family member, the Governor's Office, an attorney or a CASA/GAL. In 2005, 8 percent knew about the office from a previous contact, while 15 percent said they found the office via the Ombudsman web site or telephone directory.

**How They Heard About the Ombudsman**




Source: Office of the Family and Children's Ombudsman, February 2006

## Complaints Involving DSHS

The Department of Social and Health Services 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 95 percent of complaints in 2004 and 93 percent of complaints in 2005 to the Ombudsman.[3]

[2] Complainant profiles based on complaints closed during the reporting year.

[3] The remaining complaints were directed against: Other DSHS divisions, Washington Courts, Division of Developmental Disabilities, local CASA/GAL program, DSHS contract providers, and tribal welfare services.

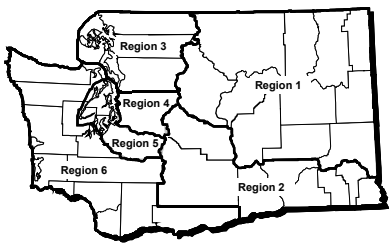
Of these, 95 percent in 2004 and 93 percent in 2005 were directed at the Division of Children and Family Services (DCFS), which includes Child Protective Services, Child Welfare and Adoption Services, and Family Reconciliation Services. A small percentage involved the Division of Licensed Resources (DLR), which licenses and investigates alleged child maltreatment in foster homes, group homes, and other residential facilities for children.

## Complaints against the Children's Administration by DSHS Region

| | 2004 | | 2005 | |
|---|---|---|---|---|
| | DCFS | DLR | DCFS | DLR |
| **Region 1 Totals** | **58** | **3** | **55** | **1** |
| Clarkston | 0 | | 0 | |
| Colfax | 0 | | 2 | |
| Colville | 6 | | 3 | |
| Moses Lake | 13 | | 8 | |
| Newport | 1 | | 0 | |
| Omak | 0 | | 3 | |
| Region 1 Central Office, Spokane | 32 | 3 | 33 | 1 |
| Wenatchee | 6 | | 6 | |
| Republic | 0 | | 0 | |
| **Region 2 Totals** | **59** | **1** | **41** | **1** |
| Ellensburg | 5 | | 4 | |
| Region 2 Central Office, Yakima | 5 | | 2 | |
| Richland/Tri-Cities | 22 | | 19 | |
| Kennewick | 1 | | 0 | 1 |
| Sunnyside | 0 | | 1 | |
| Toppenish | 1 | | 1 | |
| Walla Walla | 13 | | 6 | |
| Yakima | 11 | 1 | 6 | |
| White Salmon | 0 | | 2 | |
| Goldendale | 1 | | 0 | |
| **Region 3 Totals** | **78** | **0** | **81** | **2** |
| Alderwood/Lynnwood | 10 | | 9 | 1 |
| Arlington/Smokey Point | 22 | | 18 | 1 |
| Bellingham | 3 | | 7 | |
| Everett | 17 | | 15 | |
| Friday Harbor | 0 | | 1 | |
| Monroe/Sky Valley | 3 | | 3 | |
| Mount Vernon | 6 | | 12 | |
| Oak Harbor | 8 | | 7 | |
| Region 3 Central Office, Everett | 9 | | 9 | |

| | 2004 | | 2005 | |
|---|---|---|---|---|
| | DCFS | DLR | DCFS | DLR |
| **Region 4 Totals** | **89** | **7** | **91** | **6** |
| Belleveue/King Eastside | 18 | | 10 | |
| Kent/King South | 22 | 2 | 33 | 1 |
| King West | 24 | | 17 | 2 |
| Region 4 Central Office, Seattle | 6 | 3 | 13 | 2 |
| African-American Children's Services | 14 | | 11 | |
| Seattle Centralized Services (include NA unit) | 5 | 2 | 7 | 1 |
| **Region 5 Totals** | **59** | **1** | **68** | **1** |
| Bremerton/Kitsap | 9 | | 23 | |
| Region 5 Central Office, Tacoma | 50 | 1 | 45 | 1 |
| **Region 6 Totals** | **66** | **3** | **60** | **1** |
| Aberdeen | 12 | | 12 | |
| Centralia | 7 | 1 | 8 | |
| Kelso | 8 | | 5 | |
| Port Angeles | 5 | | 3 | |
| Port Townsend | 2 | | 3 | |
| Region 6 Central Office, Lacey/Olympia | 9 | 1 | 1 | |
| Shelton | 4 | | 4 | |
| South Bend | 0 | | 0 | |
| Stevenson | 0 | | 1 | |
| Tumwater | 4 | | 0 | |
| Vancouver | 12 | 1 | 14 | |
| Forks | 2 | | 2 | 1 |
| Long Beach | 1 | | 7 | |
| **Statewide** | **4** | **2** | **3** | |
| Central Intake Unit | 4 | | 1 | |
| Children's Administration Headquarters | | 2 | 2 | |

DCFS - Division of Children and Family Services
DLR - Division of Licensed Resources



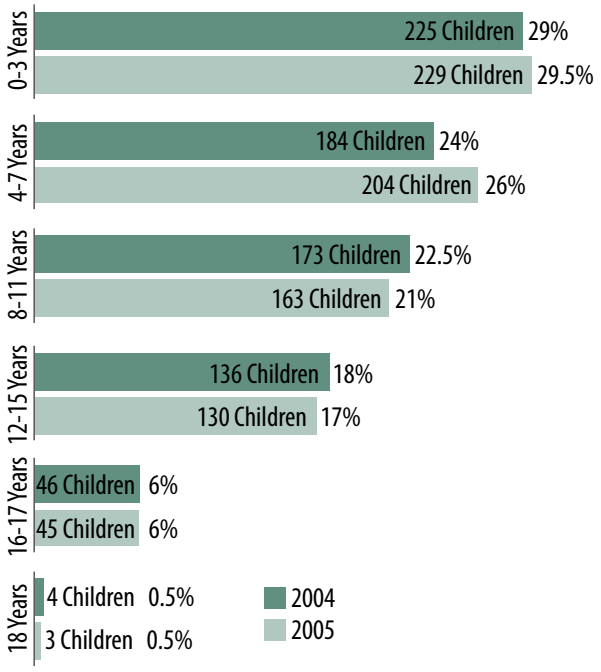
## Complaint Issues

As in previous years, safety of children was frequently identified in complaints to the Ombudsman. Complainants were concerned with the allegedly inadequate response by the Department of Social and Health Services 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 separations and reunification and the health, well-being and permanency of the children under state supervision were also identified in complaints to the office. The table below shows breakdown of complaints received in the three most frequently identified complaint categories.

**Most Frequently Identified Complaint Issues**

| (Many complaints identified more than one issue) | 2004 | 2005 |
|---|---|---|
| **Child Safety** | **218** | **164** |
| Failure to protect children from parental abuse or neglect | 156 | 109 |
| Physical abuse | 42 | 38 |
| Sexual abuse | 25 | 19 |
| Emotional abuse | 19 | 5 |
| Neglect/lack of supervision | 66 | 47 |
| Other | 4 | -- |
| Developmentally disabled child in need of protection/other | 3 | 5 |
| Children with no parent willing/capable of providing care | 13 | 15 |
| Failure to address safety concerns involving child in foster care or other substitute care | 41 | 32 |
| Failure to address safety concerns involving child being returned to parental care | 5 | 3 |
| **Family Separation and Reunification** | **212** | **186** |
| Unnecessary removal of child from parental care | 54 | 34 |
| Unnecessary removal of child from relative placement | 18 | 16 |
| Failure to place child with relative (including siblings) | 53 | 36 |
| Other inappropriate placement of child | 9 | 5 |
| Failure to provide appropriate contact between child and family | 31 | 25 |
| Failure to reunite family | 42 | 50 |
| Inappropriate termination of parental rights | 5 | 11 |
| Concerns regarding voluntary placement/service agreements for non-dependent children | -- | 8 |
| Other family separation concerns | -- | 1 |
| **Dependent Child Health, Well-being & Permanency** | **75** | **88** |
| Inappropriate change of child's foster/other placement, inadequate transition to new placement | 27 | 19 |
| Failure to provide child with needed medical, mental health, educational/other services, or inadequate service plan | 24 | 26 |
| Inappropriate permanency plan or unreasonable delay in achieving permanency | 12 | 22 |
| Failure to provide appropriate adoption support services/other adoption issues | 9 | 16 |
| Inappropriate placement/inadequate services to dependent/non-dependent children in institutions/facilities | 3 | 5 |
| **Other Complaint Issues** | **22** | **18** |
| Foster care licensing/foster parent issues | 10 | 9 |
| Breach of client confidentiality by agency | 5 | 3 |
| Unprofessional conduct by agency staff, harassment or retaliation | 7 | 6 |

**Ages of Children Identified in Complaints**




Source: Office of the Family and Children's Ombudsman, February 2006

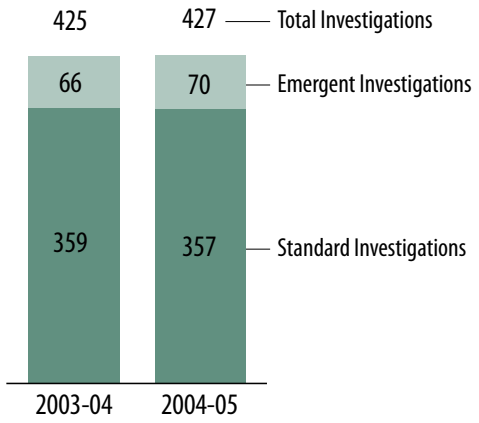
Most of the children identified in complaints to the Ombudsman were age seven or younger.

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

# Responding to Complaints

The Ombudsman investigates and analyzes every complaint that it receives.[1] Through impartial investigation and analysis, the office determines an appropriate response. 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 to August 31




Source: Office of the Office of the Family and Children's Ombusdman, January 2006

## Completed Investigations

Between September 1, 2003 and August 31, 2004 (referred to as Reporting Year 2004 throughout this report), the Ombudsman completed 425 complaint investigations.[2] For the same period in 2004-2005 (Reporting Year 2005), a total of 427 investigations were completed.[3] For both reporting years, the majority of completed investigations were standard non-emergent investigations (84%). One out of every six 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.

## 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.

[1] The Ombudsman may also initiate an investigation without a complaint. During the reporting period, the office initiated seven investigations as a result of independent information obtained, for example, by way of news reports. Three of these investigations remained open at the end of the reporting period. Two investigations were closed after the Ombudsman's concerns were resolved, and two were closed after intervention by the Ombudsman (see next section on findings). These four closed investigations are included in the data in this section.

[2] Of the 425 investigations completed in 2004, 81% were investigations of complaints received during the reporting year, while 19% were of complaints received in a previous year. At the end of the reporting year, 3% of complaint investigations were still open. Of the 427 investigations completed in 2005, those figures are 83%, 18%, and 17% respectively.

[3] For the purposes of this section, investigations of complaints raising identical issues involving the same child/family are counted only once. The actual number of complaints closed, including these identical complaints from more than one complainant, was 458 in 2004, and 453 in 2005.

## 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.

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.)*

**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.

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 Investigations

The Ombudsman criterion for initiating an emergent investigation:

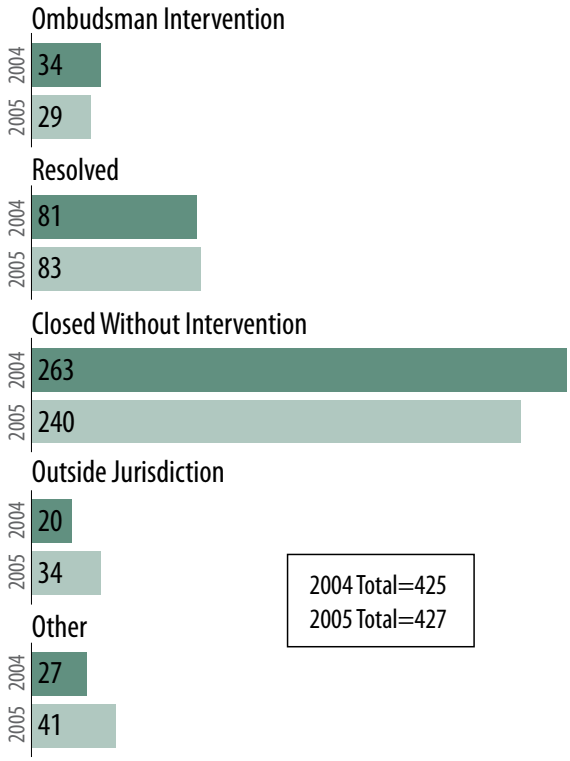
*If true, the alleged agency action or inaction places the safety or well-being of a child or family at imminent risk of harm.*

## Investigation Results

Between September 1, 2003 and August 31, 2004, 8% of all complaint investigations required direct intervention by the Ombudsman to induce the agency to correct an unauthorized or unreasonable decision or course of action (see Chart 1). These investigations were almost always closed with the complaint issue having been resolved. Another 19% of investigations were closed with the complaint issue having been resolved either with or without assistance from the Ombudsman. Examples of such cases include efforts to ensure that critical information was obtained and considered by the agency, or facilitating timely communication among the people involved in order to resolve the problem. A further 62% of investigations were closed after the Ombudsman either found no basis for the complaint, or found no unauthorized or unreasonable actions by the agency warranting the Ombudsman's intervention. Five percent of complaints fell outside the Ombudsman's jurisdiction, while the remaining investigations (6%) were closed with no further action, due to the complaint being withdrawn, becoming moot, or where further action was not feasible for other reasons.

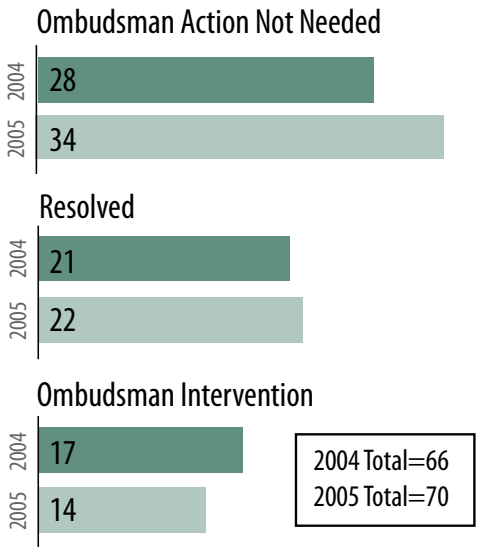
For the same period in 2004-2005, 7% of complaints required direct intervention by the Ombudsman, 19% were closed as resolved, 56% were closed with no further action, 8% fell outside the Ombudsman's jurisdiction, and the remaining 10% were withdrawn, moot, or not feasible.

**Chart 1: All Investigation Results, 2004 & 2005**




Source: Office of the Family and Children's Ombudsman, January 2006

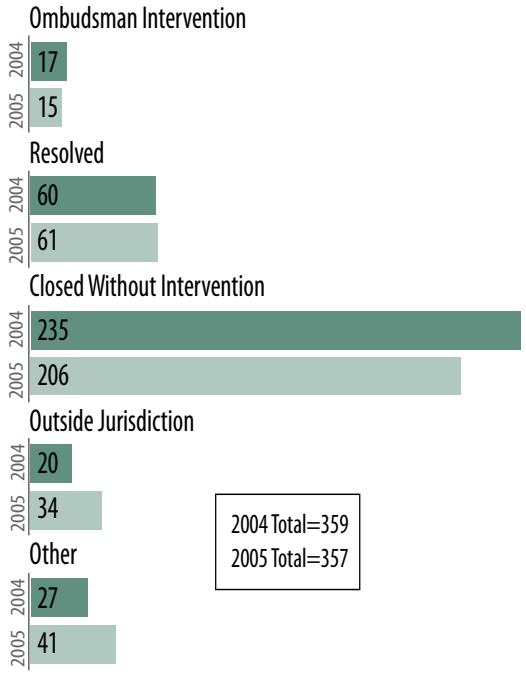
**Chart 2: Emergent Investigation Results 2004 & 2005**




Source: Office of the Family and Children's Ombudsman, January 2006

Chart 2 shows the breakdown of results of complaints that were the subject of emergent investigation for 2004 and 2005, respectively.

**Chart 3: Standard Investigation Results 2004 & 2005**




Source: Office of the Family and Children's Ombudsman, January 2006

Chart 3 shows the results of complaints that were the subject of a standard (non-emergent) investigation for each reporting year.

# 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.

**The Ombudsman is often successful in resolving legitimate concerns by working with agencies to:**

- Induce corrective action
- Facilitate resolution
- Avoid errors and conduct better practice
- Prevent future mistakes

In some cases, the Ombudsman finds that the agency's actions are not in clear violation of law or policy, but rather is poor practice. When the complaint involves a current action, the Ombudsman intervenes to assure better practice. And when the complaint involves a past action, the Ombudsman documents the issue and brings it to the attention of the agency.

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 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.

### COMPLAINT ISSUE: CHILD SAFETY FROM ABUSE

**Finding**: CPS[1] failed to convene a Child Protection Team (CPT) meeting regarding the case plan for a three-year-old non-dependent child who had been physically abused by his parent's paramour. Policy requires that a CPT be consulted in cases where a subject child is under age six and the risk level is assessed as moderately high or high, or when there is disagreement among the professionals involved regarding the case plan. All of these factors were present in this case (the physician disagreed with the plan to return the child home).

**Outcome**: The Ombudsman requested that CPS convene a CPT, which it did. The CPT recommended the child remain in the home with a number of additional safeguards. The parent signed a voluntary service agreement with all recommended services, as well as a comprehensive safety plan.

**Finding**: CPS failed to investigate allegations of medical neglect and physical abuse of two children, ages one and two, one of which was developmentally delayed and had medical problems. The most recent high-risk referral, from a medical professional, reported suspected non-accidental injury to the two-year-old (a broken leg). Because of high workload, CPS had waived the procedural requirement for the worker to investigate the referral within ten workdays. When the agency attempted to make contact with the family, they had moved to another region of the state. The referral was not forwarded to that region for investigation based upon the CPS supervisor's premature conclusion that abuse had already been ruled out as a cause of the injury. The Ombudsman found this to be unreasonable given the seriousness of the abuse allegations, the family's history, and the additional medical information obtained by the Ombudsman's investigation.

**Outcome**: The Ombudsman contacted CPS who agreed to forward the referral to the new region. The referral was investigated, and the family was provided with needed services, including family preservation services, public health nursing, and day care services.

**Finding**: CPS failed to take sufficient action to protect two non-dependent children, ages one and three, from physical abuse by their father. The safety plan established by CPS allowed the father to remain in the home with only supervised contact with the children, to be enforced by the mother. This was unreasonable, given the parents' initial untruthful explanation regarding the three-year-old's injury, the fact that the mother was protective of the father and would not agree to have him temporarily leave the home, and a previous report of physical abuse in another state.

**Outcome:** The Ombudsman discussed these concerns with the Regional Administrator, and CPS strengthened the safety plan by requiring a neutral third party to live in the home and monitor the father's contact with the children. CPS also obtained out-of-state CPS records on the family, a case review by a child abuse medical expert, parenting/psychological evaluations on both parents, and an anger management evaluation of the father. Later, during an unannounced home visit, CPS found the father in violation of the safety plan. A dependency was filed and the children were removed.

**Finding**: CPS failed to thoroughly assess the risk of harm to a pair of five-month-old non-dependent twins, when returning them to the care of their parents after a voluntary placement with relatives. One of the infants had incurred serious physical injuries suspicious for abuse. At a CPT meeting held to assist in deciding whether to return the infants to their parents, medical reports on both infants were presented. The CPT recommended returning the children home. However, in reviewing the medical reports, the Ombudsman found that there were concerning findings on the skeletal survey of the non-injured infant. In addition,

[1]Abbreviations used for agency divisions/sections: AAG=Assistant Attorney General, CA=Children's Administration, DCFS=Division of Children & Family Services, CPS=Child Protective Services, CWS=Child Welfare Services, FRS=Family Reconciliation Services, DLR=Division of Licensed Resources, OFCL=Office of Foster Care Licensing, CPT=Child Protection Team. Note that DLR has its own CPS units and those units are referred to as DLR/CPS.

## Inducing Corrective Action *(continued)*

the relatives with whom the infants were placed had not been invited to share information with the CPT, as required by policy.

**Outcome**: The Ombudsman contacted CPS and found that none of the CPT members had read the medical reports, and the concerning medical findings regarding the other infant had not been brought to their attention. CPS agreed to convene another meeting to address this new information, and allow the relative caregiver to present her observations of the infants and parents to the team. The CPT recommended filing a dependency, which the agency did, and the children were placed with the protective parent while the parent suspected of abuse was allowed only supervised contact with the infants.

**Finding**: CPS failed to document the whereabouts and safety of a twelve-year-old non-dependent child who was listed along with his older sibling as an alleged victim of physical and emotional abuse. The child had not been interviewed as part of the CPS investigation, because the family court had placed him with his non-custodial parent out-of-state.

**Outcome**: The Ombudsman contacted the CPS supervisor pointing out the lack of documentation regarding the agency's work to verify that the child was in a safe environment, and to explain why he had not been interviewed. The supervisor agreed to correct the summary records.

### COMPLAINT ISSUE: CHILD SAFETY FROM NEGLECT

**Finding**: CPS failed to screen in for investigation, a referral alleging neglect and emotional abuse of a non-dependent nine-year-old child, secondary to her parent's untreated mental illness. Instead, it was referred to the Alternative Response System (ARS) for provision of prevention services to the family.

**Outcome**: The Ombudsman contacted the CPS intake supervisor expressing concerns that given the parent's unwillingness to receive treatment for her mental illness and the five CPS referrals received in the last year, the child appeared to be at greater risk than was appropriate for services available through ARS. The supervisor agreed and assigned the referral for investigation. Finding the parent's capacity to care for the child seriously compromised, CPS facilitated a voluntary placement of the child with a relative.

**Finding**: CPS failed to adequately investigate allegations of neglect of a non-dependent infant and closed its case without services in place to assure the child's health and safety. The CPS investigation was compromised by professional misconduct on the part of the caseworker.

**Outcome**: The Ombudsman contacted the Regional Administrator and a new CPS referral was generated. A thorough investigation was conducted, and services provided to the family, including monitoring of the infant's safety. The Ombudsman verified that the agency was conducting an internal investigation into the caseworker's misconduct. The caseworker subsequently left the agency.

**Finding**: CPS failed to screen in for investigation a referral alleging that two children, ages one and two, were being exposed to methamphetamine use by a parent, and that the children appeared to be suffering symptoms of exposure to the drug. The referral was screened as "information only" as the exact location of the family was unclear. The referent had, however, indicated that the family might be staying at a local shelter.

**Outcome**: The Ombudsman requested a review of the screening decision, and following this, the referral was screened in for investigation. CPS began efforts to locate the family and assess the children's safety, enlisting the assistance of law enforcement. The family was located and the children's safety was addressed.

**Finding**: CPS failed to investigate referrals alleging neglect of a nine-year-old developmentally disabled child by the parents, due to the uncertain location of the family. The Ombudsman found the decision to screen the referrals as "information only" unreasonable, in light of the fact that the parents had been banned from homeless shelters due to chronic alcohol use, the child was not attending school, had been living in sub-standard, transient conditions over an extended period, and had reportedly lost weight.

## Inducing Corrective Action *(continued)*

**Outcome**: The Ombudsman requested that CPS review the recent and prior referrals on the family. Based on this review, CPS agreed to make efforts to locate the family, enlisting the assistance of law enforcement. The police located the family, and the child was taken into protective custody. CPS entered into a voluntary placement agreement with the parents, the child was placed in temporary foster care, and the parents were assisted with services.

**Finding**: CPS failed to provide the family of an eight-year-old child with special needs with appropriate services to assist in caring for the child safely and protecting his ten-year-old sibling from harm. The child had significant mental health problems, and engaged in behaviors endangering himself and others. The parent was clearly overwhelmed and unable to protect the children's health and safety.

**Outcome**: The Ombudsman discussed these concerns with the Regional Administrator. As a result, the agency entered into a voluntary placement agreement with the parent, whereby the child was placed in therapeutic foster care and provided with mental health treatment, and additional services provided to the family with the goal of returning the child home.

**Finding**: CPS failed to file a dependency in a timely manner to protect a non-dependent twelve-year-old child from medical neglect by her custodial parent. The child's medical provider had reported the neglect to CPS, stating that the consequences could be life threatening. CPS delayed in filing a dependency to allow the non-custodial parent to petition for custody through the family court. This delay resulted in the child remaining in hospital longer than medically necessary, and provided no legal restraint on the custodial parent removing the child from the hospital and subjecting her to further medical neglect.

**Outcome**: The Ombudsman requested a review of the case by the Area Administrator. As a result, the administrator directed CPS to file a dependency if the non-custodial parent had not obtained custody within a tight deadline. When this had not occurred, CPS promptly filed for dependency on this date.

**Finding**: CPS failed to screen in for investigation, allegations of neglect regarding three non-dependent children ages nine, seven and three years old. Referral information included ongoing domestic violence and substance abuse by the parents, as well as screaming at and harsh treatment of the children.

**Outcome:** OFCO requested that CPS review the screening decision in light of several previous referrals reporting similar allegations, and the parents' failure to engage in services. This resulted in CPS screening the referral in for investigation, and subsequently offering services and providing other assistance to the family.

### COMPLAINT ISSUE: DEPENDENT CHILD SAFETY IN OUT-OF-HOME CARE

**Finding**: DLR failed to require a foster parent with multiple reports of suspected sexual abuse of foster children, to undergo a sexual deviancy evaluation.

**Outcome**: The Ombudsman recommended to DLR that an evaluation be obtained, based on the numerous referrals (17) and sexualized behaviors reported in a number of foster children that had been placed in this home. DLR requested an evaluation, but the foster parent refused to comply. DLR removed the foster children in the home and planned to revoke the foster care license. The Ombudsman also requested that CPS provide law enforcement with information regarding the history of referrals received on this foster parent, to aid their investigation.

**Finding**: CPS delayed in checking on the safety of a dependent four-month-old infant in a "responsible adult placement" under condition that all parent-child contact be supervised, as the parent had serious mental health and substance abuse problems requiring treatment. CPS began receiving calls that the infant was being left alone with the parent, and that they were missing important medical appointments. Attempts to reach the "responsible adult" to check on the child's safety were unsuccessful.

**Outcome**: The Ombudsman requested that a child welfare check be done on

## Inducing Corrective Action *(continued)*

the home as soon as possible. Two days later this had not been done, and the Ombudsman again requested this urgently. The safety of the child was only verified four days later. The Ombudsman questioned the appropriateness of this placement since the signed safety agreement was being frequently violated. CPS agreed, and filed a motion in court requesting a change of placement, but this was not granted. Two months later, after the police were called to the home because the parent (who had been left alone with the child) was wielding a knife and threatening to kill herself and the child, the child was taken into protective custody and placed with a suitable relative.

**Finding**: CWS failed to report to CPS concerns it had regarding the safety of a foster home, as required by law and policy.

**Outcome**: The Ombudsman reported these concerns and they were investigated by DLR/CPS and OFCL. The foster home was found to be violating several licensing requirements. OFCL took corrective action with the foster parents, and educated the CWS caseworkers involved regarding the violations that should have been reported.

**Finding**: CWS failed to follow CPS recommendations that a thirteen-year-old dependent child be removed from a relative placement after a "founded" finding for physical abuse and neglect of the child. Although CWS planned to move the child within thirty days, it had no plan for increased monitoring of the child in the home or other safeguards, despite ongoing concerns about further possible maltreatment.

**Outcome**: The Ombudsman asked the Regional Administrator to review the case, who found the existing case plan to be unacceptable. A safety agreement was immediately drafted and signed by the relative, including close monitoring of the child by service providers. The child was moved two days later.

**Finding**: CWS failed to follow the recommendations of a Child Protection Team to remove a seventeen-month old dependent child from the care of relatives with a history (past and current) of domestic violence.

**Outcome**: The Ombudsman urged CWS to obtain law enforcement records on the family. The agency found that the family had not provided accurate information when they were initially considered for placement of the child. The child was removed from the home and placed in a safe environment.

### COMPLAINT ISSUE: SAFETY OF ADOLESCENTS

**Finding**: CPS planned to allow a 17-year-old non-dependent disabled youth to return to the care of a relative caregiver from a voluntary placement arranged by the Division of Developmental Disabilities (DDD), despite a long history of referrals reporting alleged abuse and neglect, and concerns of ongoing abuse of the youth in that home (37 referrals between 1991 and 2005).

**Outcome**: The Ombudsman requested that CPS review the family's history. Following this review, CPS concluded that the youth should not return to the relative's home. CPS and DDD cooperated in seeking an alternative voluntary placement for the youth.

**Finding**: Family Reconciliation Services failed to address allegations of physical abuse of a 16-year-old youth by her parent when assessing the youth for needed services. The youth was in a shelter, having run away from home and expressing fear of returning due to alleged physical abuse. FRS informed the youth that she had to return home.

**Outcome**: The Ombudsman contacted the FRS supervisor, who agreed that the concerns about physical abuse had not been adequately assessed. The case was reassigned, and further assessment revealed a need for out-of-home placement and services to protect the youth and assist the family.

**Finding**: CPS planned to return a 12-year-old non-dependent child to a relative caregiver who had failed to protect the child from severe physical abuse by a parent in the past, despite the child's expressed fears about returning, and statements that she would run away.

**Outcome**: The Ombudsman asked CPS to review the decision to return the child.

## Inducing Corrective Action *(continued)*

CPS decided that further out-of-home placement was warranted to protect the child and to provide further therapeutic services, with the goal of returning the child once the relative was able to provide a safe environment.

**Finding**: During the course of assessing a family for services, FRS failed to report to CPS allegations of physical abuse of a fourteen–year-old non-dependent youth by her adoptive parent. Additionally, CWS had failed to obtain a federal criminal background check on the parent at the time of the adoption home study, as required, since the parent had lived out-of-state within the last five years.

**Outcome**: The Ombudsman requested that FRS report the abuse allegations to CPS. A CPS investigation was conducted.

**Finding**: DCFS Intake failed to screen in for child welfare services, a referral from a children's residential facility regarding the recent return home, due to closure of the facility, of a fourteen-year-old, non-dependent youth who had been placed there voluntarily by his parent two years previously. The parent had had minimal contact with the youth during the previous two years, and the conditions that existed at the time of the youth's placement still existed currently, posing a substantial risk to the youth's safety and well being (i.e. presence of a sex offender in the home). Intake screened the referral as "information only".

**Outcome**: The Ombudsman requested that Intake review the referral to assess the apparent need for child welfare services in this case. After further review, Intake screened in the referral for child welfare assessment and services.

**Finding**: CPS failed to provide an appropriate placement in a timely manner for a thirteen-year-old developmentally delayed child with various behavior disorders, who could not be safely managed at home. The child was nearing the end of a 180-day placement at a psychiatric facility, arranged by CPS, but was soon to be discharged with no long-term placement identified. CPS was awaiting a decision from Children's Administration Headquarters regarding an application for co-funding of a placement between DCFS and the Division of Developmental Disabilities.

**Outcome**: The Ombudsman contacted CA headquarters to inquire about the status of the co-funding request, which had been made two months previously. Within days, headquarters completed its review of the case and approved the co-funding for a suitable placement.

**Finding**: CPS failed to screen in for investigation a referral reporting that a non-dependent sixteen-year-old youth was homeless (with the parent's whereabouts unknown) and living in an unsafe environment.

**Outcome**: The Ombudsman requested a review of the screening decision, resulting in the referral being screened in for investigation. CPS ultimately coordinated a substance abuse evaluation and treatment for the youth, and arranged a voluntary placement with a relative.

### COMPLAINT ISSUE: HEALTH, WELL-BEING OR PERMANENCY OF DEPENDENT CHILDREN

**Finding**: CWS failed to follow a reasonable process for deciding an adoption placement for a one-year-old dependent child, resulting in consideration of a family for adoption of the child other than the family who already had a relationship with the child and had an approved adoption home study. Permanency was delayed for the child as a result.

**Outcome**: The Ombudsman requested a review of the case by the Regional Administrator, who acknowledged that correct and reasonable procedures had not been followed by the placement committee. The administrator revised procedures governing the committee as a result. At a subsequent staffing, a decision was made to place the child with the original prospective adoptive family.

## Inducing Corrective Action *(continued)*

### COMPLAINT ISSUE: PARENTS' RIGHTS

**Finding**: CWS failed to consistently provide language interpretation of meetings and written translation of documents for a non-English speaking parent receiving services, as required by law and policy.

**Outcome**: The Ombudsman requested that CWS ensure that interpretation and translation be provided consistently in this case henceforth, and if reasonable efforts to obtain such were unsuccessful for a particular contact, that this be documented in the record. CWS agreed to do so.

**Finding**: CPS disseminated an investigative report containing inaccurate information regarding a parent, to law enforcement. The neglect allegations being investigated were concluded to be unfounded.

**Outcome**: OFCO contacted CPS, who acknowledged the error, and agreed to re-draft and resend the report, correcting the inaccurate information.

**Finding**: CPS failed to investigate a referral until thirteen months after receiving it, well outside timelines required by law and policy. Furthermore, CPS reached a finding of "inconclusive" regarding the allegation of neglect, based solely upon the child no longer being available for interviewing, and the investigation therefore being incomplete.

**Outcome**: The Ombudsman contacted the Area and Regional Administrators to question the reasonableness of this finding given the time lapse in investigating the referral, as well as other information gathered during the investigation, which made a finding of "unfounded" more appropriate. CPS changed the finding to "unfounded".

### COMPLAINT ISSUE: SERVICES TO RELATIVES

**Finding**: CWS denied a request for financial assistance made by the relative caregivers of an 11-year-old dependent child, who was in the hospital undergoing treatment for cancer. The relatives needed the assistance to allow them to be with the child around the clock.

**Outcome**: The Ombudsman asked Children's Administration headquarters to review the request after the local DCFS office cited budgetary constraints as the reason for the refusal. CA did so, and agreed to provide a monthly stipend to the family to assure optimal support for the child and decrease the financial stress the relatives were experiencing.

## 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.

### COMPLAINT ISSUE: CHILD SAFETY FROM ABUSE

**Finding**: CPS returned a physically disabled five-year-old non-dependent child to the care of her parents following her hospitalization for burns, without services in place to assist the family in managing the child in order to avert future injuries to the child. The family had a history of neglect and excessive corporal punishment of the children.

**Outcome**: The Ombudsman requested that CPS obtain a review of the case by medical experts to more carefully assess possible risks to the child's safety. This review was done, and the accidental nature of the injury was confirmed. The Ombudsman also requested that the agency provide in-home services immediately, which it did.

**Finding**: CPS failed to screen in for investigation a referral alleging physical abuse of a three-year-old non-dependent child with a history of suspicious physical injuries. The referral was screened as "information only".

**Outcome**: The Ombudsman requested a review of the screening decision. As a result, the referral was screened in, however, the investigation did not follow required procedures: the CPS worker did not interview the child, nor did she observe the injury or talk to the child's doctor or other people involved with the child to verify the parent's explanation of the injuries. The Ombudsman contacted the supervisor, and although additional investigation was later done, this occurred well beyond required timelines, jeopardizing the integrity of the investigation as a result (i.e. the three-year-old was only interviewed three-and-a-half months after being injured).

**Finding**: CPS was not planning to respond to a second referral it received alleging that a parent was exposing her two non-dependent children, ages four and eleven, to an 18-year-old whom she knew to be a registered sex offender. The caseworker had just investigated an initial referral and found no evidence of unsupervised contact between the offender and the children. CPS planned to change the screening decision on the new referral to "information only" as it contained similar information, and close the case.

**Outcome**: The Ombudsman contacted the supervisor, expressing concern that the new referral indicated the parent appeared to be continuing to allow the offender into her home, and that it was unknown whether the children were having unsupervised contact with him. The supervisor agreed to have the worker inform the parent about the new CPS referral and warn her about the risks of exposing her children to this individual.

**Finding**: CPS failed to complete an investigation of a referral alleging physical abuse of two non-dependent children ages three and five. The case was erroneously closed due to administrative error, prior to interviewing either the children or the alleged perpetrator as required by law and policy.

**Outcome**: The Ombudsman requested that CPS complete the investigation. Because it was not completed until six months after the referral, the investigation was significantly compromised.

### COMPLAINT ISSUE: CHILD SAFETY FROM NEGLECT

**Finding**: CPS delayed in investigating allegations regarding neglect of three non-dependent children, ages fourteen, ten and one, due to chronic substance abuse by their parent. There had been multiple referrals alleging the children were tired and hungry and that the ten-year-old was caring for the toddler while the parent was unconscious. CPS had not intervened effectively in response to past referrals, and eight working days had passed since the most recent referral from a community professional.

**Outcome**: The Ombudsman requested that CPS check on the children immediately. On the ninth working day the assigned caseworker found the children home alone, as the parent had been arrested for driving under the influence of alcohol the night before. The children were taken into protective custody and placed with a relative.

**Finding**: CPS failed to investigate a referral alleging neglect of a thirteen-year-old non-dependent child with mental health problems. The referral stated that the child was dirty, was not attending school nor receiving needed special services, the home was filled with garbage and clutter, and the parent was

## Facilitating Resolution *(continued)*

using drugs. The assigned CPS worker found the phone disconnected and no one at home. Assuming that the family had moved, and based upon the fact that previous allegations of neglect of this child had been investigated and unfounded, CPS planned to close its case. The Ombudsman found the agency's failure to make stronger attempts to locate the family unreasonable, given the information provided in this and previous referrals.

**Outcome**: OFCO requested that CPS make additional attempts to locate the family, providing suggestions to assist in these efforts. CPS managed to locate the family in a motel in a different city. Although the family had left the motel by the time law enforcement arrived to conduct a child welfare check, the assigned worker sent the referral to the CPS office in the out-of-state city to which the family was believed to have moved.

### COMPLAINT ISSUE: DEPENDENT CHILD SAFETY IN OUT-OF-HOME CARE

**Finding**: CWS increased the risk of harm to a nine-year-old dependent child by changing conditions for visits with her parent, without careful assessment. CWS failed to obtain adequate assessments of the parent's mental state and propensity for violence (which were indicated based on the parent's history) as well as a clear service plan to address these concerns, before allowing visits to occur.

**Outcome**: The Ombudsman contacted the Area Administrator, who directed CWS to schedule a court hearing to request a modification of the visitation plan. CWS was court-ordered to obtain additional evaluation of the parent in order for the court to decide on a suitable visitation plan.

**Finding**: CWS planned to move two dependent children, ages eight and ten, from their therapeutic foster home to another temporary foster care placement. The Ombudsman found the planned move to be unreasonable, given that one of the children had been abused in a former foster home, had yet to receive treatment, and was in the process of receiving a mental health assessment. The children had been doing well in this home until they were told they would be moved. The subject child had made statements of intent of self-harm.

**Outcome**: Although the agency's rationale for the move was not clearly unreasonable, i.e. the children had been placed in this specialized foster home temporarily, at exceptional cost, until they were stabilized, and this had been achieved, the Ombudsman expressed concerns to CWS about the harm to the children's emotional well-being that a move might cause. After further consideration, CWS agreed to maintain the children in their current placement until a permanent placement could be found.

### COMPLAINT ISSUE: SAFETY OF ADOLESCENTS

**Finding**: CPS was not effectively intervening to protect a sixteen-year-old non-dependent youth from alleged physical abuse by her parent, and assist them with appropriate services to address family conflict and the youth's risky behaviors, including running away, substance abuse, gang affiliation, truancy and depression. The most recent CPS case had been closed. The youth was currently due for discharge from a Crisis Residential Center and did not feel safe to return home.

**Outcome**: The Ombudsman requested that CPS consider filing a dependency to ensure that an out-of-home placement and services were provided for the youth and family. The agency responded by filing an At Risk Youth petition in which the agency agreed to open an FRS case, offer appropriate services, and place the youth in licensed out-of-home care.

**Finding**: CPS failed to file for dependency on a seventeen-year-old youth who had been in foster care for over twenty months through a voluntary placement agreement with the parent. This is a violation of law, which allows for voluntary placement for up to 180 days, after which a dependency must be filed.

**Outcome**: The Ombudsman contacted CPS who assured it was planning to file a dependency. The Ombudsman monitored case activity until dependency was established.

**Finding**: CPS failed to screen in for investigation a referral alleging that a sixteen-year-old non-dependent youth was being neglected and sexually exploited by her parent. Furthermore, CPS had filed dependencies on behalf

## Facilitating Resolution *(continued)*

of the youth's six younger siblings two years previously, but not for this then fourteen-year-old youth, even though the children were all living in exactly the same circumstances. The agency based this decision on the fact that the youth was involved with the juvenile justice system at the time, and its assessment that she did not need child welfare services.

**Outcome**: The Ombudsman requested that CPS review the screening decision. Although the CPS Intake supervisor agreed that the referral should have been screened in for investigation, the local CPS supervisor disagreed. The Ombudsman then contacted the Area Administrator, who agreed to have the siblings' CWS worker interview the youth and try to engage her in appropriate services. The youth was subsequently admitted to an in-patient substance abuse treatment center, and CWS stated it would assess her for services and/or voluntary placement upon completion of her treatment.

### COMPLAINT ISSUE: HEALTH, WELL-BEING OR PERMANENCY OF DEPENDENT CHILDREN

**Finding**: CWS failed to obtain authorization for a seventeen-year-old dependent youth to have necessary oral surgery in a timely manner. The lengthy delay following the oral surgeon's recommendation for surgery resulted in the youth experiencing unnecessary pain and additional complications, as well as missing school as a direct consequence.

**Outcome**: The Ombudsman coordinated efforts to remove administrative barriers contributing to the delay, including contacting the AAG to assist in expediting necessary documentation to promptly obtain a court order authorizing dental surgery.

**Finding**: CWS planned to discharge a seventeen-year-old dependent youth with special needs from his group care placement when he turned eighteen. Although this plan complied with agency policy, the youth's special circumstances appeared to warrant an exception. The youth had a history of severe maltreatment and was making excellent progress in treatment, was doing very well at school, and had no other viable placement options at that time.

**Outcome**: The Ombudsman asked the Regional Administrator to review the case plan. As a result, CWS extended the youth's placement by six months to allow his parent, caseworker and treatment providers to find an appropriate alternative placement and develop a transition plan that would sustain his good progress.

**Finding**: CWS placed a five-year-old dependent child with a parent with whom the child had no prior relationship, without adequate transition and without independently assessing the parent's suitability as a placement resource, instead relying heavily on a strong recommendation from the child's guardian ad litem (GAL). CWS then failed to seek court intervention when the parent was uncooperative with the case plan. The parent did not comply with mandated health and safety visits by the caseworker, did not obtain counseling for the child, and failed to arrange contact with his two half-siblings, with whom he had previously been living since birth.

**Outcome**: The Ombudsman contacted the Regional Administrator expressing concerns, and as a result, stronger efforts were made to obtain additional information regarding the parent's suitability to care for the child, to provide increased monitoring of the child's progress in the home, and ensure sibling contact and regular counseling. The Ombudsman also expressed concern about an apparent conflict of interest on the part of the GAL. A new GAL was later assigned to the child.

**Finding**: CWS delayed in submitting a referral for intensive in-home services to support a six-year-old dependent child in her dependency guardianship placement. The resulting two-month delay in securing services was unreasonable given the recommendation of these services by a multi-disciplinary team of mental health care providers for the child, and the fact that services could have begun much sooner.

**Outcome**: The Ombudsman monitored the agency's implementation of the in-home services recommended by the team, until they were ultimately approved and provided.

## Facilitating Resolution *(continued)*

**Finding**: CWS placed a fifteen-month-old dependent child with an out-of-state relative despite receiving a home study and psychological evaluation of the relative that described serious mental health problems and instability in the past. Although both of these reports recommended placement with the relative, they were brief and superficial. In contrast, a psychological evaluation of the child's parents completed by a DCFS-contracted psychologist recommended against placement with the relative, based on thorough information-gathering regarding the family's history. The child's guardian ad litem similarly recommended against the placement, listing a number of legitimate concerns in his court report.

**Outcome**: The Ombudsman requested that the adoptive home study on the relative that CWS planned to arrange, address the numerous questions that had been raised regarding the relative's suitability for permanent placement of the child. Before the home study could be completed, the relative experienced a serious mental health crisis causing her to be hospitalized. The child was ultimately returned to his former foster home in Washington, where he had been living since the age of two months, as an adoptive placement.

**Finding**: OFCL refused to grant a temporary administrative exception to policy, to allow a twelve-year-old child to join his sibling in a foster home that was already at full capacity. This appeared unreasonable, given that the subject child was living in a marginal foster home where contact with his sibling was not being supported, his sibling was doing very well in the foster home in question, the foster parents were eager to have both children in their care, and the child's guardian ad litem as well as other community professionals believed this placement to be the best option for the child.

**Outcome**: The Ombudsman contacted the statewide director of OFCL, who agreed to review the exception request, as agency policy allows exceptions to be made to allow siblings to be placed together. As a result, the temporary exception was granted once CWS staff presented a safety plan to ensure the safety of all the children in this foster home.

**Finding**: CWS planned to seek a non-relative adoptive placement for a ten-year-old dependent child, after she had to be removed from her pre-adoptive placement due to emotional abuse by the foster parents. Her grandparents, who had requested that the child be placed with them four years previously, were not selected for placement at that time due to the agency's lack of confidence that they would be able to protect the child from her abusive parent.

**Outcome**: The Ombudsman requested that CWS reconsider the grandparents as a permanent placement resource at this juncture, given that the child had been abused in non-relative care and wanted to live with her grandparents, and the grandparents had had minimal contact with the child's parent in the interim years. CWS agreed to reconsider the grandparents, and an updated home study resulted in a favorable assessment of their ability to provide safe care for the child. The child was permanently placed with her grandparents.

**Finding**: CWS failed to pick up a youth from a Crisis Residential Center (CRC) after his 5-day stay limit expired. The CRC explored family resources to no avail, and was therefore forced to keep the youth beyond the five days permitted by law. While the caseworker was in an all-day meeting on the fifth day of the youth's placement, and the CRC was in another part of the state, CWS should have made alternative arrangements to avoid this violation of state law.

**Outcome**: The Ombudsman contacted CWS, who picked up the youth on the sixth day and placed him elsewhere.

### COMPLAINT ISSUE: PLACEMENT WITH RELATIVES

**Finding**: CWS planned to permanently place a dependent one-year-old child with her non-relative foster parents, even though a relative with an approved home study was available. This decision, while based on the parents' preference regarding placement for the child, was not consistent with law and policy, which gives preference to placement with a relative when possible. In addition, there

## Facilitating Resolution *(continued)*

were concerns regarding the suitability of these foster parents as a permanent placement resource.

**Outcome**: The Ombudsman contacted the Regional Administrator, who was already reviewing this case, and provided information obtained through OFCO's investigation. The administrator determined that the child should be placed with the relative and directed CWS to implement this plan.

**Finding**: CWS was not planning to reconsider placing a twelve-year-old dependent child with a relative, after his planned permanent placement failed. The relative had previously been considered for placement for this child and his three siblings, but other permanent placement options were selected for all of the children at that time. The relatives had not been ruled out, however, and were still available and willing to have the child placed in their care; in addition, the child's parent wanted this to occur.

**Outcome**: Although the Ombudsman did not find the agency's failure to reconsider the relatives to be clearly unreasonable, given the subject child's failed permanent placement and limited placement options, the Ombudsman requested that the relatives be reconsidered for placement of this child. The agency agreed to do so, but ultimately the court ordered an alternative, non-relative placement for the child.

### COMPLAINT ISSUE: FOSTER PARENT ISSUES

**Finding**: OFCL erroneously referred a foster parent (who was also a day care provider) for a psychological evaluation, to a psychologist whose contract with the agency had lapsed. The agency was then unable to pay the evaluator, and hence obtain the results of the evaluation, until the lapsed contract was in order. The foster parent was unable to provide either foster care or day care until a decision was made regarding her license, based on the results of the evaluation. There were administrative difficulties getting the contract reinstated, and with the goal of getting the licensing issue resolved sooner, OFCL requested that the foster parent undergo a second evaluation with another provider.

**Outcome**: The Ombudsman contacted OFCL to question the reasonableness of this request. OFCL agreed to make further attempts to get the contracting issue expedited to avoid a second evaluation. The contract issue was only resolved five months later. The results of the evaluation were positive and the foster parent's license was reinstated, but she had experienced a great deal of stress and lost income from her day care due to the lengthy delay in resolving the licensing issue. The agency acknowledged its error and apologized to the foster parent.

### COMPLAINT ISSUE: BUREAUCRATIC ERRORS

**Finding**: CPS disclosed the identity of a confidential referent, to the person who was the subject of a CPS referral. Administrative staff covering for the CPS supervisor had inadvertently sent a report containing the identity of the referent, intended for law enforcement, to the subject of the referral.

**Outcome**: The Ombudsman informed CPS of this violation of law and policy, and CPS sent a letter of apology to the referent. The Ombudsman also ensured that CPS reviewed procedures with staff to prevent dissemination of confidential information in the future.

## Assisting the Agency in Avoiding Errors and Conducting Better Practice

In some cases, the Ombudsman does not find the agency's actions to be in clear violation of law or policy, but rather to be poor practice. If the complaint involves a current action, the Ombudsman intervenes to assure better practice. If it involves a past action, the Ombudsman documents the issue and brings it to the attention of the agency on an as-needed basis.

### COMPLAINT ISSUE: CHILD SAFETY FROM ABUSE

**Finding**: CPS failed to enter into a voluntary placement agreement (VPA) with a parent whose three non-dependent children had been taken into protective custody by law enforcement, due to allegations of physical abuse of the oldest child. The law requires that either a VPA be entered or a dependency petition filed within 72 hours of children being taken into protective custody. Instead, CPS accepted the parent's verbal consent to place the children with a relative. The parent stated that consent was given under duress.

**Outcome**: The Ombudsman requested that CPS enter a VPA or file a dependency, to solidify the children's placement in protective custody. The parent refused to sign a VPA, and CPS did not file a dependency. The children remained with the relative, with the parent's verbal consent, during the investigation by CPS and law enforcement, and CPS offered services to the family. The parent was later charged with assaulting the child.

**Finding**: CPS did not adequately protect two non-dependent children, ages three months and eighteen months, from ongoing neglect and suspected physical abuse by their parents, who had been the subject of multiple CPS referrals. The Ombudsman found the investigation of the most recent referrals, reporting a skull fracture in the eighteen-month-old, to lack thoroughness. In addition, there were no services in place to ensure the children's safety in the home.

**Outcome**: The Ombudsman requested that CPS take additional steps to ensure the children's safety, including review of the child's medical records by a child abuse expert and gathering further information from the police investigation, as well as a Child Protection Team (CPT) staffing of the case. CPS took these steps, and the CPT recommended that the parent be required to sign an agreement for specific services and a comprehensive safety plan in the home. The parent failed to comply with the agreement, and CPS removed the children and filed a dependency petition.

**Finding**: CPS failed to adequately investigate allegations of physical and emotional abuse of a three-year-old dependent child living with his parent in an in-home dependency. CPS did not interview key medical professionals who reported the suspected abuse, and did not obtain assessments available to assist in determining the cause of the child's injuries. CWS then failed to present the case to the Child Protection Team (CPT), as required by policy when deciding whether to return a child home, in cases such as this (child under age six, high risk tag assigned to case). CWS returned the child to the parent.

**Outcome**: The Ombudsman requested that the medical professionals involved be interviewed as part of the investigation, and that all key medical information be presented to the CPT. Although the CPT did not recommend removal of the child, the Area Administrator found the CWS caseworker to be biased in her assessment of the family, and the case was transferred to a different worker. Following closer assessment, CWS recommended to the court that the child be removed, but the court declined. Four months later, the child's day care reported serious physical abuse of the child in the home. A CPS investigation led to founded findings, and the child was placed with a relative.

**Finding**: CPS failed to follow required timelines regarding investigation of a referral. One month after receiving a report of suspected physical abuse of two eight- and ten-year-old non-dependent children, CPS had not yet begun its investigation. The referral had been screened in for a high standard investigation, i.e. requiring a face-to-face interview of the children within ten working days.

**Outcome**: When CPS received another high-risk referral from a medical professional a month after receiving the first report, it began investigating both referrals immediately. The earlier referral had not been assigned due to supervisor error.

**Finding**: CPS failed to take reasonable steps to ensure the safety of a five-year-old non-dependent child who was living in the custody of a parent who was facing felony charges of rape of another child. CPS delayed in investigating a referral from a community professional

## Assisting Agencies... *(continued)*

concerned about the child's safety under the circumstances. The child was not seen nor interviewed until over a month later. The child did not disclose any abuse, and on this basis the agency declined to consider either an in-home safety plan or a temporary out-of-home placement during the parent's trial.

**Outcome**: The Ombudsman requested a review of the case by the Area Administrator. No action was taken other than CPS encouraging the non-custodial parent to file for a protection order through family court. The family court ordered placement of the child with the non-custodial parent, five months after CPS received the referral.

### COMPLAINT ISSUE: CHILD SAFETY FROM NEGLECT

**Finding**: CPS failed to maintain a consistent case plan to protect a newborn infant from neglect in the same manner as it had protected the child's three older siblings. The mother had a history of mental health problems, and had had her parental rights terminated regarding her oldest child, age four, in another state. CWS had already filed a petition to terminate parental rights to the middle two children, ages one and two, who had severe developmental delays resulting from their chronic neglect. Prior to the birth of her fourth child, the mother and that child's father left the region in which they had been living, in order to avoid removal of the baby by CPS. Despite this history, the CPS office in the new region decided not to remove the newborn on the basis that the parents' current functioning was satisfactory.

**Outcome**: The Ombudsman requested a case review by the Area Administrator in the new region. Although the administrator declined to alter the case plan, CPS was directed to present the case to the CPT and invite the region with an open CPS case on the older siblings to attend. The CPT recommended intensive monitoring of the infant by CPS and various in-home service providers. Meanwhile, the parents separated and the mother began a new relationship with an individual with a criminal history and history of domestic violence. CPS then attempted to obtain a protective custody order on two occasions, with the court refusing each time. Two months later, police were called out to the home after a domestic violence incident, and based on the condition of the home, took the child into protective custody. CPS filed a dependency and placed the three-month-old infant with one of the older siblings in foster care.

**Finding**: CPS failed to document in a timely manner its investigations of two referrals alleging neglect of two previously dependent children, ages five and eleven, by their relative caregiver. There was no documentation in the case record for several months after the referrals were made. Policy requires completion of high standard CPS investigations, including all documentation and an investigative assessment summary, within 90 days of a referral being made. The case also was not presented to a CPT as planned.

**Outcome**: The Ombudsman contacted CPS to request information about what had been done regarding these investigations, in order to determine whether the children were safe. The Ombudsman also requested that the case be presented to the CPT for assistance with risk assessment. When documentation was still outstanding seven months after the referral had been received, the Ombudsman contacted the Area Administrator, and documentation was completed two days later.

**Finding**: CPS delayed in protecting two children, ages six and seven, from chronic neglect secondary to drug abuse and domestic violence by their parents. Although the agency arranged in-home family preservation services, this failed to alleviate the family's problems, and the service provider reported to CPS continued neglect of the children. CPS requested a child welfare check by law enforcement, who believed there were insufficient grounds (no imminent risk of harm to the children) to take the children into protective custody. The family then moved to another area of the state.

**Outcome**: The Ombudsman contacted CPS to express concern regarding the risks to the children in the care of their parents, and the agency's failure to intervene despite the ineffectiveness of its services in decreasing the risk of harm to the children. The Ombudsman monitored the case. When the family later returned to the area, CPS entered into a voluntary placement agreement with the parents, whereby the children were placed with

## Assisting Agencies... *(continued)*

a relative while the parents received in-patient substance abuse treatment. Subsequent interviews with the children revealed their emotional difficulties as a result of their neglect.

**Finding**: CPS was failing to intervene to protect three non-dependent children, ages eight, twelve, and thirteen, from ongoing neglect by their parent. The parent had a history of involvement with CPS, and the children had been previously dependent, but were returned to their parent's care a year ago. CPS continued to receive referrals alleging ongoing neglect of the children, including a recent referral alleging that the thirteen-year-old was working for a registered sex offender prohibited from having contact with minors, and had accompanied this individual on a trip out-of-state. CPS intake screened this referral as alleged abuse by a third party, therefore to be referred to law enforcement for investigation.

**Outcome**: The Ombudsman requested a review of this screening decision, believing that the referral warranted a CPS investigation of the parent's alleged failure to protect the child. CPS did not change the screening decision but agreed to check on whether the report was referred to law enforcement, as there appeared to have been no law enforcement response. CPS also agreed to interview the youth regarding possible exploitation by the registered sex offender, since this was an open CPS case in response to previous referrals for neglect. Before the agency was able to locate the youth, however, it received a report that that the parent had gone out-of-state leaving the two younger children in the care of a drug dealer with several arrest warrants. (The thirteen-year-old had been sent by the parent to live with relatives out-of-state.) The police took the children into protective custody and CPS filed another dependency.

**Finding**: CPS provided to law enforcement the contact information of a relative of a seven-year-old non-dependent child, knowing that law enforcement intended placing the child there, and that this would be an inappropriate placement for the child. CPS failed to inform law enforcement that the relative was living with a drug user and had an extensive history of involvement with CPS.

**Outcome**: The relative subsequently contacted CPS for assistance, and the agency provided assessment and services to the child and family. The Ombudsman contacted the CPS intake worker, who agreed that in the future such requests would be forwarded to a CPS field worker who could provide any relevant information the agency had on the desired placement resource.

### COMPLAINT ISSUE: DEPENDENT CHILD SAFETY IN OUT-OF-HOME CARE

**Finding**: DLR failed to screen in for CPS investigation a referral from a community professional who observed a foster parent "yelling and screaming" at and "beating with an open hand" two foster children ages three and four. Instead, the referral was screened as a licensing complaint (as no injury was specified) and was investigated by the licensor for alleged inappropriate use of discipline by a foster parent. The Ombudsman determined that the referral should have been screened in for investigation by DLR/CPS, given the reported serious violation of discipline policies by a foster parent, as witnessed by a community professional, and the young age of the children.

**Outcome**: The Ombudsman requested a review of the screening decision, but it remained screened as a licensing complaint. The OFCL supervisor agreed to have the children interviewed by the licensor. The foster parent was required to sign a discipline policy agreement and attend a parenting class.

**Finding**: DCFS placed an infant with an out-of-state relative, without an approved home study through the Interstate Compact on the Placement of Children, as required by law. Moreover, a home study was never done subsequent to the placement of the child.

**Outcome**: The child was removed from the relative three years later, after ongoing exposure to domestic violence and other family problems. The agency later discovered a criminal history of the relative's spouse. Despite the instability of this placement over the three-year placement, DCFS did not arrange for appropriate services to assist the child and family.

## Assisting Agencies... *(continued)*

**Finding**: CWS delayed in removing two foster children, ages five and thirteen, from a foster home where lack of supervision and inadequate parenting skills on the part of the foster parents jeopardized the safety and well-being of the children, as evidenced by accidental injuries and risky behavior of the children. When the foster parents failed an adoption home study, CWS provided services to address these problems, but they were never satisfactorily corrected and CPS continued to receive referrals for neglect. These legally free children remained in this marginal placement for four years.

**Outcome**: The foster parents failed a second adoption home study and the children were moved to a different placement, causing adjustment problems since they had bonded with their foster parents over this long period of time. CWS acknowledged its poor practice in this case.

**Finding**: CPS allowed a nine-year-old dependent child to go on a ten-day visit to the home of her parent in another region of the state without assessing the parent's home or possible risks to the child. The parent had an extensive history of CPS involvement as well as untreated, ongoing substance abuse problems.

**Outcome**: The Ombudsman contacted the supervisor expressing concern regarding the risks to the child posed by this action. No further visits occurred while CPS gathered further information regarding the parent's current circumstances and participation in services. Based on closer assessment and the parent's lack of compliance with services, CPS decided to pursue permanent out-of-home care for the child.

### COMPLAINT ISSUE: SAFETY OF ADOLESCENTS

**Finding**: CPS failed to protect a thirteen-year-old non-dependent child from ongoing neglect by her parent. The parent had a twelve-year history of involvement with CPS, secondary to a serious drug problem, and had recently left the state, leaving the youth in a local youth shelter, with no plan for a permanent living situation. The child was periodically leaving the shelter to roam the streets, and was associating with an adult male suspected to be grooming youths for sexual exploitation. The shelter did not have the authority to intervene in a parental or other capacity. CPS had an open case on the family, having just completed an investigation of a referral alleging neglect of this child and her three younger siblings, with a finding of "inconclusive".

**Outcome**: The Ombudsman requested that CPS assess the child for services and possible out-of-home placement. The agency refused, saying the case was to be closed, as the child was not interested in services or placement. CPS indicated it would respond to any new referrals with further assessment. The Ombudsman monitored the child's situation as long as her whereabouts were known. One new referral was made alleging sexual exploitation of adolescent girls by the adult male in question, but this was screened as information only due to incomplete identifying information of the alleged victims.

### COMPLAINT ISSUE: HEALTH, WELL-BEING OR PERMANENCY OF DEPENDENT CHILDREN

**Finding**: CWS planned to move a three-year-old legally free, severely physically disabled child from his relative placement, where he had been living since infancy, to a non-relative adoptive placement, after giving the relatives an ultimatum to adopt him. The agency based its position on the financial costs to the state if the child's permanency plan was anything other than adoption, given the child's extensive medical needs. The relatives, while fully committed to caring for the child permanently, were concerned about a lack of clarity in the proposed adoption support agreement regarding their long-term financial obligations under an adoption, since they had two of their own children to consider also.

**Outcome**: The Ombudsman contacted the Regional Administrator expressing concern regarding the agency's plan to move this fragile child based on financial concerns rather than what was clearly in the child's best interests. The agency did not change its position. However, the court ordered a permanency plan of dependency guardianship with the relatives, which would require that they receive long term assistance in meeting the child's medical needs.

## Assisting Agencies... *(continued)*

**Finding**: CPS failed to place a one-year-old dependent child with special medical needs in appropriate placements, resulting in her being moved to five different placements over the course of a year. Two of these placements were foster homes from which the infant had to be removed after the foster parents were found to be providing inadequate care. The Ombudsman found that the infant should not have been placed in these homes given her particular vulnerability (age and fragile medical status), in light of concerns the agency already had regarding these foster homes. This was a violation of recently established policies created to avoid multiple placements of children, following the court decision in *Braam vs. State of Washington*.

**Outcome**: The child was already moved to a suitable foster home with an aggressive plan for reunification with her parent when the Ombudsman received this complaint. OFCL took corrective action with regard to both foster homes in question. One is no longer licensed.

**Finding**: CWS failed to schedule a permanency planning court review hearing within required timelines, delaying the return of a thirteen-year-old child to her parent. The review hearing was held a month later than the timeframe allowable by law for establishing permanency for a dependent child. The Ombudsman found several violations of policy and procedure in the management of this case. The child had been placed in a non-licensed home without a court order, and the transfer of the case from one caseworker to another was not handled effectively, resulting in inadequate supervision of the child's placement and the case plan. No case activity was documented for several months (including required 90-day health and safety checks on the child), and the caseworker did not know the whereabouts of the child for approximately two months.

**Outcome**: The agency acknowledged that the unit handling this case had been without a supervisor for three months, and that many cases needed corrective action. A new supervisor was assigned to the unit, who provided increased monitoring and oversight of the case. After three months of monitoring by the Ombudsman, the child was placed with her parent out-of-state, and the dependency was later dismissed.

**Finding**: CWS managed a parent's request to dismiss a guardianship on her twelve-year-old dependent child, in an unreasonable manner. The child's dependency had been established eight years previously, due to the parent's diagnosis with an incurable mental illness, and failure to respond to substance abuse treatment. The child had been living with his guardians throughout his dependency, and had regular visitation with the parent as established by the guardianship order. The parent contacted the agency stating her desire to vacate the guardianship based on a change in her circumstances. After a meeting with the parent, the agency advised her to contact her attorney, stating it would support vacating the guardianship. The agency then left a telephone message for the guardians informing them of this development. The agency's actions were unreasonable, as it made no proper assessment of the parent's current ability to parent, or the child's current needs or wishes.

**Outcome**: The guardians requested a meeting with the supervisor and Area Administrator, with several positive results. A new caseworker was assigned to the case, a psychological evaluation was arranged to assess the advisability of reunification, and counseling sessions were arranged for the parent with the child's counselor to assess the same. The court appointed a guardian ad litem to independently assess the best interests of the child. The parent ultimately agreed to maintain the guardianship as being in the child's best interests.

**Finding**: CWS delayed in finalizing the adoption of two eight-year-old dependent siblings with special needs, for 22 months after they became legally free. The delay occurred in spite of the children having been in the care of their relatives (the prospective adoptive parents) for three years. Uncertainty over the adoption was stressful for both the children and their caregivers.

**Outcome**: The Ombudsman requested that the agency assist the relative in preparing the complicated paperwork necessary due the children's special needs. CWS assigned the case to an adoption worker specializing in adoption support to expedite the process, resulting in the adoption being finalized two months later.

## Assisting Agencies... *(continued)*

**Finding**: CWS moved a ten-year-old dependent child from her therapeutic foster home to a regular foster home prematurely, without adequate transition and preparation of the new foster parents, and before the child had received adequate treatment to address her sexual abuse in her parent's home. This inadequate planning resulted in the child's new foster parents requesting that she be moved after just one day. The child was moved back to the therapeutic foster home.

**Outcome**: The Ombudsman expressed concern about the disruption caused to the child, and the need for effective counseling. CWS met with the therapeutic foster parent and other professionals involved with the child, to develop a case plan for effective services and eventual reunification of the child with her parent.

**Finding**: CWS was planning to move a two-year-old dependent child from her foster parent, with whom she had been living since the age of five months, and who wanted to adopt her. The foster parent had undergone a home study that recommended her for adoption of the child. CWS had some concerns about the foster parent's history, and wanted to place the child together with her two older siblings in another adoptive home. The child's guardian ad litem was supportive of her being adopted by her foster parent.

**Outcome**: The Ombudsman requested that CWS obtain additional evaluations to further assess its concerns about the foster parent and more closely assess this child's needs. Further evaluation, together with the agency's inability to find an adoptive home that would adopt all three of these children with special needs, as well as the foster parent's commitment to maintaining the child's relationship with her siblings, resulted in a recommendation for the child to be adopted by her current foster parent.

### COMPLAINT ISSUE: PARENTS' RIGHTS

**Finding**: CPS made unfair statements questioning the integrity of a non-custodial parent's allegations regarding the treatment of his child by the custodial parent, in documentation of its investigations into several CPS referrals made by that parent. The veracity of the allegations was subsequently given credence by the family court, which granted full custody to the previously non-custodial parent.

**Outcome**: With the assistance of the Ombudsman, the parent contacted the CPS supervisor with a complaint. CPS acknowledged the inappropriateness of the statements in the case record, and wrote a letter of apology to the parent.

**Finding**: CPS failed to send a letter to parents who had been the subject of a CPS investigation, notifying them of the "founded" findings (i.e., that maltreatment had likely occurred). The parents only discovered this finding when they requested placement of a relative's child. By law, CPS is required to provide written notification to subjects of abuse investigations, regarding the findings.

**Outcome**: The parents requested an administrative review of the findings, and the Area Administrator concluded that the findings should have been "inconclusive" rather than "founded". A home study was done. And the child needing placement was placed with his relatives.

**Finding**: A CWS worker wrote inaccurate, subjective and misleading statements about prospective adoptive parents in an adoption home study.

**Outcome**: The Regional Administrator and Children's Administration Headquarters investigated the prospective adoptive parents' complaint and found it to be valid. CWS transferred the case to another office for a new home study. The revised home study was deemed fair and accurate by the prospective adoptive parents.

**Finding**: CWS suspended visits between a parent and a three-year-old dependent child, based on allegations that the parent was molesting the child during visits. The five-month suspension of visits was unreasonable, given the implausibility of the sexual abuse allegations, the fact that visits were supervised, and parent-child interactions were observed to be positive.

**Outcome**: The parent was asked to undergo a psychosexual evaluation, which indicated that visits could safely continue. Visits were restored after five months of no contact.

**Finding**: CPS developed a plan for the safety of a fifteen-year-old non-

## Assisting Agencies... *(continued)*

dependent youth that stated the youth was sexually abused by her custodial parent, and incorrectly implied that parent's agreement with the plan. This was unreasonable, as the allegations of abuse were still under investigation, and the parent was not in agreement with the safety plan.

**Outcome**: CPS drafted a new safety plan containing accurate information. However, the non-custodial parent had already distributed the original plan, possibly damaging the custodial parent's reputation.

**Finding**: CWS was failing to reunite an eleven-year-old dependent child with parent, despite the parent having completed all court-ordered services and indicating no deficiencies precluding parent from caring for the child. The child was refusing to see his parent, and the agency was failing to take appropriate steps to re-establish parent-child contact.

**Outcome**: The Area Administrator assigned the case to a senior caseworker, to conduct a case review and make recommendations regarding reunification efforts. This resulted in a recommendation for aggressive reunification efforts, including referring the child to a new therapist. The child was successfully returned home six months later.

### COMPLAINT ISSUE: PLACEMENT WITH RELATIVES

**Finding**: CWS failed to consider the distant relatives of a one-year-old dependent child for permanent placement, even though they were licensed foster parents in another state and had requested placement of the child at the time of the child's birth. The parents were unavailable for services aimed at reunification, and were in the process of having their parental rights terminated as to an older child.

**Outcome**: The Ombudsman contacted CWS and requested consideration of the relatives, even though they were not "relatives of a specified degree" as defined by state statute. A case staffing was held, resulting in a recommendation to transition the child from her foster home to her relatives. A home study of the relatives was requested only two months later, and a positive report was received another three months later. CWS was not satisfied and requested additional information. By the time this was received, the child was fifteen months old, and CWS decided to allow her to be adopted by her foster parents rather than disrupt the attachment and bonding that had by now occurred.

**Finding**: CWS refused to consider the relative of an eight-year-old dependent child for either placement or visits, until a year-and-a-half after he had been placed in foster care. Although the agency had concerns about the relative's history, her circumstances and suitability for placement should have been thoroughly assessed as soon as she requested placement and contact with the child. Furthermore, CWS did not pass on gifts the relative had sent for the child.

**Outcome**: The case was transferred to a permanency-planning unit, and the new worker promptly arranged visits, and requested specific evaluations to assess the relative's past problems, as well as a home study to assess her current circumstances.

**Finding**: CWS caused an unreasonable delay (almost a year) in placing a twelve-year-old dependent child with a relative, due to poor case management. The supervisor and caseworker failed to attend the child's treatment team meetings (though repeatedly invited), which could have quickly resolved the concerns they had expressed about placing the child with the relative. Agency staff also delayed in setting up meetings they had requested to review the safety plan proposed by the child's therapist to address these concerns, including canceling one of the meetings at short notice. The child experienced four different placements in the interim.

**Outcome**: The child was ultimately placed with the relative, prior to the Ombudsman receiving this complaint. The Ombudsman noted that the Regional Administrator was aware of management problems in this DCFS office, and was in the process of addressing these problems in order to improve case management.

**Finding**: CWS removed three dependent children, ages nine, five and two, from their relative placement where they had been living for almost two years, without any notice to the relative and in a traumatic manner, after receiving

## Assisting Agencies... *(continued)*

an allegation of a foster care licensing violation by the relatives (who were licensed foster parents). A subsequent CPS investigation into an allegation of physical abuse of the oldest child by one of the relatives resulted in unfounded findings. The children were not allowed contact with their relatives for three months after they were moved. This was particularly traumatic for the two younger children.

**Outcome**: The Ombudsman discussed numerous concerns regarding case management with the Area Administrator, who began actively overseeing the case and identifying training needs on the part of the caseworker and supervisor. After consultation with the children's therapists, visits with their relatives were arranged. The administrator acknowledged that the emergent and traumatic removal of the children could have been avoided by more thorough information gathering by CWS. All available relatives were thoroughly assessed for adoption of the children.

### COMPLAINT ISSUE: FOSTER PARENT ISSUES

**Finding**: CWS provided inadequate assistance to a foster parent needing respite care for her fourteen-year-old foster child with special needs. The foster parent had been requesting assistance from the agency for the past five months, unsuccessfully. Although the agency provided her with a list of respite care providers, she was unable to access care from any of them. The youth had already experienced eighteen different placements, including a failed residential treatment program. The foster parent stated that if she did not obtain respite care, she would be unable to continue caring for the youth.

**Outcome**: While the agency did not violate existing law or policy by placing responsibility for securing respite care upon the foster parent, the exceptional circumstances in this case warranted additional assistance from the agency. The Ombudsman has noted that the system for accessing respite care appears unclear and unreliable.

**Finding**: CWS failed to effectively communicate with the foster parents of a three-year-old dependent child regarding the child's case plan, resulting in a poor working relationship with the foster parents, who had a history of providing exemplary care of foster children for the agency.

**Outcome**: The caseworker's poor communication with the foster parents (as witnessed by others) resulted in increasing conflict over the case plan, culminating in the foster parents requesting removal of the child from their care. Although the child was ultimately placed back with them in an adoptive placement, the family decided to cease providing foster care services for the agency due to their negative experience with this caseworker.

## 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.

### COMPLAINT ISSUE: CHILD SAFETY FROM ABUSE

Finding: CPS failed to follow required procedures regarding child sexual abuse investigation, in an investigation involving allegations of abuse of a five-year-old child by her non-custodial parent during visits. CPS failed to follow established protocol of contacting the local multi-disciplinary team set up to manage such investigations, and as a result the child was interviewed multiple times, resulting in lack of clarity regarding the child's statements.

Outcome: The investigation results were inconclusive, and unsupervised visits with the non-custodial parent were continued. Professionals involved with the child believed the child may be at risk due to the flawed nature of the investigation. CPS acknowledged its error, stating that it was participating on a multidisciplinary committee set up to revise the local sexual abuse investigation protocol to prevent such errors in the future.

Finding: CPS failed to document a referral alleging physical abuse of four non-dependent children, ages five to ten. CPS appropriately referred the caller to law enforcement for an immediate response, as these children were about to return to their custodial parent (the alleged perpetrator) out-of-state, and could be taken into protective custody immediately by the police if needed. However, it was a violation of law and policy for the referral not to be documented in the Children's Administration's computerized records and referred to CPS and law enforcement in the children's home state.

Outcome: The Ombudsman verified with a CPS Central Intake trainer that this referral should have been documented and referred to CPS in the children's home state. The trainer noted this as a training gap to be addressed in future CPS intake training.

### COMPLAINT ISSUE: CHILD SAFETY FROM NEGLECT

Finding: CPS failed to investigate a referral alleging neglect of a toddler. The referral had been made by law enforcement, after an officer found a nineteen-month-old child at home alone. The officer had been able to locate the other parent, who returned home. CPS reduced the risk tag assigned to the referral (thereby eliminating the obligation to investigate it) due to law enforcement's involvement and high CPS workloads at the time.

Outcome: The Ombudsman brought this to the attention of CPS, which acknowledged that the referral should have been investigated. The Ombudsman monitored that office while staffing changes were made and caseloads reduced to prevent similar errors in the future.

### COMPLAINT ISSUE: HEALTH, WELL-BEING OR PERMANENCY OF DEPENDENT CHILDREN

Finding: CWS compelled a local school district to dismiss an individual serving as the "surrogate parent" for a thirteen-year-old dependent youth. This individual had been appointed in accordance with state and federal education law, in order to advocate on the youth's behalf for an appropriate Individualized Education Program (IEP). CWS instructed the school district that the youth's CWS worker would replace this individual. The worker then attended an IEP meeting and signed the youth's IEP as the child's guardian. The Ombudsman found this to be in violation of education law which specifies that employees of school districts or public agencies responsible for the child's education or care are specifically excluded from being appointed as a "surrogate parent". The youth was temporarily left without an appointed "surrogate parent" to advocate on his behalf.

Outcome: The youth's foster parent was later appointed as "surrogate parent". The Ombudsman discussed the incident with the supervisor who acknowledged concerns of possible conflict of interest and agreed to provide training for workers regarding education law.

Finding: CWS informed a ten-year-old legally free child that a relative was considering adopting him, even though the relative had not yet reached a decision and had been told that the child would not be informed of this possibility. This action was unreasonable given that the child had a diagnosis of Reactive Attachment Disorder, increasing the potential that the child would experience feelings of rejection and abandonment if the adoption did not materialize (which it did not).

## Preventing Future Mistakes *(continued)*

**Outcome:** The Ombudsman informed CWS of this finding. CWS acknowledged that this discussion should not have occurred.

**Finding:** CWS failed to consider the foster family for adoption of an almost two-year-old dependent child, though she had been cared for by them since the age of three months. The agency did not arrange an adoption home study and instead placed the child, along with her siblings, in a different foster home with the intention of having all the children adopted by those foster parents. The child was subsequently moved four more times.

**Outcome:** Although this complaint was received after-the-fact, as a result of concerns raised by the Ombudsman regarding placement committee procedures in the DCFS office involved, several revised procedures were implemented for future cases in which the child's current foster family wants to adopt the child.

**Finding:** CWS failed to thoroughly consider an out-of-state relative for placement of a dependent seven-month-old infant. The relative had already adopted the infant's four older siblings, yet the agency did not obtain a home study on the relative, and decided to allow the child to be adopted by her foster parents. CWS also failed to communicate effectively and in a timely manner with the out-of-state agency responsible for the siblings' placement.

**Outcome:** The Ombudsman requested that CWS fairly consider the relatives, but the agency declined to change its position. Based on the handling of this and other adoption cases in that CWS unit, the Regional Administrator made staffing changes in the unit and implemented new policies for more effective and fair management of adoptive placement decisions.

### COMPLAINT ISSUE: PARENTS' RIGHTS

**Finding:** CWS failed to provide court-ordered visitation between a parent and a dependent 12-year-old child, failed to provide a report to the court on the child's progress and case plan, and failed to notify the parent's attorney of a court hearing.

**Outcome:** The court sanctioned CWS on all three violations, and visitation was subsequently provided as court-ordered. This court-ordered remedy had already occurred when the Ombudsman received a complaint regarding a different aspect of this case. However, the Ombudsman noted the agency's violations.

**Finding:** CPS refused to discuss a proposed safety plan with a parent undergoing a CPS investigation, during a telephone conference call with the parent and the parent's attorney. While the Ombudsman did not find this action to be clearly unreasonable, better practice would certainly involve the parent's attorney in such a discussion.

**Outcome:** The need for training for caseworkers on their legal duties to protect the constitutional and statutory rights of children and parents was addressed by the Legislature through the passing of a new bill to require such training for CPS caseworkers (SSB 5922).

**Finding:** DCFS erroneously provided a birth parent with confidential information regarding an adoptive parent, in agency records provided to the birth parent in response to her request for public disclosure. Agency staff failed to redact the adoptive parent's contact information when preparing the requested records.

**Outcome:** The region in which this breach of confidentiality occurred changed its administrative procedures to require supervisors to redact records provided through public disclosure requests (rather than administrative staff, as had previously been the case), and to keep copies of what records were provided.

### COMPLAINT ISSUE: SERVICES TO RELATIVES

**Finding:** CPS led the relative caregivers of a dependent child to believe that the agency would be able to assist the relative in making capital improvements to their home in order to better accommodate the child. Financial assistance to foster parents and relative caregivers for capital improvements is expressly prohibited by law.

**Outcome:** The Ombudsman discussed these findings with the case supervisor and the Regional Administrator, who educated both agency staff and the relative regarding what kinds of assistance may be provided to caregivers for dependent children.

## Preventing Future Mistakes *(continued)*

### COMPLAINT ISSUE: FOSTER PARENT ISSUES

**Finding:** DLR/CPS failed to complete an investigation of alleged neglect and sexual abuse of a foster child by a foster parent, in a timely manner. The investigation was not concluded until eight months after the referral had been received, well after timelines for investigations required by agency policy. Although the findings of the investigation were "unfounded", the delay in reaching this finding was stressful for the foster parent as well as the child, who had been placed in a different home pending the outcome of the investigation. In addition, OFCL failed to follow proper procedures in investigating an earlier licensing complaint regarding the foster parent. The foster parent was neither informed about the complaint, nor given an opportunity to respond, and was not notified of the agency's finding of "valid" regarding the complaint.

**Outcome:** The Ombudsman contacted the statewide administrator for DLR expressing concerns about these violations of policy. The administrator agreed with the Ombudsman's findings and undertook to follow up with the supervisor in this case to prevent such violations in future.

**Finding:** CWS violated law and policy regarding confidential information, by disclosing the location of a child's foster home to the child's parents. This breach of confidentiality resulted in the child having to be moved to another foster home, and had negative consequences for the foster parents, who were followed by a registered sex offender known to the child's parents.

**Outcome:** The Ombudsman verified that the agency was conducting an internal investigation and taking appropriate action in response to a complaint made by the foster parent to the Regional Administrator.

**Finding:** DLR/CPS failed to complete an investigation in a timely manner, into alleged sexual abuse of two six-year-old foster children by the biological child of a foster parent. The alleged child perpetrator was not interviewed until eight months after the referral was received, and the investigation was not completed until a year after the referral, well after the ninety-day timeline required by policy.

**Outcome:** The Ombudsman received this complaint after the investigation was completed, but found that the delay in investigating not only compromised the integrity of the investigation, but also was very stressful for the foster family, who were unable to have foster children until the investigation was completed. The findings were "unfounded".

# Child Fatalities: Avoidable Tragedies

In 2004, 16 month-old Justice and 6 week-old Raiden Robinson were found dead in their home. In 2005, four year-old Sirita Sotelo was beaten to death by her stepmother. Each of these deaths shocked the conscience. They unmasked our society's inability to protect our most vulnerable. These high profile deaths galvanized advocates, politicians, parents, community members, and other citizens to take action.

Within months of the Robinson children's deaths, the Washington Legislature enacted the Justice and Raiden Act. The Justice and Raiden Act[1] allows Child Protective Services (CPS) greater ability to intervene in cases of chronic neglect. Sirita's death led to Sirita's Law, which called for a state task force to reform the child welfare system in Washington.[2] Both of these laws were inspired by the lessons learned from tragedies. They are a vivid example of positive systemic reform that can arise from a detailed review of a child fatality and a critical examination of the shortcomings in the child protection system. Other states have responded legislatively when they too have been devastated by the death of a child.[3]

**The Ombudsman reviewed the fatalities of Justin and Raiden Robinson and Sirita Sotelo and developed recommendations to address:**

- ✓ improving procedures for case reviews;
- ✓ implementing caseload standards;
- ✓ modifying statutory provisions governing investigations and interventions;
- ✓ requiring mental health evaluations in certain cases;
- ✓ strengthening case supervision;
- ✓ assuring appropriate services are provided; and
- ✓ improving assessment of other adult caregivers.

[1] ESSB 5922 sets forth the Legislature's intent that DSHS and the justice system intervene in cases of chronic neglect, where the well-being of a child is at risk and specifically includes a parent's substance abuse as an important factor in determining whether negligent treatment or maltreatment exists.

[2] "Sirita's Law" was named after four year-old Sirita Sotelo who was beaten to death by her stepmother in Lake Stevens, Washington. "The bill started as a three-strikes law for parents who abuse or neglect children, but it was modified to call for a task force to study the safety of children in the child welfare system." http://seattlepi.nwsource.com/local/224440_billsign16.html (Seattle PI, May 16, 2005)

[3] For example, in 1994, 7-year-old Megan Kanka was lured away from her home, raped, and killed. Megan's death led to Megan's Law, which increased community knowledge about sex offenders by providing the public with certain information on the whereabouts of sex offenders so that local communities could protect themselves and their children. Megan was a New Jersey girl who was raped and killed by a known child molester who had moved across the street from the family without their knowledge. In the wake of the tragedy, the Kankas sought to have local communities warned about sex offenders in the area. All states now have a form of Megan's Law. http://www.meganslaw.ca.gov/homepage.aspx?lang=ENGLISH. In 1996, 9 year-old Amber Hagerman was abducted and murdered while riding her bicycle in Arlington, Texas. Amber's death led to the creation of the Amber Alert System in 1996. Broadcasters team with local police to develop an early warning system to help find abducted children. AMBER stands for America's Missing: Broadcast Emergency Response. Other states have now implemented their own AMBER plans. http://www.amberalert.gov/faqs.html.

## OFCO Reviewed the High Profile Child Fatalities of Justice and Raiden Robinson and Sirita Sotelo[4]

In 2004 and 2005, the Ombudsman reviewed the fatalities of Justice and Raiden Robinson and Sirita Sotelo at the request of the state Legislature. Based on reviews of these child fatalities, the Ombudsman developed several recommendations. The recommendations from the Justice and Raiden Robinson fatality review addressed:

- improving procedures for case reviews by CPS supervisors;
- implementing caseload standards for CPS workers and supervisors;
- modifying the statutory provisions governing CPS investigations and interventions; and
- requiring CPS to attempt to obtain mental health evaluations of a parent when mental health issues contribute to the alleged child abuse or neglect.

The recommendations from the Sirita Sotelo Fatality Review addressed:

- strengthening case supervision following a child's return to a parent's care;
- assuring that appropriate services for successful reunification are provided; and
- improving assessment of other adult care-givers in the parent's home.

## JUSTICE AND RAIDEN ROBINSON

On November 14, 2004, 16-month-old Justice Robinson and six-week-old Raiden Robinson were found dead in their home. The children died of malnutrition and dehydration, despite food in the refrigerator and pantry. Police officers had been summoned to conduct a welfare check on the children, and a two-year-old child assisted the officers in opening the front door. Uncooked food was scattered throughout the home, indicating that the two-year-old child had been foraging for food for some time. The responding officers found the children's mother, Marie Robinson, intoxicated and passed out in a bedroom. Police officers also discovered over 300 empty beer cans in the mother's bedroom.

Ms. Robinson's history of alcohol abuse, and the related risk of harm to her children, was well known to Child Protective Services (CPS). Prior to the children's death, CPS received six referrals between 2002 and 2004 reporting chronic alcohol abuse by the mother and related physical neglect of the children. Two referrals were accepted for CPS investigation, two referrals were referred to Alternative Response Services (ARS),[5] and two referrals were screened as "information only" and were not investigated.

The Office of the Family and Children's Ombudsman conducted a case investigation of CPS' involvement with this family and the circumstances leading to Justice and Raiden's death.[6] The Ombudsman

[4] The full text of the Ombudsman's fatality reviews of the Robinson and Sotelo children is available at http://www.governor.wa.gov/ofco/reports.htm.

[5] Alternative Response Systems (ARS) "provide delivery of services in the least intrusive manner reasonably likely to achieve improved family cohesiveness, prevention of re-referrals of the family for alleged abuse or neglect, and improvement in the health and safety of children." These services are voluntary and are not intended to be investigative for purposes of determining whether child abuse or neglect occurred. RCW 74.14D.020

[6] Shortly after deciding to conduct an investigation, several legislators contacted the Ombudsman requesting a case investigation.

reviewed all records and reports from CPS, available treatment reports from service providers, ARS records, as well as applicable Children's Administration (CA) Policy and Procedure, and state law. The Ombudsman also interviewed CA staff. The purpose of the Ombudsman's investigation was to determine whether CPS responded to reports of child neglect secondary to Ms. Robinson's alcohol abuse, in a manner consistent with department policy and state law, and to identify changes in law, policy and procedure that will better protect children from abuse and neglect.

## Justice and Raiden Fatality Findings

1. **CPS investigation and case activities were not completed in a timely manner**. For example, CPS failed to complete an investigation within 90 days of a referral received on February 7, 2004.[7] This referral was accepted for a high standard investigation. CA procedures required, at that time, that in a high standard investigation the assigned social worker must "interview child victims face-to-face within 10 working days from the date of referral."[8] On March 1, 2004, 23 calendar days and 15 working days after the referral was received, the CPS worker completed an initial face-to-face interview with the mother, father and two children. The referral remained open at the time of Justice and Raiden's death, nine months later.

2. **CPS investigations were inadequate and insufficient.** In the course of its investigations, CPS did not obtain relevant collateral information from sources such as medical professionals, law enforcement, or service providers.[9] For example, on October 8, 2003 CPS accepted for investigation a referral stating: the mother just completed drug/alcohol treatment 30 days ago and has now relapsed; the children were filthy, had feces all over and had urinated in their pants; and they had not been fed and were starving.

   CPS failed to obtain the children's medical records, or interview medical providers, regarding allegations that the children were filthy and starving. A review of medical records[10] shows that while CPS was conducting its investigations, Justice was seen by a pediatrician on October 29, 2003 for failure to thrive, he had not gained weight in the past month, and in the four months following his birth, he had dropped from the fiftieth to the tenth percentile in weight. Because no inquiries were made, this information was not known to CPS, and the correlation between the mother's binge drinking and the child's failure to thrive was not addressed.

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[7] Children's Administration Practices and Procedures Guide, Section 2520 states: "The social worker shall complete an investigative risk assessment on all investigations of child abuse and neglect upon completion of the investigation and no later than the 90th day after the referral is received unless the requirement is waived by the supervisor . . . ."

[8] Id. Section 2331(D)(2). On August 8, 2005, at the direction of Governor Gregoire, DSHS implemented a requirement that social workers must now interview child victims within 72 hours of moderate to high risk referrals. Interviews must take place within 24 hours in emergent cases.

[9] Id. Section 2331(D)(27) states: "The assigned social worker must: . . . Interview . . . professionals and other persons (physicians, nurse, school personnel, child day care, relatives, etc.) who are reported to have or, the social worker believes, may have first-hand knowledge of the incident, the injury, or the family's circumstances."

[10] The children's medical records were obtained by DSHS CA after repeated requests by the Ombudsman in the course of the Ombudsman's fatality review.

3. **Inadequate factual basis to support CPS' investigative findings.** CPS' conclusion that the referral received on October 8, 2003 was "Unfounded"[11] for child abuse or neglect, was not adequately supported by the information available to the CPS worker. Specifically, the allegation was not refuted that the children were filthy, had feces all over and had urinated in their pants, had not been fed and were starving at the time of the mother's relapse. Additionally, the mother admitted a history of alcohol abuse, treatment and relapse. Moreover, there was no independent information in support of CPS' conclusion that the mother was hospitalized due to low potassium levels, not alcohol consumption, and no independent information regarding the health and welfare of the children.

4. **CPS case records contain several instances of inaccurate or misleading entries.** In each case, these statements minimize the gravity of the mother's history of alcohol abuse or the potential risk to her children. For example, an Investigative Assessment of December 11, 2003 erroneously states "No prior hx [history] with WA CPS." At that time however, the mother had two prior reports to CPS alleging alcohol abuse and related neglect, which were referred to ARS. This Investigative Assessment also stated: "Mother appears to understand addiction process well and sees how she needs to maintain sobriety." The worker failed to record in this assessment that the mother's alcohol evaluation states that Ms. Robinson had not committed to treatment at that time, and that she failed to comply with an agreed Safety Plan. Similarly, a Transfer/Closing Summary dated December 16, 2003 also omitted information that Ms. Robinson did not engage in recommended treatment.

5. **CPS Service Agreements failed to compel the mother to engage in services or reduce the risk to her children.** Twice CPS entered or offered a service agreement, requiring the mother to seek treatment for her alcohol abuse. When these attempts were unsuccessful, CPS did not take additional steps to compel the mother to seek treatment.

6. **Alternative Response Systems (ARS) services failed to adequately assess or address the mother's needs.** In September 2002, CPS received two referrals concerning alcohol abuse, mental health, and child safety issues. Instead of opening these referrals for CPS investigations, they were accepted and referred to the Alternative Response System, which provides services but does not conduct investigations.

7. **Inappropriate Screening Decision by CPS Intake.** Two CPS referrals received in September 2002 were referred to ARS, and were not investigated by CPS. The second referral, received on September 17, 2002, stated that the mother had been hospitalized for suicidal ideation, that she was discharged on that date (9/17/02) and was still expressing concerns about hurting herself. The referral also stated that the mother reported there was no food in the home, and that the mother lived alone with her six month-old baby.

   This referral was initially accepted for CPS investigation, with a risk tag of 5. After reviewing the referral, the CPS intake supervisor reduced the risk tag from 5 to 2 stating: "ARS Wkr [worker] is

[11] Children's Administration Practices and Procedures Guide, Section 2540(A) provides: at the conclusion of a CPS investigation, "the worker must complete a CAMIS Investigative Risk Assessment (IRA) which includes: . . . a record of case findings regarding alleged abuse or neglect. [Findings are based on the following definitions:] (a) **Founded** means: Based on the CPS investigation, available information indicates that, more likely than not, child abuse or neglect as defined in WAC 388-15-130 did occur. (b) **Unfounded** means: Based on the CPS investigation, available information indicates that, more likely than not, child abuse or neglect as defined in WAC 388-15-130 did not occur. (c) **Inconclusive** means: Following the CPS investigation, based upon available information, the social worker cannot make a determination that, more likely than not, child abuse or neglect did or did not occur."

involved with services and client is receptive to services." CA Practices and Procedures permit the intake supervisor to change the risk tag and screening decisions when "additional information supports the change."[12] Here however, there is no documentation, either by the intake supervisor, or the ARS worker, that the supervisor obtained information from ARS regarding specific services provided to Ms. Robinson or the level of her compliance.

## Justice and Raiden Fatality Recommendations

### Recommendations Regarding Children's Administration Policy

- **Improve Supervisory Reviews of CPS Investigations.**

  High quality and timely supervisory reviews are essential to ensuring that investigations are conducted in a manner consistent with best practices and agency policy and procedure.

- **Case referral to Alternative Response Systems should not preclude investigation by CPS.**

  CA Policy should be amended to provide that in addition to providing ARS services, CPS may conduct investigations into allegations of child abuse or neglect.

- **Implement Caseload Standards.**

  In order for CPS workers to conduct thorough and timely investigations, assess risk and child safety, engage families in essential services, and monitor case progress, CA must establish and implement reasonable caseload standards. While computing caseloads is an inexact science, the Child Welfare League of America (CWLA) recommends that CPS workers be limited to 12 active investigations per month.[13] CA should use this as a guide in determining and implementing caseload standards.

### State Law Recommendations

- **Modify the statutory definition of child abuse and neglect and allow CPS to intervene earlier in an investigation to protect children at risk of abuse or neglect.[14]**

  The Legislature should consider amending the definition of child neglect, to recognize the harm that may result from an act or omission, or pattern of conduct, that constitutes a substantial danger to the child's health, welfare or safety, and allow earlier CPS intervention. The Legislature should consider changes to statutory provisions regarding child abuse and neglect, permitting the court to establish an in-home dependency for the purpose of implementing appropriate service and safety plans. A parent's failure to comply with a service plan or safety plan is a relevant factor which should be considered when determining whether conditions present a substantial threat of harm to the child.

- **Require CPS to attempt to obtain an evaluation when it is determined that mental health issues are a contributing factor to the alleged child abuse or neglect.**

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[12] Id. Section 2220(F)(2).

[13] CWLA Guidelines for Computing Caseload Standards, http://www.cwla.org/programs/standards/caseloadstandards.htm.

[14] The Ombudsman previously made this recommendation in the Office of the Family & Children's Ombudsman 2000 Annual Report. The Legislature modified the definition of abuse and neglect by passing ESSB 5922.

When substance abuse is a contributing factor to alleged child abuse or neglect, state law requires CPS to cause a comprehensive chemical dependency evaluation to be made.[15] Similar statutory requirements should exist to identify and treat mental health issues contributing to the neglect or abuse of a child.

## SIRITA SOTELO

Three weeks before she was born, Sirita[16] Sotelo was the subject of a CPS referral, alleging prenatal substance abuse by her mother. After she tested positive for cocaine at birth on February 12, 2000, CPS filed for dependency and placed Sirita in foster care.

Over the next three years, the department made numerous attempts to reunite Sirita with her mother. Services were provided to address the mother's substance abuse and mental health issues. Four times Sirita was placed with her mother, only to again be removed due to allegations of abuse or neglect. During this period, Sirita experienced seven different placement episodes, alternating between foster care and placement with her mother. She spent over 25 months in foster care, in eight different foster homes,[17] and 19 months placed with her mother. Significant periods of placement with the mother lasted four months, five months and ten months. While efforts were being made to reunite Sirita with her mother, the child's father, Mr. Ewell, who was notified of the dependency action, did not involve himself in the dependency process, or seek placement of Sirita.

In May 2003, the department filed for termination of parental rights, based on the length of time Sirita had been in state care, the failed reunification attempts with the mother, and the father's lack of participation in the dependency action or reunification efforts. However, after learning that the department was seeking to terminate parental rights, Sirita's father stepped forward and requested that she be placed with him and his wife. The department then conducted a home study and developed a service plan for the father, which included a drug/alcohol assessment, parenting classes, weekly visits with Sirita, and a psychological evaluation. The father successfully completed these services, and in November 2003, Sirita was placed with her father, stepmother and their four children.

Over the following 12 months, the department continued to supervise Sirita's placement with her father and provide case management services. Monthly visits to check on Sirita's health and safety occurred in December 2003, January 2004, February 2004, and the last visit occurred in May 2004. Although caseworkers identified a need for counseling, this service was not implemented. In November 2004, the dependency was dismissed, as the father had established a parenting plan gaining custody of Sirita.

On January 22, 2005, only two months after the dependency case was closed, CPS received a referral from law enforcement reporting a suspicious death of four-year-old Sirita. The stepmother and another relative had been with Sirita the night of her death and reportedly called poison control stating that Sirita had gotten sick eating glue. Later that evening, the relative checked on Sirita and found her dead, and then called 911. According to law enforcement, the child appeared gaunt, malnourished and pale. Medical examiners later determined she died as a result of blows to the head and body causing a fractured skull and severed liver. The stepmother later stated that she couldn't handle Sirita's fits and tantrums and admitted she threw her in a cold shower and beat her after the child wet her pants.

[15] RCW 26.44.170.

[16] Case records list various spellings of the child's name, including Sereta, Sireta, and Serita.

[17] Length of placement in any one foster home ranged from one night to 13 months.

The Ombudsman conducted a case investigation of the Division of Children and Family Services' (DCFS) involvement with Sirita and her parents. The Ombudsman reviewed all records and reports from DCFS, treatment reports, professional evaluations, as well as applicable CA Policy and Procedure and state law. The purpose of the Ombudsman's investigation was to determine DCFS' compliance with department policy and procedure, and state law, and to identify changes in law, policy and procedure that will better protect children from abuse and neglect.

The Ombudsman identified the following areas of concern:

- Lack of services provided to Sirita, her father and stepmother, following her placement in their care.
- Delay in establishing permanency for Sirita.
- Frequency of health and safety checks did not comply with CA policy.
- The father's and stepmother's CPS referral history may not have been fully considered prior to placing Sirita in their home.
- Although the father completed both a psychological evaluation and drug/alcohol assessment prior to Sirita's placement, there was no similar evaluation of the stepmother.

## Sirita Fatality Findings

1. **DCFS delayed establishing permanency for Sirita.** Ideally, a safe, stable and permanent home for a dependent child should be achieved before the child has been in out-of-home care for 15 months.[18] In this case, Sirita was the subject of a dependency action for over three and a half years before a permanent placement with her father was established. Before she was placed with her father, Sirita experienced seven different placement episodes, alternating between foster care and placement with her mother. During this time, Sirita spent a total of over 25 months in foster care, and 19 months placed with her mother.
2. **The father's and stepmother's CPS history may not have been considered.** The screening decision not to investigate the CPS referral received in March 2001, regarding one of the Ewell's children was not clearly inappropriate or unreasonable under the circumstances according to existing CA policy.[19] As a result of this screening decision, however, concerns regarding substance abuse and criminal conduct in the home were never investigated. Additionally, the department's consideration of Mr. Ewell as a potential caregiver for Sirita, erroneously concluded he had a clean slate with CPS. Although the CPT presentation summary briefly mentioned the March 2003 CPS referral stating that the father allowed Ms. Sotelo unsupervised access to his child, the summary states that there was a minimum level of risk in placing Sirita with her father,

[18] RCW 13.34.145(1)(c).

[19] Children's Administration Case Services Policy Manual, Section 2131(C) states:
"The department shall investigate complaints of any recent act or failure to act on the part of a parent or caretaker that results in death, serious physical or emotional harm, or sexual abuse or exploitation, or that presents imminent risk of serious harm, and on the basis of the findings of such investigation, offer child welfare services in relation to the problem to such parents, legal custodians, or persons serving in loco parentis, and/or bring the situation to the attention of an appropriate court, or another community agency: Provided, that an investigation is not required of non-accidental injuries which are clearly not the result of a lack of care or supervision by the child's parents, legal custodians, or persons serving in loco parentis." See also RCW 74.13.031.

in part because he had "no apparent involvement with CPS concerning his own children." Although a CPT presentation summary was prepared by the caseworker, the CPT did not occur. Consequently, a CPT did not review this case prior to the child being placed with the father.

3. **DCFS did not fail to evaluate Mrs. Ewell pre-placement.** The department did not fail to evaluate Mrs. Ewell and her capacity to provide adequate care for Sirita prior to placing her in the Ewell's home. Mrs. Ewell participated in the home study, and complied with a criminal background check. But the department did not seek further assessment or evaluation of her ability to care for Sirita. This was not clearly unreasonable under the circumstances, as the department lacked specific information or concerns that would have warranted further evaluation. However, information presented during Mrs. Ewell's criminal proceedings described events from her personal history that clearly would have justified further assessment regarding her ability to care for Sirita.
4. **Frequency of health and safety checks did not comply with existing policy.** Although both CCS and CWS caseworkers conducted home visits after Sirita was returned home, these visits did not occur with the frequency or consistency required by then existing department policy. Children's Administration Policy, in effect in 2003 - 2004, required that during the first 120 days of a child being placed back in the home, contact with the child must occur at least twice a month for children age birth through five. Sirita was placed in her father's and stepmother's home in November 2003. The CCS caseworker visited the home in December 2003, January 2004 and February 2004, in order to check on Sirita's health and safety. The CWS caseworker visited the home in May 2004. No further health and safety checks occurred after May 2004, even though the department was responsible for supervising this case for an additional 6 months.
5. **Lack of services provided to Sirita and her father and stepmother.** The predominate area of concern was the lack of services to Sirita, her father, and her stepmother following Sirita's placement in the Ewell's care. Caseworkers noted that support services were needed to assist the father and stepmother to address Sirita's behavior issues. These services, however, were not provided.

## Sirita Fatality Recommendations

- **Heightened assessment of non-parent adult caregivers in the home.**

  Policymakers should require greater assessment of other adults in a parent's home, if it is likely that such person will be providing care for a dependent child on a regular basis. Stepparents or partners of a parent may be thrust into a position of providing daily care for a child with whom they are neither bonded nor related.[20] Their ability to care for a child and their family background is relevant to assessing the child's safety and welfare in the home. A criminal background check of other adult caregivers and a general home study are not sufficient to fully address these issues. At the very least, current home studies should specifically address in detail the extent and nature of care provided by other adults in the home, examine bonding/attachment issues between the child and such adults, and explore whether further evaluation/assessments of an adult caregiver is warranted.

[20] Lack of attachment between child and caregiver, and a caregiver's ambivalence towards the child, are factors identified in previous fatality reviews. See, ZyNia Nobles Fatality Review, Rafael Gomez Fatality Review and Justice and Raiden Robinson Fatalities Review.

- **Revise and implement policy requiring regular health and safety checks for children returned to a parent's care.**

  In 2001, Children's Administration implemented policy[21] requiring in-home contact with the child, twice a month, during the first 120 days of in-home placement, for children age birth to five. After the first 120 days, visits must occur at least monthly. Although this policy has remained in effect since 2001, these requirements have not been incorporated into either the Practices and Procedure Guide, or the Case Services Policy Manual. The absence of these requirements creates confusion as to whether health and safety checks for dependent children placed in a parent's home are required.

- **Increase efforts to provide services once a child is returned to a parent's care.**

  In addition to requiring regular and consistent in-home contact between the caseworker and the child and parent, the department should increase efforts to provide services to a child and family once a child is returned home. Existing tools, such as safety plans and service contracts, should be utilized to assure that families engage in appropriate services. The case record should specifically document steps taken to provide services.

[21] Children's Administration Policy 01-02,"Case Management Requirements for In-Home Dependencies" (Effective May1, 2001; revised November 1, 2002).

# Child Fatalities: Opportunities for Reform

The Ombudsman monitors and recommends changes in DSHS procedures with an eye toward ensuring the health and safety of children.[1] In its capacity as a watchdog of the child protection and welfare system, OFCO routinely reviews child fatalities across the state.

In 2005, the Ombudsman dedicated additional resources to compiling and analyzing data[2] on all unexpected child fatalities in 2004 of children who were in the care of, or receiving child welfare services from, DSHS CA[3] within one year of their death, or who died while in state licensed care.[4] This sobering number totaled 87 children. The victims in these less visible cases were no less sympathetic, and the circumstances of their death were often no less egregious, than the high profile deaths of the Robinson and Sotelo children.

A thorough review of the Robinson and Sotelo child fatalities yielded valuable information about the shortcomings of the child protection system and how the system can be improved to safeguard children. We believed that a review of these lesser known cases presented a similar opportunity for reform. Our purpose was to identify critical factors and patterns so as to inform policy makers about developing better strategies to avoid these tragedies, and more simply, to show that taking the time to review fatalities yields significant information that can make a difference.

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[1] RCW 43.06A.030.

[2] OFCO receives notice of child deaths known to DSHS from an automated critical incident notifier via e-mail from the CA Administrative Incident Reporting System (AIRS). This provides the date of the critical incident and sufficient identifying information so that the Ombudsman is able to conduct further research on the child via DSHS records, law enforcement reports, medical records, and autopsy reports to create a profile of the fatality. OFCO records this profile in its data base. It includes information such as the circumstances of the death; age, gender, and race of the child; family history; child abuse and neglect concerns; and legal status of the child at the time of death.

[3] These are services provided by the Division of Children and Family Services (DCFS) within DSHS CA. "[D]CFS is the largest provider of direct client services. Children and families enter [D]CFS through three primary program areas, Child Protective Services (CPS), Child Welfare Services (CWS) and Family Reconciliation Services (FRS). These programs are responsible for the investigation of child abuse and neglect complaints, child protection, family preservation, family reconciliation, foster care, group care, in-home services, independent living, and adoption services for children age 0 to 18 years." http://www1.dshs.wa.gov/ca/about/abServices.asp

[4] OFCO's review criteria are the same factors that trigger a fatality review by DSHS CA under the law, RCW 74.13.640.

## Summary and Discussion of 2004 Child Fatalities Examined by OFCO

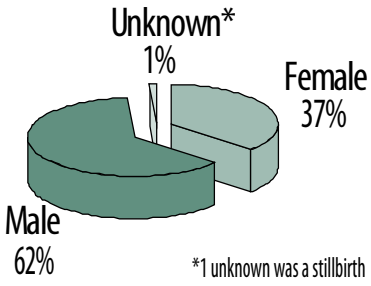
Among the 87 fatalities reviewed, just over half (44) were children who had an open case with DCFS at the time of their death. Four of these children were dependents of the State of Washington when they died.

### 2004 Child Fatalities by Age

| Age at Time of Death | # of Fatalities | Percentage |
|---|---|---|
| 0 (<age 1) | 46 | 52.87% |
| 1 | 3 | 3.45% |
| 2 | 4 | 4.60% |
| 3 | 0 | 0.00% |
| 4 | 1 | 1.15% |
| 5 | 2 | 2.30% |
| 6 | 1 | 1.15% |
| 7 | 1 | 1.15% |
| 8 | 1 | 1.15% |
| 9 | 1 | 1.15% |
| 10 | 0 | 0.00% |
| 11 | 1 | 1.15% |
| 12 | 3 | 3.45% |
| 13 | 2 | 2.30% |
| 14 | 1 | 1.15% |
| 15 | 8 | 9.20% |
| 16 | 5 | 5.75% |
| 17 | 7 | 8.05% |

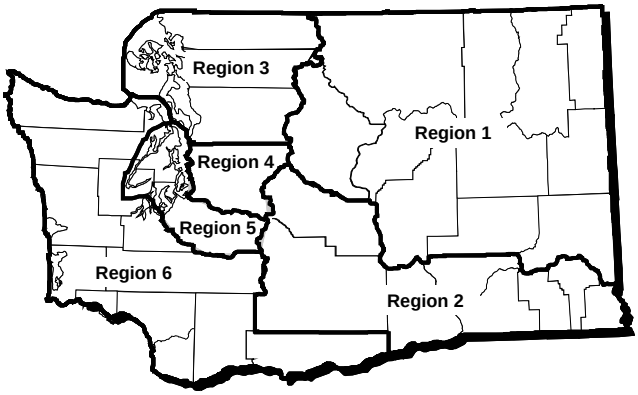
Source: Office of the Family and Children's Ombudsman, February 2006, based on analysis of DSHS CA data

### 2004 Child Fatalities by Gender



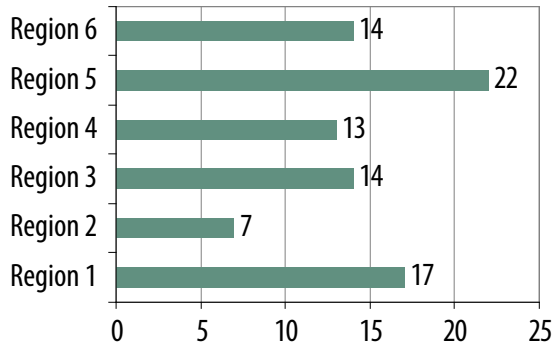

Source: Office of the Family and Children's Ombudsman, February 2006, based on analysis of DSHS CA data

## DSHS Regions



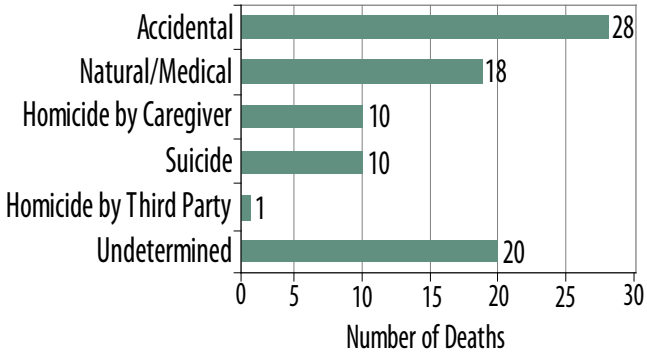

**Regional Offices: Region 1—Spokane; Region 2—Yakima; Region 3—Everett; Region 4—Seattle; Region 5—Tacoma; Region 6—Vancouver**

### Number of Child Deaths by Region



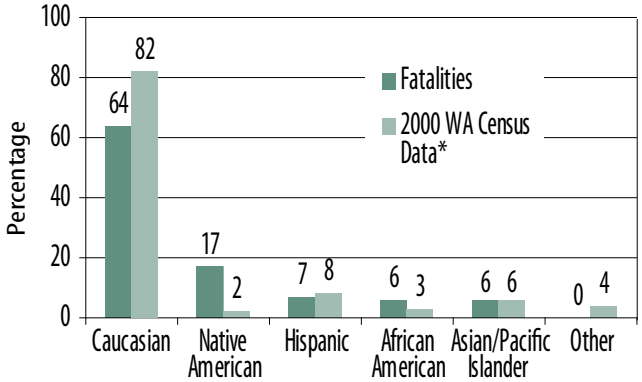

Source: Office of the Family and Children's Ombudsman, February 2006, based on analysis of DSHS CA data

### Type of Death (as determined by a medical examiner or coroner)




Source: Office of the Family and Children's Ombudsman, February 2006, based on analysis of DSHS CA data

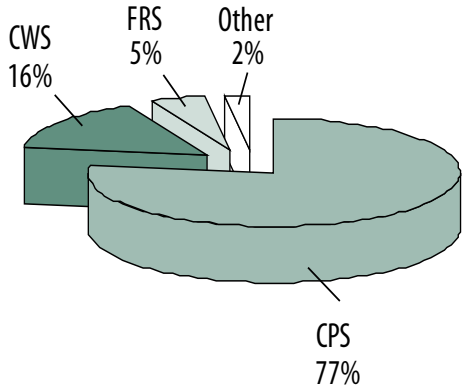
### Race of Child Victims Compared to Race of State Population




*Census data adds up to over 100% because it allows people to self-identify with multiple races.

Source: U.S. Census Bureau, 2000 Census; Office of the Family and Children's Ombudsman, February 2006, based on analysis of DSHS CA data

### Type of Open Case at Time of Death Total=44

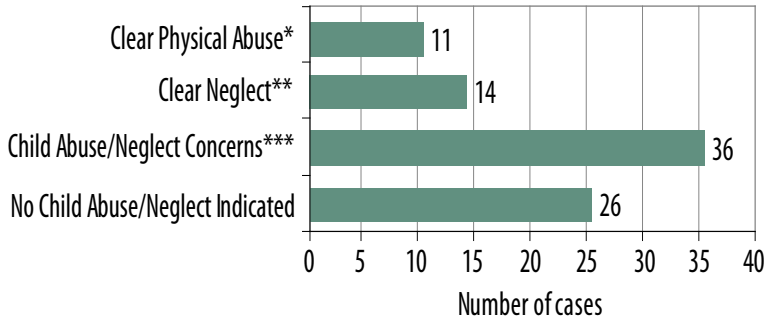



Source: Office of the Family and Children's Ombudsman, February 2006, based on analysis of DSHS CA data

## Child Abuse and Neglect Concerns

The Ombudsman reviewed cases to determine if child abuse and/or neglect contributed to the fatalities, and if so, how. We found that in 11 cases (13%[5]), clear physical abuse contributed to the child's death. Clear neglect contributed to the child's death in 14 cases (16%). In 36 deaths (41%), the Ombudsman noted significant concerns about child abuse or neglect in the family's recent history, but there was no conclusive proof that the abuse or neglect was a factor leading directly to the children's deaths. In 26 cases (30%), there were no indications of abuse or neglect having contributed to the fatalities.

**Child Abuse/Neglect Types**
**(as determined by OFCO review)**




Source: Office of the Family and Children's Ombudsman, February 2006, baed on analyis of DSHS CA data

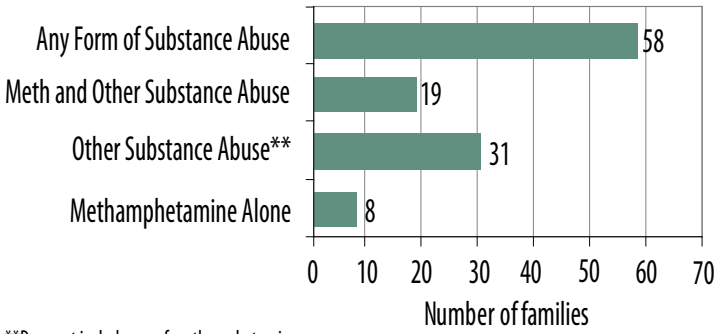
## CPS Referral History

In 55 cases (63%), the child's family had been the subject of 3 or more prior CPS referrals alleging child abuse or neglect. The referrals spanned the case history of the family.

## Substance Abuse

Among the children who died, 58 (67%) came from families in which one or more forms of substance abuse were noted in their CPS records. Methamphetamine abuse along with other forms of substance abuse existed in 19 case histories, and methamphetamine abuse alone in 8 cases. Other substance abuse, e.g., alcohol, cocaine, marijuana, etc. (without an indication of methamphetamine abuse) was present in 31 cases.

**Substance Abuse**




**Does not include use of methamphetamine

Source: Office of the Family and Children's Ombudsman, February 2006, based on analysis of DSHS CA data

*_Clear Physical Abuse:_* Case and Management Information Systems (CAMIS)† records or references from law enforcement reports noted that physical injuries, intentionally inflicted, caused the child's death.

**_Clear Neglect:_* Circumstances in the family's case history documented that neglect (e.g. leaving an infant unattended for 12 hours) clearly contributed to the child's death.

***_Child Abuse/Neglect Concerns:_* The Ombudsman found the presence of factors in the family's case history associated with abuse and neglect of children. These included factors such as substance abuse, domestic violence by the parent in the presence of children, mental health issues that impair a parent's ability to appropriately care for a child, and prior substantiated abuse of other children in the family. OFCO staff reviewed and reached a consensus to determine if child abuse or neglect contributed to the fatality in those cases where one or more of these factors were present. OFCO did not find it necessary to have a clear association between the concerns as the direct cause of the child fatality (e.g. child died from an impact injury to the head, inflicted by the parent), only that it was a contributing factor (e.g. the parent was under the influence of methamphetamine and alcohol and rolled over in bed, suffocating an infant).

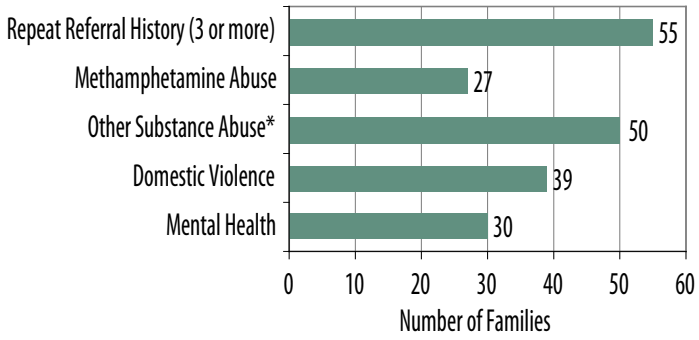
†CAMIS was developed in 1989. It is a computerized database and is the primary system used by CA to document the services it delivers to children and families statewide. OFCO has access to CAMIS.

[5] In the data presented from OFCO's analysis of 2004 fatalities, percentages have been rounded up or down for ease of interpretation.

## Summary of Family Characteristics

The majority of the children who died came from families with drug or alcohol abuse and the majority had a CPS history of 3 or more referrals. Forty-one of the child victims (47%) came from families who exhibited 3 out of the 4 family characteristics typically associated with families where abuse or neglect occurs: a repeat referral history (3 or more referrals to CPS); substance abuse; a history of domestic violence; and mental health issues.

**Family Characteristics**



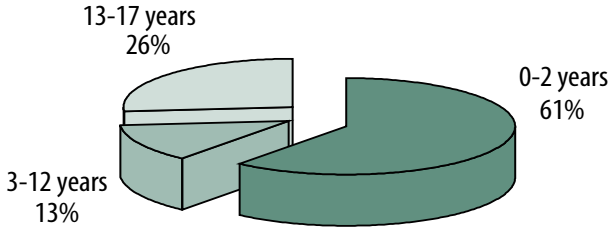

*Other Substance Abuse: Alcohol, cocaine, marijuana, etc.

Source: Office of the Family and Children's Ombudsman, February 2006, based on analysis of DSHS CA data

## Vulnerability of Children by Age

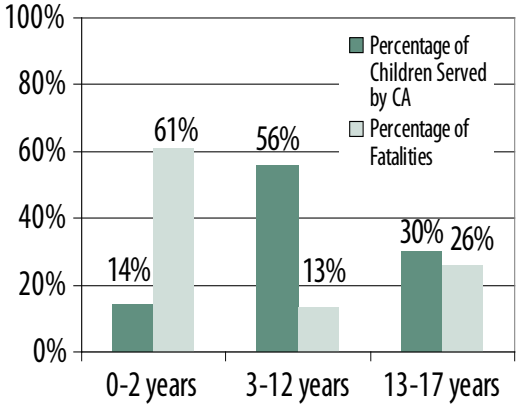
The data provides clear evidence that young children and teens comprise the largest proportion of those who died while in the care of, or who had received services from, DSHS CA in recent history—86%. Young children comprised only 14% of the children served by DSHS CA (in 2002 to 2003),[6] but were approximately 61 % of the children who died in 2004. While teens represented approximately 30 % of the children served by DSHS CA in 2002 to 2003, they were 26% of the dead children in 2004.

**Age at Time of Death**




Source: Office of the Family and Children's Ombudsman, February 2006, based on analysis of DSHS CA data

**Fatalities Compared to Children Served by CA**




Source: Office of the Family and Children's Ombudsman, February 2006, based on analysis of DSHS CA data

[6] This is based on data submitted to OFCO by DSHS CA and reflects children served between July 2002 and June 2003. Data on children served by DSHS CA in 2004, the year of deaths reviewed by OFCO, were not available. OFCO recognizes that the data provided by DSHS is for a different year than the year of deaths we reviewed, however we still believe that these numbers provide an interesting context in which to review the deaths of children in various age groups.

## Ages 0-2

***Summary:***

**Fifty-three (61%) of the children who died were age 2 or younger, with the large majority of these (46 children) being less than one year old.** Thirty-four (34) of the fatalities were infants age 3 months or younger. **Sixty-eight** (68) **percent of the children were male.** OFCO found that the deaths of 8 children were clearly caused by physical abuse, 11 were clearly caused by neglect, and in 25 cases there were serious concerns of abuse or neglect in the history that could have contributed to the fatalities, but could not be clearly proven. There was an absence of child abuse and neglect indicators in 9 of the histories of these youngest children.

***Children Less than One Year of Age:***

**More than half (46 children or 53%) of the 2004 child fatalities reviewed involved children less than one year old**. Five infants—a 6-week-old, a 2-month-old, a 2 ½-month-old, a 3-month-old and an 8-month-old--died as a result of clear physical abuse, i.e. homicide by their caregivers. In eight cases, the Ombudsman found that neglect clearly contributed to the infants' deaths--two stillborn infants, a 1 month-old, a 6-week-old (Raiden Robinson), a 3-month-old, a 4-month-old, a 5-month-old, and an 11-month-old. In 25 of the fatalities in this age group, there were child abuse or neglect concerns. For 8 of the 46 fatalities of children less than age 1, OFCO could find no indications of child abuse or neglect having contributed to the deaths. **At the time of these 46 infant deaths, 25 cases were open with DCFS:** 20 within CPS, 4 within CWS, and 1 within the Division of Licensed Resources (DLR), which was investigating the facility where the child died.

***Children Age One at Time of Death:***

**Among the three 1-year-olds who died in 2004, the Ombudsman found that serious neglect contributed to each of these deaths.** Two died by drowning and the third was the fatality of 1-year-old Justice Robinson.

***Children Age Two at Time of Death:***

Of the 4 children who were **age 2** at the time of their deaths, OFCO found that 1 was an accidental death with no child abuse or neglect indicated. However, the other 3 deaths of 2-year-olds were the direct result of homicide by their caregivers.

## Representative Case Histories:

### The following are representative case histories of infant fatalities:[7]

A 3-month-old died without explanation after being left unsupervised by the parents for 12 hours. Marks were found on the infant's neck, leading to a suspicion of strangulation, but the medical examiner ruled the cause of death to be "undetermined." There were 12 prior referrals on the child's family (some of which related to the parents' history as juveniles, indicating a chronic history of intergenerational abuse). The infant's family history included substance abuse and domestic violence, and the family moved frequently between Washington and other states. The most recent referral was made about abuse of older siblings, before this infant was born. The older siblings were placed with grandparents. The CWS case was closed one month prior to the infant's death when the dependencies on the older children were dismissed. **Closed CWS case. Clear Neglect.**

A 4-month-old was found dead in a crib after being put down for a nap in the family's home. The medical examiner determined the cause of death to be "SIDS of a drug affected at birth child." Caseworker records indicate that the father provided two different accounts of his whereabouts at the time of the death—being at home and checking on the infant and gone to the store for 20 minutes. The records also indicate that drug abuse during pregnancy may have contributed to the child's death. Both parents had a history of substance abuse. Methamphetamines, cocaine and heroin were detected in the infant's system at birth. There were four prior referrals regarding allegations of prenatal injury and neglect related to drug use, the last one at the time the infant was born. The infant was placed with the father (after father had spent some time in a drug rehabilitation program) with the stipulation that the mother was to have no contact with the infant. Records indicate that this safety plan was violated when the father left the child with the mother. Father agreed to the safety plan again and the infant remained in his care. There was a report that the mother had moved and the caseworker was monitoring the safety plan. However, later records indicate that the mother had been having continual contact with this infant and her older children. The family's CPS case was open at the time of the death. **Open CPS case. Child Abuse/Neglect Concerns.**

A 3-month-old was found dead on the couch in the family's home. The medical examiner found methamphetamines and nicotine in the infant's urine but not in the infant's blood. The cause of death was determined to be "pneumonia." Both parents were suspected methamphetamine abusers and were the subject of five prior referrals regarding neglect, related drug abuse and possible sexual abuse of an older sibling. At the time of this infant's birth, the parents fled the hospital after refusing urinalyses. A few days later, a social worker made an unannounced home visit and documented possible signs of drug use. The caseworker requested that the parents submit to random urinalyses and work with a public health nurse. The parents denied drug use, refused to be tested and refused public health services. The CPS case remained open at the time of the death. There is documentation by a casework supervisor six weeks prior to the fatality that the department planned to close the case "as the allegations of mother's drug usage appear not provable" and "non-cooperation by parents. Likely that parents are using drugs and refusing all offers of services." **Open CPS case. Child Abuse/Neglect Concerns.**

A 10-month-old was found dead in the family's home, swaddled in a sleeping bag, a usual sleeping place. The medical examiner found a piece of food lodged in the child's throat and methadone in the child's system. The cause of death was determined to be "asphyxiation". In the prior year, there were four referrals on the child's teen parent regarding serious neglect related to drug abuse, domestic violence, and a documented history of the mother's mental health issues including post-partum depression (there were ten other referrals related to the parents' respective families, indicating intergenerational child abuse and neglect). The family was referred to Alternative Response Services (ARS) for counseling. A public health nurse did provide services to the family. Prior to the time of the child's death, the CPS case had been closed "due to family's relocation". The parents were reportedly out of compliance with services at the time of case closure. The social worker's closing documentation indicated that "due to low level concerns, a CPS worker in [the family's new location] would not be assigned." **Closed CPS case. Clear Neglect.**

[7] In order to protect confidentiality we have not noted the sex of the child or date of death.

A 2-month-old was found dead after sleeping in bed with the parents. The coroner determined the cause of death to be "mechanical asphyxiation". As children, the infant's parents had over 20 referrals made to the department on their respective families. As parents of this infant, they were the subject of three referrals alleging neglect and unsanitary living conditions. The most recent referral was made one week prior to the infant's death regarding concerns about the infant's sleeping face down on a waterbed, filthy living conditions and lack of supervision of the infant and toddler sibling. The referral was accepted for non-emergent investigation. Records do not indicate that there was contact between the department from the time this last referral was made and the date of the infant's death. The fatality occurred within the department's required investigative timeframe. **Open CPS case. Child Abuse/Neglect Concerns.**

A 3-month-old was found dead after being placed face down to nap at daycare. There were 12 prior referrals on the daycare facility, eight of which pertained to licensing and four for child safety. There was an open DLR/CPS investigation on the facility at the time of the child's death (alleging neglect for lack of supervision). The child's family had no history with the department. Licensing requirements prohibit daycare providers from placing infants face down and the parents had not signed a waiver stating that the child could be placed face down to sleep. Open DLR/CPS case. **Child Abuse/ Neglect Concerns.**

A 6-week-old infant was found dead after being put down for a nap by the parent. Law enforcement reported the infant was found with bruises, lesions, and a swollen lip. A toxicology report indicated high levels of methamphetamines in the infant's bloodstream. The degree to which methamphetamines contributed to the child's death could not be determined with medical certainty. The possible causes of death as related/not related to methamphetamines were discussed in detail in the autopsy report but the official conclusion was "undetermined". The parents had a documented history of substance abuse and neglect, noted in seven prior referrals made to CPS. Approximately three months before the infant's death, there was a referral alleging mother's use of methamphetamines while pregnant, which was taken as "information only" and not investigated. The latest referral on the parents alleged neglect of an older sibling. The department arranged for daycare for the sibling and then closed the CPS investigation. **Closed CPS case. Clear Physical Abuse.**

A 2-½-month-old infant died from injuries as a result of physical abuse by the teen father. Medical reports indicated that the infant was abused over time. The father admitted to a variety of acts of physical abuse over several weeks time, and he was subsequently charged with homicide by abuse. The family had 12 prior referrals, 11 of which were in regard to the father and his family. The father had a documented history of chronic assaultive and defiant behavior as a juvenile and was himself abused as a child. At the time of the infant's death, there was an open CPS investigation regarding an older sibling, based on a referral made by a community professional. The referent reported a concerning pattern of injuries to the toddler, including bruises and black eyes. Domestic violence services, parenting classes, childcare, medical care and housing assistance services had been offered to the teen parents, but they refused each service. **Open CPS case. Clear Physical Abuse.**

A 2-month-old died in bed while sleeping with the mother who reportedly fell asleep while breast feeding. The medical examiner listed the cause of death as "death during infancy, no identifiable cause". Methamphetamines were found in the child's tissues but not at toxic levels. According to the medical examiner, it is "medically uncertain how the drug exposure contributed to the infant's death". The mother had a documented history of substance abuse, including alcohol, marijuana, and methamphetamines. There was an open CPS investigation at the time of the death. There had been 13 prior referrals on the infant's mother, 12 of which pertained to her as a child. The most recent referral was regarding prenatal methamphetamine use and related neglect of the older siblings, as well as the mother breast feeding while using methamphetamines. Prior to this infant's birth, a Child Protection Team suggested a hospital hold on the new infant and removal of the older siblings. The agency decided against removal when the mother and infant tested negative for drugs at birth. A safety plan was arranged which stipulated that the family live with a designated relative and the mother was not to remove the children without prior approval. Reports indicate that the mother left the relative's home with the children approximately a month later and there was no CPS visit prior to the mother's departure. The relative did not report the mother's departure to the department for several days and the relative reported the mother had lied saying the caseworker had given approval. **Open CPS case. Child Abuse/Neglect Concerns.**

### The following is a case history of a 1-year-old who died: [See also complete fatality report on Justice and Raiden for another example.]

A 1-year-old child drowned in a bathtub when left unsupervised by the mother. A CPS investigation was open, but in inactive status, at the time of the child's death. The referral was made alleging prenatal drug abuse by the mother. The child was born drug addicted and had been voluntarily placed with a relative

while the mother received treatment and parenting classes. Family Preservation Services (FPS) were provided and reportedly completed. However, FPS reports indicated that the mother had not been complying with drug treatment and documented an earlier incident where she had left another child unattended in the bathtub; supervision while bathing was addressed with the mother. FPS closed the family's case two days prior to this child's death. The CPS case was slated for closure based on FPS reports of service completion. **Open CPS case. Clear Neglect.**

### The following are case histories of 2-year-olds who died:

A 2-year-old child was found under a pillow in bed with two siblings while visiting the non-custodial parent. The parent reported finding the child unresponsive. The parent's explanation was not considered plausible by the medical expert and the death was ruled a homicide by abuse. There was no open CPS case at the time of the child's death but there had been nine prior referrals on the parents alleging physical neglect and substance abuse. The most recent referral was accepted as "low risk" six months prior to the child's death. It was alleged the custodial parent was providing poor supervision of two young children and had allowed them to live in "unsuitable conditions". The custodial parent was referred to Alternative Response System (ARS) but did not engage in services. **Closed CPS case. Clear Physical Abuse.**

A 2-year-old child died from an impact injury to the head resulting from physical abuse by the father. The child was found with multiple bruising. Reports indicate the child was beaten to death. Initially, the parents claimed the child had been in the care of a babysitter. The child's father was an alleged drug dealer with a documented history of perpetrating domestic violence. He had been previously restrained from the biological mother's other children. A dependency was previously filed on one of the child's siblings due to medical neglect but it was dismissed because the parents complied with recommended services. However, in contradictory CAMIS service records there is documentation that both parents were hostile and not complying with services. The family case was closed at the time of this child's death. The child's father and step mother were charged with homicide by abuse. **Closed CPS case. Clear Physical Abuse.**

## Ages 3-12:

There were 11 fatalities (13%) of 4- to 12-year-old children and no deaths of 3-year-olds. OFCO identified clear physical abuse as a cause of death in 2 of these cases; clear neglect in 2 cases; and 1 in which there were child abuse or neglect concerns. No abuse or neglect concerns were indicated in 6 of these fatalities. No trends emerged from reviewing the histories of this age group.

A 7-year-old was killed in an auto accident in which the child's father was driving while intoxicated. The father was arrested and investigated for vehicular homicide. This incident occurred one month after the child had been placed with the father by DCFS, after the mother had chronically neglected and abandoned this child and older siblings. The father had previously abandoned the family, had a history of domestic violence, and reported drug abuse and alleged child abuse and neglect. These concerns in the father's history were not adequately addressed before the child was placed with him. There was an open CPS investigation at the time of this death. The most recent referral occurred two months prior to the death, alleging this child and three siblings were living alone without adequate facilities. **Open CPS case. Clear Neglect.**

A 4-year-old died in an auto accident while the parent was driving under the influence of multiple substances.

A 5-year-old was shot to death by a caregiver who had mental health issues.

A 5-year-old with extensive medical problems requiring 24-hour care died of natural causes while living in a licensed facility.

A 6-year-old with developmental delays drowned as a result of neglect by a parent.

An 8-year-old died as a result of cancer but the family had a chronic history of abuse and neglect which may have contributed to the child's suffering.

A 9-year-old died from fatal injuries incurred by a car accident but there were no further details available about the circumstances.

An 11-year-old with severe physical and developmental problems since birth died of natural causes, with no indications of child abuse or neglect contributing to the death.

A 12-year-old with a seizure disorder drowned in the bathtub at home.

A 12-year-old was a passenger in a car and died in an accident when thrown out of the vehicle.

A 12-year-old died from complications following surgery.

## Ages 13-17:

Twenty-three (26%) of the victims of fatalities were teenagers: 11 males and 12 females. Nine had open cases at the time of their deaths, 6 with CPS, 1 with CWS and 2 with FRS. One youth's death was related to clear physical abuse, another to clear neglect, and in 10 of these deaths, OFCO had definite concerns that child abuse or neglect contributed to the fatalities. In 11 of the 23 cases, the Ombudsman could not find any child abuse or neglect concerns related to the deaths.

Six teens (four 17-year-olds, one 16-year-old and one 15-year-old) died as a result of auto accidents in which there was no indication that child abuse or neglect or substance abuse was involved.

One 17-year-old died in a motorcycle accident while trying to elude police, with evidence of methamphetamines and marijuana involved.

Two 15-year-olds and one 13-year-old died as a result of chronic diseases. In one case the death was most likely hastened by severe and chronic parental neglect, and in another there was a question as to whether medical neglect contributed to the fatality.

A 17-year-old was stabbed to death by an unknown person.

Nearly half (10) of the teen fatalities occurred as a result of suicide (or possible suicide). There were 5 suicides by hanging: a 13-year-old, a 14-year-old, two 15-year-olds and a 16-year-old. There were 3 suicides by shooting: a 15-year-old and two 16-year-olds. There were 3 deaths by drug overdose: 2 were classified as suicides and the other 1 as possible suicide vs. accidental drug overdose.

A 14-year-old committed suicide by hanging in parent's home. Department reports note that the youth had been abusing substances and was exhibiting behavioral problems. The youth's family had two prior CPS referrals, the first alleging physical abuse of the youth by the father (unfounded). The most recent referral (three months before the suicide) was generated as a result of the youth's mother requesting services for her child, one day after the mother reportedly pressed charges against the youth for assault. The youth had run away and was later temporarily detained. Records indicate that the mother was seeking a longer detention period for the youth. There was no documentation in CA service records, including CAMIS, as to whether any services were or were not offered to the family following the mother's request. The case was closed at the time of the youth's death. **Closed CPS Case. Child Abuse/Neglect Concerns.**

A 15-year-old committed suicide by self-inflicted gunshot. The youth used the parent's gun, which was kept unlocked in the home. Reports indicated the youth was upset about losing driving privileges due to poor performance in school. The family had four prior CPS referrals regarding physical abuse of an older sibling. The most recent referral alleged the father beat the youth with a belt, and the family was referred to Alternative Response Systems (ARS). ARS made contact with the family and the father did not admit to the abuse but characterized the beating as physical discipline. The father declined parenting resources offered to him. ARS discussed after school and summer activity programs with the youth and closed the case five months before the suicide occurred. **Closed Case. Child Abuse/Neglect Concerns.**

A 16-year-old dependent youth was shot to death by the foster mother's biological son, a convicted felon. This son was put in charge of the foster youth while the foster mother was out of town. Department reports indicated that the shooting may have been an accident because there had been no apparent problems between the youth and the foster mother's son. The foster mother had been previously instructed to inform the department whenever she would be leaving town, in order for arrangements to be made for an authorized caregiver, but she failed to do so on this occasion. **Open CPS Case. Clear Neglect.**

A 15-year-old youth committed suicide by overdosing on drugs. The youth had made previous suicide attempts and had been hospitalized for related mental health issues. Reports indicated that one prior suicide attempt had been prompted by the child's disclosure of sexual abuse by a sibling, with the mother being very protective of the abusive sibling and not supportive of the abused child. The youth disclosed that the sibling had been abusive for five or six years. There had been two prior referrals to CPS on the family. The latest referral was four months prior to the suicide. The referent reported the youth's suicide attempt and expressed concerns about the mother's unsympathetic response to the child's disclosure of sibling abuse. The first referral was generated when the mother requested help in obtaining an

ARY petition for the older sibling (who was incarcerated soon thereafter). A worker's closing summary was written the day before the suicide, reporting that the youth (the victim) had finished counseling, was no longer in need of services, and would have access to a school counselor if needed. The summary also documented phone contact with the youth's mother who reported the abusive sibling would be released from custody soon and she had nowhere to place the sibling. CPS was to be notified if the abusive sibling was to be released back to the home of the mother and sibling. **Open CPS case. Child Abuse/Neglect Concerns.**

## Practice Recommendations

Based on the behavioral patterns of the family as well as the vulnerability of victims, the Ombudsman developed several practice recommendations that could significantly improve outcomes for children:

- Carefully monitor parents with a history of drug abuse who have young infants: require current drug/alcohol evaluation and administer regular, random urinalyses to determine drug usage;
- More closely monitor parents with infants where there is a current referral alleging abuse or neglect of siblings and a pre-existing CPS history of referrals on the siblings;
- Consistently drug test infants after death to detect presence of illegal substances if the parents have a drug history;
- Give greater weight to parents' histories of abuse in their families of origin, particularly in cases of teen parents, in assessing risk and developing a case plan;
- Screen in for investigation all referrals on infants in cases where the parent has had parental rights terminated on other children (this would likely require a change in the law to give CPS broader authority to investigate such referrals, which may in some cases not meet the current statutory definition of abuse or neglect in RCW 26.44);
- Carefully monitor parents' compliance with voluntary service agreements (VSAs) over the course of the VSA and pursue appropriate legal action to safeguard the children if the parents have not complied.[8] In situations where the parents refuse to sign a VSA, or refuse to comply with services, promptly assess the risk to the children and take swift and appropriate legal action;[9]
- Implement a weighted caseload distribution so that cases with a chronic risk of recurring abuse and/or neglect and high risk cases are counted differently, resulting in a more balanced workload among caseworkers; and
- Ensure that parents and teens requesting services to assist families in crisis, such as Family Reconciliation Services (FRS), are provided with sufficient assistance and direction from DCFS on pursuing legal remedies, such as a Child in Need of Services (CHINS)[10] or At-Risk-Youth

[8] The Ombudsman has found numerous instances, brought to our attention in complaints that we have reviewed and investigated, in which DSHS CA has either not monitored parental compliance with VSAs and/or has closed a CPS case due to non-compliance with services by the parents, even when the risk factors that prompted initial agency action appear to still exist.

[9] See changes to the chronic neglect law implemented by the enactment of ESSB 5922 in 2005.

[10] A CHINS petition is a mechanism by which the child, parent, or DSHS may petition the court to place the child outside of the home of the parent in situations where there is serious conflict between the parent and children and reasonable but unsuccessful efforts have been to resolve the situation in the home. RCW 13.32A et seq.

(ARY)[11] petition, to access appropriate services. The State should be as responsive and informative as possible to put requested services in place and to follow through with ensuring that the family received services. DCFS should reexamine and modify existing protocols to determine if they are sufficient to accomplish these goals.

## The National Landscape

Child fatalities touch every state across the country. These tragedies underscore the inadequacy of state child protection systems to consistently identify and mitigate factors that make the death of a child more likely to occur, such as a parent's proclivity to abuse or neglect their child. In 2003, the Office on Child Abuse and Neglect,[12] relying on data submitted by individual states to the National Child Abuse and Neglect Data System (NCANDS),[13] concluded that there were 1,500 children who died due to abuse or neglect, with parents being the primary perpetrators.[14] It found in 2002 that 17% of all child abuse and neglect related child deaths are inflicted on children known to the states' child welfare system.[15]

National figures on the number of children who die as a result of abuse or neglect, as reported in NCANDS,[16] are likely to be conservative for several reasons. Not every child death in each state is reviewed and reported on in the same way and some deaths receive a higher level of scrutiny than others.

## Causes of Underreporting and Inconsistent Fatality Review

In Washington, the cause of death of a child is not investigated or identified consistently across the state. These regional differences impact record keeping and reporting. Child deaths in certain counties receive a more thorough investigation by medical professionals simply based on the population of the county in which the child died. For example, counties with a population of 250,000 or more may appoint a medical examiner.[17] Less populated counties must use coroners, and in the smallest counties (40,000 people or

[11] ARY petitions may only be filed by the parent of the child and are used to obtain assistance and support from the juvenile court in maintaining the care, custody and control of the child and to assist in the resolution of family conflict, after alternatives to court intervention have been attempted. RCW 13.32A et seq.

[12] The Office of Child Abuse and Neglect originated as the National Center on Child Abuse and Neglect (NCCAN), which was created in 1974 by the federal Child Abuse Prevention and Treatment Act (CAPTA) to serve as an information clearinghouse; Public Law 93-273; 42 U.S.C. 5101.

[13] The National Child Abuse and Neglect Data System (NCANDS) is a federally sponsored data collection effort developed by the Children's Bureau of the U.S. Department of Health and Human Services' National Center on Child Abuse and Neglect (NCCAN) in partnership with the states to collect and present annual statistics on the volume and type of child maltreatment from state child protective services agencies. NCANDS was established in response to the enactment of the Federal Child Abuse Prevention and Treatment Act (CAPTA), Public Law 93-273; 42 U.S.C. § 5101. Available at http://nccanch.acf.hhs.gov/pubs/factsheets/canstats.pdf.

[14] Available at http://nccanch.acf.hhs.gov/pubs/factsheets/canstats.pdf. Consistent with OFCO's findings in Washington state, infant boys had the highest rate of fatalities on a national basis.

[15] This was based on data submitted by individual states to NCANDS. U.S. Department of Health and Human Services. "Child Abuse and Neglect Fatalities: Statistics and Interventions." April 2004. http://www.nccanch.acf.hss.gov/pubs.

[16] NCANDS codes, for purposes of data collection and analysis, a child death as the result of abuse or neglect when either: "(a) an injury resulting from the abuse or neglect was the cause of death; or (b) abuse and/or neglect were contributing factors to the cause of death." See http://www.ndacan.cornell.edu/NDACAN/Datasets/UserGuidePDFs/114user.pdf.

[17] RCW 36.24.190 provides that "[t]o be appointed as a **medical examiner** pursuant to this section, a person must either be: (1) Certified as a forensic pathologist by the American board of pathology; or (2) a qualified physician eligible to take the American board of pathology exam in forensic pathology within one year of being appointed.

less), the local prosecuting attorney serves as the coroner.[18] These individuals often do not have the time, medical training or expertise of a medical examiner/forensic pathologist to thoroughly investigate the cause of death and to make an accurate diagnosis of the cause of death in more nuanced situations, such as Sudden Infant Death Syndrome (SIDS).[19]

These county differences may explain, in part, the lack of standardization in how child deaths are described by medical examiners and coroners.[20] In several of the 2004 cases reviewed by OFCO, the Ombudsman found abuse or neglect clearly contributed to the death of the child, yet the coroner ruled the death resulted from SIDS or as an "unidentified infant death."[21] State law does not currently define sudden infant death syndrome. The range of description used to explain the cause of death may result in misdiagnosis and failure to appropriately designate a death as the result of abuse or neglect. A standard definition of SIDS may result in more accurate diagnoses of child deaths and better record keeping on the incidence of child abuse and neglect as it relates to these deaths.

Washington law establishes protocols for coroners or medical examiners conducting autopsies of children under the age of three who have a sudden, unexplained death (referred to in this annual report as the SIDS law).[22] The law also provides for special training for law enforcement, emergency medical personnel, and other individuals responding to emergencies and what may become a death scene. Other states have specialized training and protocols as well.[23] Although the law appears to go far in helping to prevent the inappropriate designation of SIDS, there is currently no monitoring to determine the degree of county

[18] RCW 36.16.030.

[19] See Teichroeb, Ruth, "Uniform state system needed for investigating deaths, critics say." Seattle Post Intelligencer (October 31, 2002); According to Deborah Robinson, infant death specialist of the SIDS Foundation of Washington, Washington state is one of the test sites that was selected by the National Center on Disease Control for training to be developed for the certification of child death investigators. This signifies a movement toward increased standardization of procedures used to investigate the deaths of young children.

[20] See chart herein listing different terminology used by medical examiners or coroners to describe sudden, unexplained deaths in 2004 fatalities reviewed by OFCO.

[21] e.g. 5-month-old infant was found dead in his crib. The coroner determined the cause of death to be SIDS. An acute sub-arachnid hemorrhage was found on the infant's brain during autopsy. Two months prior to the death, the infant's mother had pled guilty to a misdemeanor charge of child abuse for inflicting a skull fracture on the infant while the mother was intoxicated.

[22] RCW 43.103.100 directs the Washington state forensic investigations council to research and develop appropriate training on "sudden, unexplained child death, including but not limited to sudden infant death syndrome." The law lists the training components, which include medical information on SIDS for first responders; information on community resources and support groups available to assist families who have lost a child to SIDS; and the value of timely communication between the county coroner or medical examiner and the public health department to achieve a better understanding of these deaths. The law requires the council to work with volunteer groups with expertise in the area of sudden, unexplained child death, including but not limited to the SIDS foundation of Washington and the Washington association of county officials. The law mandates that each county use a protocol developed by the council for death scene investigations of sudden unexplained deaths of children under the age of three and requires the council to develop a protocol for autopsies of such children. The council is authorized to study and recommend cost-efficient improvements to the death investigation system in Washington and report its findings to the Legislature. RCW 43.103.030. Twelve members serve on the council, which includes at least one county coroner, medical examiner, prosecuting attorney, pathologist, members of law enforcement, and legislators. RCW 43.103.040. In amendments to the law in 1991, the Legislature recognized that "sudden and unexplained child deaths are a leading cause of death for children under age three. The public interest is served by research and study of the potential causes and indications of such unexplained child deaths and the prevention of inappropriate designation of . . . SIDS as a cause of death."

[23] The National Conference of State Legislatures provides a summary of state laws on sudden infant death syndrome. Available at http://www.ncsl.org/programs/health/sidsleg.htm.

compliance with the SIDS law, specifically, whether and to what extent deaths are being investigated where the cause and manner of death are unknown.[24]

Moreover, because Washington lacks a statewide system for organizing independent child fatality reviews, not all child deaths in the state receive review.[25] Under the current system, DSHS CA is the only agency currently funded on an ongoing basis to conduct reviews, but these are limited in scope. Only those children who have an open DSHS case at the time of death, were receiving services in the year preceding death, or died while in a state licensed facility are currently required to be reviewed by the agency.[26] Consequently, the death of a child who has not had DSHS CA involvement will not be reviewed; nor will those of children who may have significant prior CPS histories for abuse and neglect, but escape the agency's attention because their case is closed or there have been no recent referrals.[27]

Furthermore, there is inconsistency from county to county as to information that is shared with community professionals investigating a death. Groups of professionals reviewing fatalities should have access to the same types of information, rather than being dependent on local entities to interpret what type of information can be released for review.[28]

[24] Deborah Robinson, infant death specialist of the SIDS Foundation of Washington, reported to the Ombudsman that there are several cases she is aware of in which the death was given an undetermined cause and manner and yet the death scene was not investigated by law enforcement or the medical examiner. This group is in favor of a state audit to determine compliance with the SIDS law. The SIDS Foundation of Washington is one of the groups that RCW 43.103.100 expressly states the state forensics investigations council should work with because of its expertise in sudden and unexplained deaths of young children.

[25] All states, "except Idaho and Washington have child death review programs in place at the state and/or local levels." National Conference of State Legislatures. Available at www.ncsl.org/programs/cyf/childfatal.htm.

[26] "(1) The department of social and health shall conduct a child fatality review in the event of an unexpected death of a minor in the state who is in the care of or receiving services described in chapter 74.13 RCW from the department or who has been in the care of or received services described in chapter 74.13 RCW from the department within one year preceding the minor's death. (2) Upon conclusion of a child fatality review required pursuant to subsection (1) of this section, the department shall issue a report on the results of the review to the appropriate committees of the Legislature and shall make copies of the report available to the public upon request. (3) The department shall develop and implement procedures to carry out the requirements of subsections (1) and (2) of this section." RCW 74.13.640; HB 2984 enacted in 1994.

[27] There are several factors that can influence whether a CPS referral history accurately reflects the living situation in the home. For example, despite Washington's mandatory reporting law, the Ombudsman has found instances in which mandated reporters have not made referrals of suspected abuse or neglect to CPS. The agency also screens out referrals for abuse and neglect if it believes they do not meet sufficiency criteria.

[28] See Washington State Child Death Review Program Progress Report 1998-2000 (May 2001). Available at http://www.doh.wa.gov/Publicat/cdr_program_progress_report.PDF.

### Terminology for Sudden, Unexplained Deaths in Young Children

Here are the different terms, used by medical examiners & coroners, referred to in DSHS CA case records to describe unexplained infant deaths in 2004; these are verbatim from specific cases:

- SIDS
- Undetermined
- Unidentified infant death
- SIDS of a drug affected child at birth
- Asphyxiation
- Mechanical asphyxiation
- Natural and caused by SIDS
- SIDS/natural death
- Layover suffocation
- Death during infancy, no identifiable cause
- Undetermined/possible overlay
- Unexplained causes
- Accidental…and caused by positional asphyxiation
- Cardio-pulmonary arrest (SIDS)
- Positional asphyxia, co-sleeping
- Undetermined…voiced concern
- Asphyxia by entrapment
- May be SIDS
- Sleeping with parents, incomplete information

## History of Washington's Collection and Review of Child Fatality Data

### Initiation of Statewide Department of Health Child Death Review System

In 1993, the state Legislature authorized local health jurisdictions to conduct child death reviews of infants less than one year of age on a voluntary basis.[29] In 1994, the Legislature extended the scope of review to include the unexpected deaths of children from birth through age 17.[30]

This system of review was formalized and expanded in 1997 with the initiation of the Child Death Review (CDR) system. In a 1997 executive directive, Governor Gary Locke established the CDR system and provided funding to the Department of Health (DOH) to develop and implement a comprehensive statewide child death review system to collect and analyze death review data utilizing local community based teams. This gubernatorial action was preceded by legislative action to amend RCW 43.79.45 to provide that funds be appropriated during the 1997-99 biennium for the purpose of statewide DOH child mortality reviews.

DOH compiled aggregate data to identify factors and trends that contributed to the death of children based on reviews of all unexpected child deaths of children aged birth through 17 years of age across the state by the community based teams facilitated by local health jurisdictions, and annually published its

[29] The law provided that the review may include "a systematic review of medical, clinical, and hospital records; home interviews of parents and caretakers of children who have died; analysis of individual case information; and review of this information by a team of professionals in order to identify modifiable medical, socioeconomic, public health, behavioral, administrative, educational, and environmental factors associated with each death. RCW 70.05.170 (2) (1993).

[30] WA bill 5205 revised RCW 70.05.170 to extend comprehensive reviews to deaths of all children from birth to age 17.

child fatality review findings based on this data. In 2003, DOH lost its funding to conduct these reviews, although the law authorizing CDRs is still in effect.[31]

Some local health jurisdictions have continued to conduct these reviews despite the loss of funding, but most are no longer in operation. The importance of a comprehensive, multi-disciplinary review of child deaths was recently articulated in a DOH presentation[32] to the legislative Joint Task Force on Child Safety.[33] The operating principles of such reviews are that:

- The death of a child is a community responsibility.
- A death requires multidisciplinary participation from community professionals.
- A review of case information should be comprehensive and broad.
- A review should lead to understanding of risk factors.
- A review should focus on prevention of other deaths and the health and safety of other children.
- Reviews should lead to action.

## Role of DSHS CA in Child Death Review

DSHS CA is required by state law to review all unexpected deaths of children who have been in the care of or receiving child welfare services from the department within one year of the child's death. This includes children who died while in licensed care.[34] Department policy requires either a Child Fatality Review (CFR)[35] or Executive Child Fatality Review (ECFR)[36] of these child deaths, if child abuse or neglect is

[31] According to DOH, at the time funding was eliminated, the 29 local CDR teams were reviewing 92% of all unexpected child deaths across the state and submitting data and recommendations to DOH. Information available at http://www1.leg.wa.gov/documents/joint/cstf/DOH8-23-05.pdf. Presentation and Handout to Child Safety Task Force by Melissa Allen, Washington State Department of Health, Office of Maternal And Child Health. Washington State Department of Health CHILD DEATH REVIEW A Public Health Tool for Injury Prevention. October 2005.

[32] Information available at http://www1.leg.wa.gov/documents/joint/cstf/DOH8-23-05.pdf. Presentation and Handout to Child Safety Task Force by Melissa Allen, Washington State Department of Health, Office of Maternal And Child Health. *Washington State Department of Health CHILD DEATH REVIEW A Public Health Tool for Injury Prevention.* October 2005.

[33] In 2005, HB 2156, also known as "Sirita's law," established a legislative task force to review issues pertaining to the health, safety and welfare of children receiving services from child protective services and child welfare services. OFCO serves on this task force.

[34] RCW 74.13.640; HB 2984 enacted in 1994.

[35] The CFR is participated in "by local/regional staff and/or others appointed by regional administrator (RA). CA may invite community partners who had involvement with and/or provided services to the child's family. [The] CFR [is] prepared and coordinated by regional CPS program manager in Administrative Incident Reporting System (AIRS). Regional CPS program manager completes review within 90 days or RA may authorize extension." Administrative Incident Review Activity. 9-29-05. Provided to OFCO by the Office of Practice Consultation & Risk Management, CA on 2/3/06. Included as an Appendix in this annual report.

[36] According to DSHS, "[a]n Executive Child Fatality Review [ECFR] may be convened by the CA Assistant Secretary **in select** cases when a child dies of apparent abuse by their parent or caretaker and the case was actively receiving services at the time of the child's death. Participants are appointed by the Assistant Secretary and are individuals that had no involvement in the case, but whose professional expertise is pertinent to the dynamics identified in the case. CA convened two such fatality reviews during Calendar Year 2004." Emphasis added. http://www1.dshs.wa.gov/CA/pubs/2004perfrm.asp. See also the Administrative Incident Review Activity for an explanation of the ECFR. Included as an Appendix in this annual report.

alleged.[37] An ECFR provides an independent review by individuals not directly involved in providing services to the family. However, this more independent form of review is never required and is only implemented at the discretion of the Assistant Secretary of CA. Unexpected deaths in which child abuse or neglect is not alleged, do not receive an Executive Fatality Review.[38]

DSHS must issue a report on the results of its fatality review to the appropriate committees of the Legislature and make copies of the report available to the public upon request.[39] Although the current law governing DSHS' review of child fatalities was enacted in 2004, the obligation to review child fatalities in conjunction with other entities such as DOH dates back to at least 1995.[40] DSHS CA collaborated with DOH on the community based review teams until DOH's loss of funding in 2003.[41]

DSHS CA is making significant efforts to improve data collection on child fatalities as well as to fill the void created by DOH's loss of funding for regular use of CDRs. A step in this direction has been the agency's development and implementation of the Administrative Incident Reporting System (AIRS).[42] AIRS establishes uniform requirements for reporting serious and emergent incidents involving DSHS CA, including child fatalities, near fatalities, and other critical incidents known to the department.[43] It is a system which is evolving in complexity and is increasingly designed to analyze policy and practice concerns that come to light in the context of a fatality.[44]

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[37] Fatality Review Matrix (Matrix) provided to OFCO by the Office of Practice Consultation & Risk Management, CA on 2/3/06. This Matrix is included as an Appendix in this annual report.

[38] The practice as set forth in the Matrix and Administrative Incident Review documents referred to in the preceding footnotes varies from the DSHS CA policy and practice set forth in the DSHS Operations Manual and DSHS Practices and Procedures Guide available online at http://ca.dshs.wa.gov/intranet/main/CAMain.asp. DSHS CA needs to update its manuals and guides to incorporate current and accurate practices and procedures.

[39] Enacted during the legislative session, HB 2984 (RCW 74.13.640) requires the department to report annually on each child fatality review conducted by the department and provide a copy to the appropriate committees of the Legislature. Quarterly reports issued between December 2004 and September 2005 are available at http://www1.dshs.wa.gov/legrel/LR/CIYA.shtm.

[40] During the 1995 session, the Washington State Legislature passed Substitute House Bill SHB 1035 mandating that DOH and DSHS develop a consistent process of review of the deaths of children receiving child welfare services. CA Policy 5210 provides that: "Chapter 204, Laws of 1995 required the department, in conjunction with the Department of Health (DOH), local jurisdictions, coroners, medical examiners, and other appropriate entities, to develop a consistent process for review of unexpected deaths of minors in the state of Washington who are in the care of or receiving services described in chapter 74.13 RCW from Children's Administration (CA)."

[41] The Washington State Child Death Review Committee, co-chaired by DOH and the DSHS, directed the activity of the CDR process. It reviewed data gathered by local teams to identify trends and prevention strategies for the entire state. Volunteer experts with a range of expertise served on these teams. DSHS continues to participate on some of the child death review teams convened by local health jurisdictions. Children's Administration Performance Report, p. 20. http://www1.dshs.wa.gov/CA/pubs/2004perfrm.asp.

[42] AIRS Policy DSHS Children's Administration Policy, Administrative Incident Reporting, effective January 1, 2005. Available at http://ca.dshs.wa.gov/intranet/Manuals/AIRSPolicy.pdf.

[43] For a more detailed explanation of what incidents are reported in AIRS, see http://ca.dshs.wa.gov/intranet/Manuals/AIRSCheatSheet.pdf.

[44] "AIRS also maintains specific information about the fatality as well as provides a format and recording document for the fatality review. AIRS also collects aggregate data of child fatalities." Children's Administration Performance Report 2004. Available at http://www1.dshs.wa.gov/CA/pubs/2004perfrm.asp; see also the AIRS Companion Guide for specific information on the type of data entered. Available at http://ca.dshs.wa.gov/intranet/Manuals/AIRSGuide.pdf.

DSHS CA has also reported to the legislative committees on a quarterly basis on its review of some child fatalities.[45] Until March 2006, the department had not prepared an annual report with comprehensive aggregate data on child fatalities, as required by law.[46]

## Identified Concerns

Based on OFCO's review of 2004 child fatalities and routine review of other fatalities, the Ombudsman has identified several areas of concern:

- **Lack of a coordinated statewide child fatality review process.**
- **Sole discretion of DSHS CA Assistant Secretary to decide whether to conduct an Executive Child Fatality Review. Need for Ombudsman recommendation to trigger an Executive Child Fatality Review.**
- **Lack of clarity about how cases, once they meet threshold criteria for a possible Executive Child Fatality Review, are then selected by DSHS CA Assistant Secretary for such a review.**
- **Lack of auditing implementation of child fatality review recommendations.** Recommendations that are developed from DSHS CA child fatality reviews have not been made public consistently and consequently there is no procedure to assess their value or to monitor their implementation.
- **Lack of parity in investigative resources among counties. This may affect the thoroughness and accuracy of investigations into child deaths and result in inappropriate designation of SIDS in situations that have not been adequately investigated.** Medical examiners, coroners, and other professionals charged with diagnosing sudden and unexpected death of infants and young children do not appear to have comparable training in each county. Inconsistent terminology is sometimes used to describe unexplained deaths from the same cause.
- **Insufficient research to show how methamphetamine use by a parent affects infants.** Since the effects are uncertain, medical officials' autopsy reports do not indicate how the drug may have contributed to the child's death.
- **Lack of documentation of the caseworker's caseload, at the time of the fatality or near fatality, in the DSHS CA Administrative Incident Reporting System (AIRS).**

## Systemic Recommendations:[47]

- **Reinstate a coordinated effort between DOH and DSHS to implement a statewide child fatality review process.[48]**

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[45] Quarterly reports issued between December 2004 and September 2005 are available at http://www1.dshs.wa.gov/legrel/LR/CIYA.shtm.

[46] RCW 74.13.640. On March 6, 2006, OFCO received a copy of DSHS CA's 2003 report.

[47] These are system wide recommendations to address deficiencies in the current fatality review process.

[48] See Missouri law, which is frequently cited by experts as a best practice model: RSMo 210.192 became effective August 28, 1991, and Missouri's Child Fatality Review Program (CFRP) was implemented on January 1, 1992. See http://www.dss.mo.gov/stat/back.htm.

- **Require an Executive Review of both child fatalities and near fatalities upon the recommendation of OFCO.**

- **Require DSHS to establish clear criteria, available to the public, on which cases will receive an Executive Child Fatality Review.**

- **Establish a professional multidisciplinary technical team that will assist DSHS in prioritizing and evaluating the usefulness of implementing recommendations from child fatalities.** Implement an auditing process that requires DSHS to annually report to the Legislature and the Ombudsman on the status of implementation of child fatality review recommendations.

- **Implement consistent methodology in the investigation of child deaths and enactment of a SIDS labeling law[49] so that consistent terminology is used.** Ensure that each child death is investigated by an experienced investigator with specialized training who uses clear and consistent protocol to investigate the death scene and that medical examiners in each county, or their equivalent, employ the same autopsy protocol on sudden unexplained deaths. Consider the viability of making available a medical examiner/forensic pathologist in each county, regardless of its population and/or requiring all unexpected child fatalities to be reviewed by a medical examiner/forensic pathologist. Conduct a review of child fatality notification practices between professional entities (i.e. hospitals, law enforcement, DSHS) to ensure that there is an open exchange of information allowing for timely notification of a child death.[50]

- **Audit counties to ensure that when the manner and cause of unexplained sudden deaths of young children are undetermined, the death is investigated by the county medical examiner or equivalent in that county, and that established death scene and autopsy protocols are followed.**

- **Require DSHS to document caseworker caseloads, at the time of the fatality or near fatality, in AIRS and incorporate in child death review reports for future analysis.**

- **Require DSHS CA to establish a plan and report to the Ombudsman on the implementation of recommendations the Ombudsman makes in its fatality reviews.** In the absence of implementation, require CA to provide OFCO with a reasonable basis for the decision not to implement recommendations and report this to OFCO.

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[49] Several states define "sudden infant death syndrome." While definitions may be similar, the age covered within the definition may vary. A uniform definition may assist with consistent data gathering. For example, Tennessee defines SIDS to mean the death of an infant less than one year of age whose death is unexplained after "thorough case investigation, including performance of a complete autopsy, examination of death scene and review of clinical history." Tenn. Code Ann. § 68-1-1101. Available at http://www.ncsl.org/programs/health/sidsleg.htm.

[50] RCW 74.13.515 provides the Secretary of DSHS with the authority to "make the fullest possible disclosure [of personally identifying information of the child who died] consistent with chapter 42.17 RCW and applicable Federal law in cases of all fatalities of children who were in the care of, or receiving services from, the department at the time of their death or within the twelve month previous to their death." See also 74.13.500. It does not appear that DOH has comparable authority under the law.

## Conclusion

OFCO was established in 1996 largely in response to the death of 3-year-old Lauria Grace. The Legislature and the Governor recognized the need for increased oversight of DSHS by a neutral, impartial entity to improve the system. This imperative drives our priorities. For that reason, the Ombudsman's review of fatalities will continue to be a significant part of our day-to-day work.

Our ability to look at a complex set of factors in an impartial manner and to identify the shortcomings in a system is what we do. This is especially critical in the absence of a statewide coordinated system of child death review. In the year ahead, the Ombudsman will continue to monitor DSHS' development of the AIRS system to ensure that critical data is not only collected and recorded, but analyzed in a meaningful way that translates into real, systemic reform.

Child fatalities represent the greatest failure of the child protection system, but also the most meaningful opportunity for reform. For the review of a child's death by DSHS CA to result in improved practice, two conditions must be met. First, the reviews must be based on complete, accurate, and impartial data. Thorough investigations at the front end by law enforcement, medical professionals, and CPS investigative workers and the sharing of investigative findings with the fatality review team is essential. Second, a multidisciplinary group of professionals must evaluate recommendations that arise from these reviews to prioritize them, and determine how they should be implemented. Without a concrete system for considering and implementing such changes, the reviews are an exercise in futility.

The most promising strategy to improve outcomes for children is to involve professionals who use a coordinated, collaborative, and multidisciplinary approach in the investigation of fatalities and critical incidents. This will result in more accurate diagnoses of the manner and cause of child deaths, better record keeping on the incidence of child abuse and neglect as it relates to these deaths, and consistent child death reviews. In turn, these steps can put a halt to avoidable tragedies such as the deaths of Justice, Raiden, and Sirita.

# Foster Parent Retaliation

## Background

In 2001, the state Legislature enacted a statute that provides foster parents with the **right to be free of coercion, discrimination, and reprisal in serving foster children**, including the right to voice grievances about services provided or not provided to a foster child. The law, however, did not specify the acts against which a foster parent was protected. Moreover, the statute did not provide foster parents with a remedy against the Department of Social and Health Services for retaliation.

The Legislature addressed the issue of retaliation more expansively in 2004, when it enacted RCW 74.13.333. This law establishes the clear right of foster parents to file a complaint with the Ombudsman if they believe they have been retaliated against. The new law sets forth specific protected actions. Specifically, RCW 74.13.333 provides that:

> A foster parent who believes that a department employee has retaliated against the foster parent or in any other manner discriminated against the foster parent because:
>
> (1) The foster parent made a complaint with the office of the family and children's ombudsman, the attorney general, law enforcement agencies, or the department, provided information, or otherwise cooperated with the investigation of such a complaint;
>
> (2) The foster parent has caused to be instituted any proceedings under or related to Title 13 RCW;
>
> (3) The foster parent has testified or is about to testify in any proceedings under or related to Title 13 RCW;
>
> (4) The foster parent has advocated for services on behalf of the foster child;
>
> (5) The foster parent has sought to adopt a foster child in the foster parent's care; or
>
> (6) The foster parent has discussed or consulted with anyone concerning the foster parent's rights under this chapter or chapter 74.15 or 13.34 RCW,
>
> may file a complaint with the office of the family and children's ombudsman. The office of the family and children's ombudsman shall include its recommendations regarding complaints filed under this section in its annual report pursuant to RCW 43.06A.030. The office of the family and children's ombudsman shall identify trends which may indicate a need to improve relations between the department and foster parents.

## Ombudsman Action

**Development of Analytical Framework:** The foster parent retaliation law does not explicitly define retaliation. Thus, the Ombudsman developed an analytical framework to analyze whether retaliation has occurred by looking for guidance in other contexts, such as the employment law arena. In analyzing an allegation of retaliation, the Ombudsman considers:

1) Was the foster parent engaged in protected activity;
2) Was the foster parent subjected to an adverse action by the Department; and
3) Is there is a causal connection between the adverse action and the protected activity?

The Ombudsman interprets "protected activity" to mean those activities set forth in RCW 74.13.333. The harm that a complainant is alleging is the "adverse action." If the facts of the complaint establish that the adverse action occurred **prior to** the Department learning that the foster parent engaged in protected activity, then the action of the Department would not meet the Ombudsman's threshold criteria to find retaliation. If, on the other hand, the adverse action occurred **after** the foster parent engaged in protected activity, then further investigation is warranted.

This analytical framework was presented to foster parents attending the 2004 Foster Parent Association of Washington State conference. The Ombudsman elicited input and feedback on the framework and demonstrated how it would be applied to various fact patterns.

**Ensuring Compliance by the Department with the Retaliation Law:** The Department proposed revisions to the Children's Administration Practice and Procedure Manual to bring the agency's procedures into compliance with the foster parent retaliation law.[1] The Ombudsman suggested revisions of the proposed changes to ensure that the section on Complaint Resolution specifically addressed 1) the right of foster parents to contact OFCO if they have a complaint and 2) the required response of Children's Administration if the agency is contacted by OFCO regarding retaliation. These revisions are pending.

**Foster Parent Rights in Other States:** The Ombudsman also researched foster parent rights established in other states. Washington is one of only a handful of states that provide protection against retaliation or reprisal.[2] We are frequently asked if the retaliation law specifically provides for a legal cause of action against DSHS for retaliation. At this time, it does not, which is consistent with other states' laws.

## Nature of Retaliation Complaints

Retaliation complaints, by their nature, are complex and nuanced. More than with other types of complaints, the events leading to this type of complaint are prone to dramatically conflicting interpretations by the parties involved. The adverse action alleged may be apparent, such as the agency's decision to remove a particular foster child without sufficient cause or to clearly restrict the parameters of the foster license so that the capacity of children is reduced or the age of children served is narrowed. Other times, the adverse action is more subtle such as when the agency stops placing children with a foster parent, even though the foster parent has the capacity and inclination to foster more children.

[1] RCW 74.13.334 requires the department to develop procedures for responding to recommendations of OFCO as a result of complaints filed by foster parents under the retaliation law, RCW 74.13.333.

[2] Alabama, Illinois, Missouri, Oklahoma, and Tennessee are other states that have laws that address retaliation.

The Ombudsman works carefully to fairly determine if there is a retaliatory motive behind the actions of the Department. There may be situations where an allegation does not meet the criteria to qualify as retaliation, but the agency action still constitutes a violation of law, policy, or procedure. Under these circumstances, if the situation involves a current action, the Ombudsman will intervene to seek corrective action.

## Examples of Differing Perspectives

The following scenarios, which are derived from composites created from actual factual circumstances investigated by the Ombudsman, provide examples of the challenge in fairly assessing a retaliation claim:

> **Foster parent: "**I am receiving less money each month for my foster youth ever since I strongly advocated for services for him. I am being punished for being the squeaky wheel."
> **DCFS:** "The youth has made significant progress while in placement, is not demonstrating the same behaviors, and does not require as much supervision. Therefore, the foster parent should be compensated at a lesser rate."
>
> **Foster parent:** "They removed the foster child because I complained about the case plan and advocated for the child."
> **DCFS:** "We removed the foster child because the foster parent was not cooperative with the case plan and was a barrier to reunifying the child with the parents."
>
> **Foster parent:** "The agency will not place any more children in my home because I have been critical of the caseworker who is not competent."
> **DCFS:** "There have been no limitations imposed on this foster parent's license. She does better with small children and we have not had any children that meet this profile who need placement currently."
>
> **Foster parent:** "They retaliated against me by making a licensing complaint that was not valid."
> **DCFS:** "Our case workers are mandated reporters and have an obligation to report complaints of all licensing violations. It is up to the DLR/CPS worker to then determine if the complaint is valid. We cannot determine the validity of a complaint until an investigation has been done."

**Community Outreach to Foster Parents:** The Ombudsman has met with several foster parent groups over the past two years. Some of these groups are formally organized entities such as Foster Parents of Washington. Others we have met, only by agreeing to maintain their anonymity, as they fear reprisal by DCFS employees. The following is a summary of concerns that have been expressed to the Ombudsman by foster parents in the course of our meetings:

1) Children are routinely placed in homes without the agency implementing a safety plan for children who present special challenges, e.g. a history of being sexually abused. This undermines the placement because adequate monitoring and other safeguards are not put in place.
2) Communication by the DCFS is inaccurate, and at worst, intentionally misleading. Different stakeholders are given conflicting information. This promotes misunderstanding and suspicion.
3) The Department separates foster parents from guardians ad litem, parents, and caseworkers, which promotes suspicion and misunderstanding.

4) There is a lack of accountability for caseworkers. There are no consequences for chronic dereliction of duties or intimidation by caseworkers.

5) There are inaccuracies in written documentation and no opportunity for foster parents to correct the record at or near the time the record is made. There are inaccuracies in the service episode records, home studies, Individual Service Plans.

6) Foster parents are not provided a copy of completed home studies of themselves when they are pursuing adoption of a child.

7) DLR/CPS investigations of foster parents are not completed on a timely basis, and, in some instances, never completed.

8) Removal of children is unnecessarily traumatic and inhumane: minimal notice; lack of informed communication about basis for removal; lack of basic information to child about what is occurring; failure to return phone calls of foster parents about what to expect even when a child has been in their home for 1 ½ to 2 years.

9) Foster parents are not informed on a timely basis that they are under investigation by DLR/CPS. Sometimes notice is not given at all or is significantly delayed (e.g. a year after the alleged incident occurred) and then notice is communicated casually in the context of the caseworker giving other information to the foster parent.

10) In cases where a foster parent has been investigated and the complaint is invalid or the referral is unfounded, the DCFS continues to treat the foster parent as though they are guilty of the allegations. Consequences have included failure of the agency to return children removed and failure to place additional children in the home.

11) Foster parents are required to submit to expensive and intrusive psychological evaluations. Foster parents state they are "scared off" by not being able to afford to do the evaluation or, even after submitting and paying, if the recommendations are positive, DCFS disregards them.

12) Foster parents do not have legal representation to inform them of their rights or provide a means to challenge DCFS assertions. DCFS automatically "wins" through intimidation and by having the advantage of legal representation.

13) Many regions do not presently have a foster parent liaison.

14) Foster parents do not receive placement papers or documentation for children when they are placed. Consequently, they are uninformed or misinformed about behavioral problems, developmental challenges, placement history and other things that they could prepare for which could help stabilize the placement.

15) Foster parents are forced to comply with visitations for children in their care that are detrimental to the well being of the foster child.

16) DCFS does not provide foster parents with a write-up of findings/observations from a 90-day health and safety check.

# Issues and Recommendations

In addition to conducting investigations, the Ombudsman is required by state law to develop recommendations for improving the child protection and welfare system.[1] 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 areas:**

- ✓ Reducing caseloads
- ✓ Increasing opportunities for caregivers to be heard
- ✓ Providing relatives with ongoing contact

The Ombudsman identified areas for reform based on recurring issues that are brought to OFCO in complaints from a broad spectrum of individuals: parents, children, relatives, foster parents, and community professionals including DCFS employees, Guardians ad Litem, service providers, and attorneys. These are significant issues that either compromise the safety or welfare of children, or lead to inconsistent or inequitable outcomes for children and families. Adopting these recommendations will promote equity among stakeholders in dependency cases, and make it more likely that children, and the individuals who care for them, are given equal and consistent treatment around the state.

## Recommendation 1: Reduce Caseloads of Caseworkers and Supervisors

- **Direct DSHS to develop and submit a proposal to the state Legislature that would create a method for reducing caseloads and keeping them at a level that is consistent with standards established by the Child Welfare League of America (CWLA)[2] or the Council on Accreditation of Services for Families and Children (COA).[3]**

### Background

State law sets forth a goal for DSHS CA to complete accreditation of its children's services by an independent entity in order to meet nationally recognized standards of practice in child welfare by July

[1] RCW 43.06A.030. Additionally, in 2005, SHB 2156 created the Joint Task Force on Child Safety for children receiving services from child protective services and child welfare services. OFCO is a designated member of this task force and is charged with making recommendations to the Legislature and the Governor to improve the health, safety, and welfare of children. Chapter 430, 2005 Laws, effective 5/13/05.

[2] The Child Welfare League of America (CWLA) is the nation's oldest and largest membership-based child welfare organization. Its goals, in part, are to develop policies and practice standards as benchmarks for high-quality services to promote the well-being of children, youth, and their families. http://www.cwla.org/whowhat/mission.htm.

[3] The Council on Accreditation of Services for Families and Children (COA) is "an international, independent not-for-profit organization. COA accredits approximately 1400 programs that provide child welfare services, behavioral healthcare services, and financial management/debt counseling services in the United States and Canada." It develops standards of best practice and a program of provider accreditation. http://www.coanet.org.

2006.[4] As of June 2005, eighteen DCFS offices across the state, in addition to Children's Administration Headquarters, had earned national accreditation status from COA.[5] Accreditation, which includes voluntary peer review and a 4-year certification process,[6] means in part that the caseloads of workers in these qualifying offices met the standards set out by COA.

In reviewing complaints to the office, the Ombudsman has identified a pattern of CPS and CWS caseworkers and DCFS supervisors carrying caseloads that exceed standards established by the COA or the CWLA. COA recommends a ratio of cases to worker based on the type of service a worker is providing. A CPS worker's caseload, for instance, is not to exceed between 15 to 30 cases, depending on the complexity of the case.[7] CWLA recommends a caseload of 12 to 15 cases per caseworker and a maximum of 12 for an investigative worker.[8] Caseload ratios vary for different categories of workers. According to CWLA, its caseload standards are "based on the field's consensus of what constitutes best practice. They're also supported by the findings of caseload and workload studies and by projects that show particular success in reaching agency goals."[9]

Although CA successfully reduced caseloads to a level consistent with best practice at the time of accreditation, once accreditation was achieved, there has not been careful monitoring to ensure that caseloads remain at accreditation levels. This concern is based on the Ombudsman's periodic and random checks of caseloads across the state.

For example, in a random review of caseloads in December 2005, the Ombudsman reviewed an accredited office with three units handling primarily CPS cases. In one unit, 80 % of the workers had caseloads exceeding 25; another had 57 % exceeding 25 cases; and the third had 25% of the workers exceeding 25 cases.[10] Thus, accreditation alone is not a guarantee that caseloads will be held to a manageable level. A mechanism must be put in place to ensure that even after specific offices have been accredited, caseloads will be maintained at this accreditation standard.

## Rationale

Our investigations reveal that high caseloads result in incomplete abuse and neglect investigations, inconsistent monitoring of the safety and welfare of children, poor follow through on offering services

[4] RCW 74.13.017.

[5] In 2001, the state Legislature enacted SSB 1249—Chapter 265, which directed the Children's Administration to undertake the process of accreditation, with the goal of completion by July 2006. RCW 74.13.013; 74.13.017. The following offices have met accreditation standards: CA Headquarters, Wenatchee, Walla Walla, Moses Lake, Omak, Vancouver, South Bend, Long Beach, Sunnyside, Ellensburg, Kent, Bremerton, Shelton, Centralia, Tumwater, Aberdeen, Long Beach, South Bend, Colfax and Clarkston. http:www1.dshs.wa.gov/mediareleases/2005/pr05141.shtml.

[6] See http://www.coanet.org/Files/GAOReport.pdf.

[7] For a more in depth discussion of COA standards, see http://www.coanet.org.

[8] See http://www.cwla.org/programs/ standards/caseloadstandards.htm.

[9] http://www.cwla.org/programs/standards/caseloadstandards.htm.

[10] The Ombudsman relies on CAMIS, the agency's own computerized information system, to extract this data. Caseload numbers can be affected by many factors: whether the case counts reflect every child, or simply the family (in general CWS counts cases by the number of children); whether the case is listed as inactive or shows that services are pending. Our calculation includes all cases listed for a worker. Even accounting for cases listed as "services inactive," caseloads of several workers exceeded COA standards.

to families, and delayed permanence for children. We have also found excessive caseloads to be a contributory factor in several of the high profile child fatalities over the past several years that we have either independently reviewed or have knowledge of from reviewing DSHS' reviews of these cases.[11] The conclusions of the Ombudsman are consistent with research done in other jurisdictions.[12]

In addition to compromising child safety, high caseloads and excessive workload[13] lead to caseworker burnout. In a 2003 report to the U.S. Congress, the United States General Accounting Office (GAO)[14] found that "high caseloads [along with] administrative burdens, limited supervision, and insufficient time to participate in training reduce the appeal of child welfare work, making it difficult for staff to stay in their positions."[15] This, in turn, leads to even more excessive caseloads as staff turnover continues.

Despite what appears to be broad recognition by child welfare professionals that high caseloads have a deleterious effect on the quality of caseworker practice, which compromises child safety, high caseloads still appear to be the norm. In its May 2001 report, the American Public Human Services Association (APHSA) reported that, based on a survey mailed to all state public child welfare agencies and a sample of county agencies, caseloads for individual child welfare workers ranged from 10 to 110 children, with workers handling an average of about 24 to 31 children each.[16]

Some states have responded to the problem of high caseloads with promising legislative solutions.[17] In 2000, the state of Delaware enacted a law that requires the Department of Services for Children, Youth and Families (Delaware's equivalent of Washington's DCFS) to project the number of child abuse and neglect cases and the number of child care facilities to be licensed and monitored in the upcoming fiscal

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[11] High caseloads or excessive workload were identified as factors in the following fatalities: Eli Creekmore (1986); Lauria Grace (1995); Zy'Nyia Nobles (2000); Champagne Loup (2003); Justice & Raiden Robinson (2004); and Sirita Sotelo (2005). Copies of OFCO's fatality review reports on Sirita Sotelo and Justice and Raiden Robinson may be accessed from our website at: http://www.governor.wa.gov/ofco/reports.htm. Further discussion of the Sotelo and Robinson fatalities is also within this annual report.

[12] A March 2003 report by the General Accounting Office states that "[a] 1998 study of New York's child welfare services found that high workload resulted in incomplete abuse and neglect investigations, an inability of workers to regularly monitor clients, and prolonged permanency decisions for children." (State of New York Comptroller, Division of Management Audit. [1998]. Caseworker Deployment in Selected Child Welfare Programs Report (96-S-52). U.S. General Accounting Office, (March 2003) *Child Welfare HHS Could Play a Greater Role in Helping Child Welfare Agencies Recruit and Retain Staff*. Available at http://www.gao.gov/cgi-bin/getrpt?GAO-03-357.

[13] Workload may include non-case related time spent performing tasks not directly related to services for the child and family, such as administrative documentation, training, and participation in task forces.

[14] The General Accounting Office is the arm of the federal government that conducts audits, investigations, and research studies.

[15] General Accounting Office, (March 2003) *Child Welfare HHS Could Play a Greater Role in Helping Child Welfare Agencies Recruit and Retain Staff*. Retrieved from http://www.gao.gov/cgi-bin/getrpt?GAO-03-357.

[16] Forty-three states (84%) completed the survey. American Public Human Services Association. *Report from the Child Welfare Workforce Survey: State and County Data and Findings,* May 2001. Retrieved from http://www.aphsa.org/Policy/Doc/cwwsurvey.pdf.

[17] In addition to Delaware, several other states have established caseload standards, or established work groups to study such a proposal, through legislation. Arizona—Protective Services Caseload Standards Advisory Committee; California—Assembly Bill 364 (2002) Work group to recommend minimum caseload standards; Delaware—State law requires CWLA caseload ratios +2. Funding tied to increases in caseloads greater than 10 %; Florida—Legislation prohibits caseloads from exceeding CWLA standards by more than 2 cases; Indiana—Statewide caseload standards established through legislation; Maryland—Maryland-specific caseload ratios based on CWLA consultation. Retrieved from http://www.cwla.org/conferences/2004nationalrecapday.ppt.

year. Based on these projections, the law requires the Delaware Legislature to fund, subject to a specific appropriation, adequate worker positions to ensure that their caseloads do not exceed, by more than two, those caseload levels recommended by CWLA. If caseloads exceed these standards by more than 10% during any fiscal year, the state budget office must authorize, "to the extent monies are available," casual seasonal positions as a temporary mechanism to keep caseloads within these standards.

Other states have addressed caseload and practice standards as a result of settlement agreements or court orders that have arisen from litigation.[18] In Washington state, the work of the Braam panel in overseeing a settlement agreement reached after six years of litigation over the state's foster care system will influence caseloads and caseworker practice.[19] The Braam Panel requires DSHS CA to develop a plan to reduce caseloads to COA standards and to submit the plan to the Panel for review by June 30, 2005. CA did not submit a "plan" to the Panel until November 7, 2005 stating it was delayed "due to the need to allocate new positions funded under the 2005-2007 biennium budget." CA states that:

> it will submit its decision package through the regular budget process related to the development of the 2007-09 biennium budget. The decision package will include the cost to phase in the required resources over the 2007-09 biennium period. The intent, subject to budget approval, would be to have the resources required to meet COA out of home caseload standards by June 2009-the end of the biennium period. [20]

The 2006 Supplemental Budget Request (to the 2005-07 budget) unveiled by Governor Gregoire in December 2005 proposes additional funding to address safety issues related to children under state supervision. The Governor recommends funding to support a safety package so that front-end investigations can be conducted more quickly and regular health and safety checks of dependent children are done every 30 days. A benefit of this safety plan will be to reduce caseloads.[21] According to Children's Administration officials, the safety plan is a two-year phased-in effort.

The Ombudsman recognizes that DSHS CA is making efforts to reduce caseloads. This effort is critical because by removing this variable from the equation, we will have a better understanding of other, perhaps subtle, issues that may be compromising a child's safety or a family's chance at reunification.

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[18] In Alabama, a 1998 ruling in a federal lawsuit required DHS to comply with standards established in a 1991 consent decree. In Connecticut, a 1999 court order regulates caseloads. In Colorado, there was a 1994 settlement agreement with the Colorado Lawyer's Committee. In Kansas, there was a 1992 settlement agreement. Day, Pamela. *Size Matters: Achieving Optimal Caseloads for Child Welfare Workers.* Available at www.cwla.org/conferences/2004nationalrecapsize.htm.

[19] Braam v. State, 150 Wn.2d 689, 81 P.3d 851 (2003); http://www.wsipp.wa.gov/braampanel/.

[20] The Braam panel directed CA to establish a workgroup to develop the plan and estimate costs and resources and then have CA Management review and approve the plan. *Proposed Plan for Achieving Council on Accreditation (COA) Caseload Standards.* Document sent from DSHS to Braam Panel on November 7, 2005. Moreover, CA indicates in a year end status update report submitted to the Panel to show the status of action steps in the Braam Settlement Agreement, that "[a] revised plan is being developed and will be submitted to the Panel in January 2006." *Update Report of Braam Settlement Items* (12.31.2005).

[21] DSHS Children's Administration 2006 Supplemental Budget. Available at http://budget.dshs.wa.gov/index.asp. See also McGann, Chris, "Gregoire blends spending, savings in new budget plan." Seattle Post-Intelligencer. December 21, 2005.

## Recommendation 2: Provide Caregivers with a Greater and More Consistent Opportunity to be Heard

- **Direct the Washington State Institute for Public Policy (WSIPP)[1] to study and propose improved procedures for providing caregivers of dependent children a greater and more consistent opportunity to be heard in court hearings related to dependency cases.**
- **Require DSHS to survey foster parents and relative caregivers as to how consistently they are notified of hearings, the manner of notification, whether notification was timely, and what it means to "be given an opportunity to be heard" (written input to the court, in person presentation), and what changes, if any, could improve the notification process (e.g. access to online form for providing written input).**
- **Require DSHS to modify and improve its procedures for providing caregivers of dependent children a greater and more consistent opportunity to be heard in dependency court hearings, taking into account the results of the survey and implementing the recommendations for improved procedures and best practices recommended by WSIPP.[2]**

### Background

Congress recognizes that "as the child's primary caregivers, foster parents and relatives caring for the child often have information about the child that is relevant to placement proceedings."[3] This recognition led to the enactment in 1997 of the Adoption and Safe Families Act (ASFA).[4] This law requires that, as a condition of receiving federal foster care funds, states must provide caregivers with the opportunity to be heard in juvenile court hearings regarding the children in their homes. Under ASFA, any foster parent, pre-adoptive parent, and any relative providing care for a child must be given "notice of, and an opportunity to be heard, in any review or hearing to be held with respect to the child" in their care.[5] Federal law, however, does not require that foster parents, preadoptive parents, or relatives providing care for the child be given

[1] WSSIP was established by the Legislature in 1983 "to carry out practical research, at legislative direction, on issues of importance to Washington State." http://www.wsipp.wa.gov.

[2] The Braam Panel has addressed the need to improve notice to foster parents and relative caregivers. The Braam settlement requires the department to both provide written notification to licensed foster parents and relative caregivers and to provide support to increase their participation in meetings, staffings, and hearings involving planning for children in their care. CA reports that "significant work" has been done on this action step: "The Administration of Courts (AOC) has sent a notice to all Juvenile Court Judiciary indicating the need to determine if foster parents are present at each court hearing and to provide [an] opportunity for foster parents' views to be heard. At the February 2006 Management meeting, a proposed policy will be presented requiring CA send caregivers a separate notice inviting them to participate in staffings and hearings. In addition to the policy, social workers will also receive a template for sending notice to the caregivers." *Update Report of Braam Settlement Items. Foster Parent Training and Information, Item #3* (12.31.05).

[3] H.R. Rep. No. 105-77. 1st Sess. (1997) p. 14.

[4] Adoption and Safe Families Act (ASFA), Pub.L.No. 105-89, (Nov.19, 1997), 111 Stat. 2115 (codified as amended in 42 U.S.C.); the federal regulations also make clear that the notice and opportunity to be heard applies to six-month review and permanency planning hearings. 45 C.F.R. § 1356.21(o) (2000).

[5] 42 U.S.C. § 675(5)(G). Care providers may be allowed to attend and be heard at a review or permanency planning hearing or be allowed to provide written input for the judge to consider.

standing as a party to the juvenile court action.[6] Prior to ASFA, foster parents and relative caregivers were routinely denied access to hearings about the foster child, as the proceedings were closed to maintain confidentiality.

But, federal law does not specify the manner in which notice and an opportunity to be heard is to be implemented. This is left to the discretion of each individual state. Thus, although a state must provide notice of court hearings to the individuals caring for the child, the manner in which notice is provided, and how an individual is heard by the court, varies.

The state of Washington, incorporated ASFA's notice provisions by mandating that "[t]he supervising agency shall provide a foster parent, preadoptive parent, or relative with notice of, and their right to an opportunity to be heard in, a review hearing pertaining to the child, but only if that person is currently providing care to that child at the time of the hearing. This section shall not be construed to grant party status to any person who has been provided an opportunity to be heard."[7] Children's Administration incorporates this legal notice requirement into state policy.[8] State policy also makes clear that the manner in which a care provider is permitted to give input to the court is determined by local jurisdictions.[9] This flexibility under the law results in regional differences and even differences from case to case within the same county. Certainly, there are some cases where the court has granted party status to relatives or foster parents, but this is on quite a limited basis.[10]

Several states have expanded the rights of foster parents and relative care providers beyond the federally recognized rights.[11] This expansion of rights reflects an increasing recognition on the part of legislators, policy makers, and other child welfare stakeholders that foster parents and relative care providers hold vital information about the child that can inform the court in a meaningful way and result in better case outcomes.

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[6] 42 U.S.C. § 675(5)(G); 45 C.F.R. part 1356.21(o) (2000) clarifies that the federal law does not grant a right to standing as a party to the case. A "party" to a proceeding is entitled, not only to be notified and to be heard, but to other rights such as the right to initiate a legal proceeding, introduce evidence, cross-examine witnesses, and examine court records. The Adoption and Safe Families Act: Foster Parent Notice and an Opportunity to be Heard, by Madelyn Freundlich, Policy Director, Children's Rights.

[7] RCW 13.34.138(1).

[8] DSHS policy requires licensed foster parents to be notified of court hearings through a copy of the ISSP. CA Practices and Procedures Guide § 43091. The ISSP provides the date and time of the hearing.

[9] CA Practices and Procedures Guide § 43021 provides that "[t]he court will make the final decision about whether and how the caregiver will provide input at the hearing."

[10]Intervention typically grants individuals party status. Intervention of right is provided for in civil cases only if the intervening party claims "an interest relating to the property or transaction which is the subject of the action". State v. Bianchi, 92 Wn.2d 91, 593 P.2d 1330 (1979); In re Dependency of J.H., 117 Wn.2d 460, P.2d 1380 (1991) (the meaning of "interest" is broadly and flexibly interpreted by the court on a case-by-case basis, taking into account the concerns of the prospective intervenor, the concerns of the original parties to the lawsuit, and the public's interest in the efficient resolution of controversies). Washington Superior Court Civil Rule 24 (a) (intervention of right) & (b) (permissive intervention).

[11] Note, however, that according to the National Conference of State Legislatures (2002), Washington is one of six states which have enacted laws that establish the rights of foster parents. This refers to state law prohibiting foster parent retaliation, RCW 74.13.333. See OFCO Annual Report section on foster parent retaliation for a greater discussion of those rights.

States have taken a variety of approaches to broaden the ability of foster parents and relative care providers to participate in the process.[12] Some expand the types of hearings for which foster parents are entitled to have notice and an opportunity to be heard.[13] Others confer the right of participation to previously appointed care providers, as well as current ones.[14] Still other states grant care providers the right to intervene as a party in the legal proceedings.[15] A few states even authorize foster parents to initiate a petition to terminate parental rights.[16]

### Failure to Inform Relative Caregiver of Court Hearing

A grandparent who was in the process of adopting two eight-year-old grandchildren called the Ombudsman's office because of the length of time it was taking the agency to finalize the children's adoption. During OFCO's investigation, the grandparent was not informed about a dependency review hearing. The grandparent was angry about the agency's failure to notify her about this hearing. She felt that her absence at the hearing and lack of input to the court could affect the outcome of the case. As a relative caregiver in the process of adopting the children, she believed it was important to demonstrate her commitment, care, and concern about the children to the Judge. By not being informed about the court hearing, she was deprived of this opportunity. The grandparent worried that the Judge might conclude she was not doing a good job of parenting the children, and that this would put the adoption at risk.

The adoption process can be precarious. There is no certainty to the outcome until the adoption is finalized. A misperception by the caseworker, court, GAL, or other decision maker could shift the permanent plan and the children could be moved. In this situation, the grandparent's fears were not unreasonable, as the adoption process had languished with a change in caseworkers and from complications with the adoption support paper work. Although those issues were eventually resolved and the children's adoption was finalized, the Ombudsman documented the failure by the agency to give appropriate notice to the caregivers of dependency hearings, as required by the law. Moreover, OFCO found the actions of the agency had an adverse impact on the relatives as they were subjected to unnecessary delay and anxiety.

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[12] See Freundlich, M. *The Adoption and Safe Families Act: Foster Parent Notice and An Opportunity to be Heard*. Children's Rights.

[13] Maine and Minnesota extend the right of foster parents, pre-adoptive parents, and relative caregivers to be notified and heard to any review or hearing. See 22 Me. Rev. Stat. Ann. Secs. 4005-C; Minn. Stat. Sec. 260C.152. See also Wisconsin law at WI Acts sec. 48.62[2] (right to be heard includes hearings of a termination of parental rights petition and may be through a written or oral statement); North Carolina at N.C. Gen Stat sec.7B-506, 7B-907, 7B-908 (notice and opportunity to be heard extends to post-termination hearings and must be given 15 days or more in advance).

[14] See Illinois law at Ill. Comp. Stat. Ann. Secs. 405/1-5[2][a], 405/1-5[2][d]. Illinois also provides that if a foster parent is denied the opportunity to be heard, they may file a legal action against the court or the public agency to enforce their right to be heard. Id.

[15] New Mexico law provides that the court may permit foster parents, pre-adoptive parents, and relative caregivers to intervene as a party at any stage of the proceeding if it is a foster parent with whom the child has resided for a period of at least 6 months; a relative within the fifth degree of consanguity with whom the child has resided; a stepparent with whom the child has resided; or a person who wishes to become the child's permanent guardian. See N.M. Stat. Ann. 32-A-4-27; Oregon law provides, in part, that the court may grant intervention to an individual who has a "caregiver relationship" with the child if it is in the child's best interest and the existing parties cannot adequately protect those interests. ORS 419B.116(1)-(11); in California, some counties appoint and fund an attorney for care providers who have been granted "de facto parent status," that state's equivalent of party status in dependency cases.

[16] Michigan law allows a foster parent to file a termination petition as a "concerned person" (1) if they have specific knowledge of the parent's behavior as a basis to terminate; and (2) they have contacted the child welfare agency and other specified parties and is satisfied that none of those parties intends to file a petition. See Mich. Stat. Ann. Sec.712A.19b. New Hampshire provides a similar right, but only after the child has lived continuously with the foster parent for 24 months. See N.H. Stat. Ann. sec.170-C 4. New Mexico also allows foster parents to initiate termination proceedings, but there are clear requirements that the foster parent must give notice to the child's current foster parents and any other foster parents with whom the child has lived for 6 of the previous 12 months. The law gives parties served an opportunity to file a written response to contest the petition. See N.M. Stat sec.32A-4-29.

## Rationale

Foster parents, and relative care providers are a critical source of in depth knowledge about the child in cases where there has been high turn over in caseworkers. The Ombudsman finds that foster parents and other care providers are not consistently informed of review hearings as required by state and federal law. This is consistent with the findings of the federal Child and Family Services Review (CFSR) for the State of Washington:

> The CFSR found that the State conducts 6-month and 12-month permanency reviews in a timely manner. However, the CFSR also found that foster parents and other caretakers are not informed about these hearings on a consistent basis, or when they are informed, are not routinely given an opportunity to be heard during the proceedings.[17]

The Ombudsman has observed that significant changes in a case plan typically occur when a case is transferred from one caseworker to another. Continuity of information and institutional knowledge are vital. The longer a care provider has a child, the more knowledgeable they are likely to be. Consequently, states are more inclined to grant party status to individuals who have cared for the child for an extended period of time, or have demonstrated a permanent commitment to the child where reunification with the parent is not possible.

In meetings the Ombudsman had with foster parents in both Eastern and Western Washington, they cited the agency's failure to inform them of review hearings as a chronic source of dissatisfaction and frustration. In some instances, this led foster parents to stop providing care for children because foster parents did not feel they could meet the children's needs without being better informed and providing valuable input to the court. Foster parents also reported that because they did not have an effective and consistent means of providing information to the court about the child, they felt their role in the case was marginalized. It made them less inclined to take future children into their homes.

Foster parents also cited poor communication and a lack of responsiveness by the caseworker and even the supervisor. These complaints ranged from the agency not informing them of unusual medical or behavioral needs in advance of the foster parent taking the child into care to significant changes in the permanent plan that were not told to the foster parent in a timely manner. At times, critical decisions were made about the child that the care provider sometimes learned months after the fact or indirectly from parties other than the caseworker. In one complaint handled by the Ombudsman, the foster parents who hoped to adopt a 2-year-old child they had had in their care since 6 months of age, were informed by e-mail that the child was being permanently moved out of state.

DCFS must make additional efforts to inform care providers of their right to be heard in court, provide training to prepare them to contribute more fully in the juvenile court process, and communicate clearly and compassionately about case planning so that expectations are managed. The goal of such efforts must be to guide caregiver input so that it enhances judicial decision-making and leads to improved outcomes for children in care.[18]

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[17] U.S. Department of Health and Human Services Administration for Children and Families (February 2004) *Washington- Child and Family Services Review*, p.8.

[18]OFCO wishes to acknowledge the helpful assistance of Regina Deihl, J.D. Ms. Diehl is currently the director of a non-profit organization in California, Legal Advocates for Permanent Parenting (LAPP) which has done a substantial amount of work on foster caregiver issues. She is also an author of the book: *CAREGIVERS AND THE COURTS: Improving Court Decisions Affecting Children in Foster Care:* Judicial Council of California, Administrative Office of the Courts, and the Center for Families, Children & the Courts (January 2002).

## Recommendation 3: Provide Relatives who have an Established Relationship with a Child, Ongoing Contact after the Child has been Placed Out of the Home Pursuant to a Dependency Action

- **Direct DSHS to facilitate regular and consistent contact between dependent children and their relatives with whom they have a relationship.**

### Background

Although Washington state and Federal law create a preference for placement of children with relatives where out of home placement is necessary,[1] state law does not create an explicit right for relatives to have contact with dependent children if they are not caring for them. This contact is left to the discretion of the court and may occur if Children's Administration facilitates visitation at the request of the relatives and with agreement of the parties.

Some states have adopted laws that specify the factors a court should consider in determining whether to allow visitation, such as the prior relationship between the relative and the child, the mental and physical health of the parties, and the preference of the child, if the child is old enough to express a preference.[2]

In the Office of the Family and Children's Ombudsman's 2003 Annual Report, the Ombudsman recommended that CA identify relative/kinship placement resources even before the actual need for out of home care arises for families involved with CPS. The Ombudsman, based on its review and investigation of complaints into the office, now recognizes a need to improve ongoing contact between dependent children and the relatives with whom they have a relationship, even where the relative cannot be a placement resource.

### Rationale

Although CA, over the past two years, has been making greater efforts to identify relatives and kin earlier in the process and to engage them in case planning,[3] there has been no similar move toward establishing regular visitation between relatives and dependent children. In fact, visitation in general, including parent-child contact, has been curtailed by budget cuts.

The Ombudsman is frequently contacted by relatives who are upset and perplexed that they are not allowed to have contact with their grandchildren, nieces and nephews once these children are placed out of the home in foster care and become dependent. They express the belief that during a vulnerable time the children, more than ever, would benefit from the comfort and support of seeing their relatives. In many complaints that the Ombudsman reviewed, these relatives, prior to dependency, had cared for these children off and on through voluntary arrangements with the parents. These relatives may no longer be a placement resource because of restrictions imposed by their health, finances, or work obligations. Nonetheless, they wish to continue to have contact with these children and to maintain an important relationship.

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[1] RCW 13.34.060(1)(a); RCW 13.34.130(1)(b)(2); RCW 13.34.130(2); and RCW 74.13.600. Additionally, Children's Administration Practices and Procedures Guide § 4251 B. 2 lists relatives as a least restrictive placement option which is favored under the law.

[2] See RCW 26.09.240.

[3] In 2003, the Legislature granted relatives the right 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). See also footnote 2 under Recommendation 2 of this Annual Report for additional information on CA's proposed policy to enhance the involvement of relative care providers by providing them with a separate notice inviting them to participate in staffings and hearings.

Washington should recognize that even when a relative is not a placement resource for a child, there can be significant value to maintaining the relationship. The relative can serve as a source of emotional support and may give the child a greater feeling of being anchored in the world. The relative may also help provide stability to the child's foster care placement by providing respite to the foster care placement.

Certainly, there are many cases where DCFS arranges relative-child contact and permits the relative to provide respite care for a child in foster care placement. The CA Practices and Procedures Guide contemplates this.[4] However, the Ombudsman has found that whether a relative is permitted contact with the child can be unpredictable and somewhat arbitrary. It appears that contact is often influenced by the relationship between the relative and the caseworker, rather than by the best interest of the child.

The Ombudsman has also received complaints from relatives who desire visits with a child who has been adopted. An adoption cannot occur until a parent's rights are terminated. This removes all rights and responsibilities of the parent to the child.[5] In some instances, relatives may have visitation if provided for in an open adoption agreement between the adoptive parents and the biological parents. Current Children's Administration policy states that "the rights of the affected relatives of specified degree do not extend beyond adoption of the child except through an open adoption agreement as described in RCW 26.33.295."[6] However, the policy further states: "Children's Administration acknowledges a continuing relationship between relatives of specified degree and children whose parental rights have been terminated in those cases where the relatives choose to continue a relationship with the child and the continuing relationship is in the best interest of the child. This acknowledgment applies to all legally free children in the custody of the department."[7]

The State, through law, agency policy and practice, should further support established, positive relationships between dependent children and their relatives. Increased relative contact will drive a culture shift that places greater priority on the importance of maintaining family connections.

[4] Children's Administration Practices and Procedures Guide § 43023 provides the "child's social worker will discuss the monitoring of the child's contact with parents and relatives with the out-of-home care provider and ensure that the child's right to privacy regarding private telephone calls and uncensored mail is maintained."

[5] RCW 13.34.200(1).

[6] Children's Administration Practices and Procedures Guide § 4350 E. Furthermore, in 1998, Congress passed the Visitation Rights Enforcement Act, which mandates that a visitation order granted to a grandparent in one state be recognized in any state where the grandchild is living. 28 U.S.C.1738A.

[7] Children's Administration Practices and Procedures Guide § 4350 A.

## Additional Issues of Concern

In addition to the above recommendations, OFCO has identified the following areas of concern. These are issues that are either currently in a state of transition due to pending legislation, or DSHS CA efforts to resolve administratively; or are issues that warrant further review and investigation by the Ombudsman to determine if a recommendation by the Ombudsman is necessary.

### Concern # 1:

**Inadequate recruitment, licensure, and retention of foster homes:** There is a critical shortage of foster homes for all children throughout the state, not only for those segments of the population that have traditionally been underserved, such as adolescents, children with behavioral problems, and those living in rural areas. This crisis has been identified by numerous DSHS employees who have contacted the Ombudsman confidentially. They attribute this shortage primarily to the Division of Licensed Resources' licensors who, as a result of high caseloads, are not able to screen and license prospective foster homes in a timely manner. Prospective foster parents have also complained of unreasonable delays in the licensing process. The agency's inability to recruit and retain foster homes also contributes to this problem. The concerns of the Ombudsman are consistent with the Federal review of Washington's child welfare program.[1] The lack of foster homes has resulted in sibling groups being separated and sent to different regions, even in the case of young children. This complicates casework and reunification efforts because visitation involves time consuming travel over long distances. In some cases, the agency has been unable to provide necessary foster homes altogether. **The Ombudsman recently reviewed a case in which two siblings, a 3 and 5 year old, had to spend the night in a motel with the caseworker because there were no foster homes available. They were then placed in weekend respite care and a subsequent foster home, which failed after a few days. The children are now in a temporary placement.**

### Concern #2:

**Inadequate screening of individuals who provide care to dependent children and youth under the supervision of the state as well as non-dependent children in licensed day care:** The public assumes that an employee working in a licensed day care, group home, or residential treatment facility, has been thoroughly screened for any criminal history or a history of child abuse and neglect as recorded in CAMIS.[2] Unfortunately, this is not always the case. Background checks about prospective care providers lack uniformity in terms of the type of information provided to employers and fail to adequately identify individuals who may have a history of committing child abuse or neglect. The public has a right to expect that licensed homes and facilities are safe for children and youth, and that they are not coming into contact with individuals who may harm them willfully or through neglect. The Ombudsman's concerns arise from investigating complaints and/or receiving information from employers of day cares, group homes, and residential treatment facilities. Our concerns also

[1] Stakeholders who were interviewed by the Federal review team cited placement instability as attributable to: "(1) a lack of appropriate matching of foster parent and children; (2) poor relationships between foster parents and the agency; (3) a lack of adequate resources, particularly for children with emotional or behavioral problems; (4) lack of adequate training of foster parents; (5) insufficient respite care in some areas of the State [the Ombudsman has received reports from foster parents that the system for obtaining respite is unclear and unreliable and that in some DCFS offices there is a culture that discourages the use of respite even when foster parents are requesting it within the provisions of established policy]; and (6) lack of support for unlicensed relative foster care providers." Washington--Child and Family Services Review (Final Report February 2004) U.S. Department of Health and Human Services, Administration for Children and Families, at 16-17.

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

result from reviewing the death of 4-year old, Sirita Sotelo.[3] The Legislature has initiated hearings and convened a task force to study background checks for all care providers in conjunction with the enactment of SSB 5899, which went into effect on July 24, 2005. This law requires broader disclosure by applicants and employees to entities that provide care to children and other vulnerable adults of convictions of any crime and finding in civil adjudications involving domestic violence, abuse, sexual abuse, neglect, exploitation, or financial exploitation of a child or vulnerable adult.[4]

## Concern #3:

**Failure of the Division of Children and Family Services to encourage the maximum parent and child and sibling contact possible, consistent with existing law**. [5] RCW 13.34.136 (b) (2) provides that "[v]isitation may be limited or denied only if the court determines that such limitation or denial is necessary to protect the child's health, safety, or welfare." Over the past year, the Ombudsman has found instances in which DCFS has failed to abide by the terms of court orders setting forth the conditions of visitation. DCFS employees, in Region 4 in particular, have conceded to OFCO that they have not provided visitation to the degree ordered by the court, even in cases where the parent is in substantial compliance with court ordered services and contact would not jeopardize the child's health, safety, or welfare, due to budgetary restrictions.[6] They state that budget cuts have made professional visitation supervisors less available and that the cuts have stalled the implementation of contracts providing for such supervision. The courts have found the agency in contempt and imposed sanctions in some of these cases.[7] Efforts by OFCO to have the agency make up visits for these families have been largely unsuccessful.

### Failure to Provide Parents with Court Ordered Visitation

A parent contacted the Ombudsman with concerns about DCFS failing to provide court ordered supervised visitation with their two dependent children. The children had been in foster care for 7 months and the court had ordered twice-weekly supervised visits of two hours each. Over the course of 15 weeks, DCFS did not provide visits between the parent and the children.

Upon investigation, the Ombudsman discovered that DCFS was not providing visitation due to budgetary constraints in the region where the family lived. Although DCFS explored a number of avenues to provide professional supervised visits for this family, lack of funding proved to be a roadblock. DCFS also considered other family members as supervisors, but concluded this was not feasible.

After the children had been in care for nearly 8 months, the parent's visitation with the two children was occurring consistently, but at a lesser frequency than ordered by the court. Although the siblings expressed a desire to see one another, DCFS failed to establish consistent contact between them for many months.

[3] The Ombudsman recommended that there be improved assessment of adult caregivers, in addition to the biological parent, in the home. The stepmother who was responsible for the death of Sirita was not evaluated and it appears that her CPS referral history may not have been fully considered prior to Sirita being placed in the home. This is discussed in more detail in the section of this report entitled: Two Reviews of Child Fatalities: Justice and Raiden Robinson and Sirita Sotelo.

[4] Final Bill Report SSB 5899. http://apps.leg.wa.gov/billinfo.

[5] This was identified as an area needing improvement by the Federal audit of the state's child welfare system. U.S. Department of Health and Human Services Administration for Children and Families (February 2004) *Washington-Child and Family Services Review, at* 27.

[6] DCFS Region 4 formally implemented changes to its visitation program, effective October 1, 2005, when new contracts were being issued. These changes include: requiring parents to come to the children, rather than children going to the parents; holding visits where the greatest number of children reside (the Ombudsman received a complaint from a parent who was required to travel to three different locations to visit her children. She reported that she suffered from a social anxiety disorder, did not own or drive a car, and that this was a hardship on her); restricting visits to the child and the persons with whom the child is reunifying; and invalidating visits after three "no shows" or cancellations in a six month period, until a new court order reschedules visits. September 29, 2005 memorandum from Jacquelyn Buchanan, RA DCFS Region 4 to DCFS R All Staff re: Changes in Parent Child Visitation Program.

[7] See Rowe, Claudia. "Social workers can't keep up with child-welfare visits." Seattle Post-Intelligencer. November 22, 2005. http://seattlepi.nwsource.com/local/249280_visitation22.html (states that the agency "has defended itself against 13 motions for contempt, three of which have been founded.").

## Concern # 4:

**Removal of children from long term foster care pre-adoptive placements.** DCFS' decision to remove children from foster parents who have grown attached to them after months, or even years, of caring for them are among the most emotionally charged complaints OFCO receives. As noted in last year's report, at times the Ombudsman receives complaints from competing parties involved in the same case. Conflicting policies govern placement of children. The guiding principle under the law is supposed to be the best interest of the child, but this concept is viewed differently by different individuals, some of whom place more priority on the attachment the child has formed to a foster parent in the first few years of life; others who think placement with relatives is paramount regardless of when it occurs. Moving children long after they have bonded in a secure nurturing environment is disruptive, can be emotionally damaging, and possibly traumatizing in the long term. DCFS can assure better outcomes by identifying relatives earlier in the process and making such moves early on; managing foster parent and relative expectations by communicating clearly and consistently about expected outcomes; and by articulating in advance the rationale for any change in placement, such as a significant change in circumstance.

### Failure to Establish Early Permanence

A foster parent contacted the Ombudsman with concerns about DCFS' plan to remove two foster children, ages 2 and 4. The children were half-siblings whom DCFS intended to place with a relative of the older child. The relative resided out-of-state. The relative had visited the children as arranged by DCFS in anticipation of the move; other than this, the children did not have a relationship with the relative.

The younger child had lived with the foster family since he was 6 months of age. The foster family accepted placement of the child with the goal of providing him a permanent home.

The older sibling was originally placed with a relative within Washington State. This was a failed placement due to several factors including medical neglect, which contributed to developmental delays. The older sibling was then moved to the foster family at age 3 to live with his half-sibling. DCFS informed the foster parents that this older child had a relative who resided out-of-state who might be a placement resource for him. The foster parents recognized it was possible this older child could be removed from their home to be placed out-of-state with his relative. They expected, however, that if this was the plan, it would be implemented as soon as the relative was approved for placement.

Placement of the oldest child out-of-state was approved through an interstate compact placement agreement. However, due to the parties' concerns about separating the siblings, the move was delayed and the case was staffed by a Diversity Child Protection Team (DCPT). It recommended keeping the children together in the foster home rather than sending the child to relatives he had not, at that time, ever met.

The foster parents underwent an adoptive home study, which they passed. They were informed over the course of several months that DCFS' case plan was to maintain both children with the foster parents.

The case plan was changed approximately 15 months after the youngest child had been placed with the foster parents. The new plan was to move both children out-of-state to the oldest child's relative.

The foster parents requested that a bonding assessment be done by a professional so that it could be considered in determining what would be in the children's best interest. DCFS would not agree to this, citing budgetary constraints; delays that would result from such an assessment; and the fact that the decision to move the children was unlikely to be reversed.

Both children were removed from the foster parents' home—the youngest one 21 months after being placed with the foster parents; the oldest one 19 months after placement with the foster parents and 11 months after interstate compact approval of the out-of-state relative.

# Response to OFCO 2003 Annual Report

## Response to the Ombudsman's Systemic Recommendations

In addition to responding to specific complaints, the Ombudsman is statutorily charged with developing recommendations for improving the state child protection and child welfare system. This section briefly presents the recommendations included in the Ombudsman's 2003 Annual Report and the Children's Administration's Responses to those recommendations.

This section also briefly describes the response by the Legislature to the Ombudsman's concerns about adolescents, ESB 5583; and chronic neglect, ESSB 5922; both signed into law in 2005.

## The 2003 Office of the Family & Children's Annual Report

In the 2003 Annual Report, the Ombudsman reported on its review of the Rafael Gomez fatality. The report detailed the key issues that the Ombudsman had asked the Community Fatality Review Team convened by DCFS to address. Second, the Ombudsman reviewed the use of Child Protection Teams (CPTs), including findings and recommendations because of reports about the inconsistent use of CPTs. Finally, the Ombudsman recommended improvements in four other child welfare/child protection areas: evidence-based assessment and treatment; protecting adolescents; children with developmental disabilities; and relative and kinship care.

### THE RAFAEL GOMEZ FATALITY

#### *Ombudsman Issues*

The Ombudsman asked the DCFS-convened Community Fatality Review Team studying the death of Rafael Gomez to address the following seven issues:

1. **Screening and Investigation** – Rafael received several injuries while in his parents' care. Case records indicated that CPS did not investigate reports of these injuries.
2. **Risk Assessment** – Instead of assessing the parents' risk for physical abuse, the worker obtained a "psycho-social" evaluation of both parents.
3. **Child Protection Team** – The DCFS worker failed to provide the CPT with complete information, such as medical reports of all of the child's injuries and other reports of maltreatment.
4. **Support Services** – The CWS worker did not ensure that critical in-home services, such as a public health nurse were in place.
5. **Non-compliance –** No evidence that DCFS worker's support for the mother was shaken despite her lack of compliance with substance abuse treatments.
6. **CPT Staffings** – Asked review team to consider how CPT could be more effective.
7. **In-home Service Providers** – Asked review team whether Family Preservation Service and Home Support Service providers were sufficiently equipped to address issues identified in psycho-social evaluation of Rafael's parents.

### *Children's Administration Responses*

In August 2004, Children's Administration (CA) produced a comprehensive report responding to each recommendation made by the DCFS-convened Fatality Review Team. This report included descriptions of actions CA had already taken, actions CA planned to take, and CA's timelines for completion. Children's Administration then updated this report in January 2005. Although these reports were not created to directly respond to the Ombudsman, the responses adequately covered the Ombudsman's concerns.

As of January 2005, CA stated that the agency had fully completed 4 recommendations:

- CA had made the Fatality report available to employees and stakeholders in English and Spanish;
- CA had compiled a comprehensive list of responses to each recommendation;
- CA had provided additional training to workers and supervisors in Moses Lake and had made several modifications in the Academy training; and
- CA already had a policy in place that social workers should not carry cases until they had received basic training and that when they changed positions they received training.

As of January 2005, these were the only 4 completed recommendations. CA stated that 7 other recommendations were partially completed, 20 recommendations were in the process, and 6 were of an ongoing nature.

## CHILD PROTECTION TEAMS (CPTS)

### *Ombudsman Recommendations*

Second, the Ombudsman reviewed DCFS use of Child Protection Teams. Based on this review, the Ombudsman offered five recommendations:

1. **Clarify policy and practice guidelines for CPTs** – Although CA policy does contain some guidelines, they are too ambiguous leaving room for wide interpretation. The Ombudsman suggested that the CA define more clearly when a CPT is required, what should be the membership of the team.

2. **Create a system of accountability for following CPT policy** – There is no system to ensure that DCFS holds a CPT review in all case in which the policy requires a CPT, such as an information system to track compliance and report CPT results. At a minimum, DCFS should be required to document whether a CPT is required in the CAMIS-GUI information management system.

3. **Require training of DCFS staff** – Workers need to be trained on the value of the CPT as well as on how to provide full and accurate information for a CPT.

4. **Provide support, authority, sufficient time and specialized training for CPT coordinators/ facilitators** – CPT coordinators must be trained to be effective.

5. **Require orientation and training for all volunteer CPT members** – At the time, CPT volunteers were not required to receive training.

***Children's Administration Response*** *(responses are taken verbatim from a CA report from Jan. 2005)*[1]

- The Gomez Child Fatality Review Team report reflected the Ombudsman's concerns related to Child Protection Teams, and made detailed recommendations to review and revise the CPT program.
- The CA fully supports these recommendations and has included the strengthening and improvement of CPTs within its Kids Come First II comprehensive reform plan (KCF II: Safety 4.4).
- A multi-disciplinary team has been established to review the CPT program and will report its recommendation to CA management in April 2005.
- Based on these recommendations, CA will:
    - Clarify policies and practice guidelines;
    - Develop a revised CPT handbook for CA staff and CPT members;
    - Provide training to CPT members and CA staff;
    - Clarify the role of CPT coordinators; and
    - Provide ongoing support to CPTs.

In May 2005, CA and its CPT workgroup produced a draft of the Practice Guidelines for "Child Protective Teams." The Ombudsman has not received additional information from CA that this draft has been finalized and implemented.

## EVIDENCE-BASED ASSESSMENT AND TREATMENT

***Ombudsman Recommendation***

Direct the Washington State Institute for Public Policy (WSIPP) or other entity to convene a multidisciplinary summit to examine effective models of assessment and treatment and make recommendations to DSHS.

***Children's Administration Response*** *(responses are taken verbatim from a CA report from Jan. 2005)*

- CA is committed through a process of collaboration with providers, academics, clinicians, and child welfare experts:
    - To expand the menu of evidence based services available to children and families; and
    - To identify and address infrastructure issues.
- CA will participate in every opportunity to expand and implement evidence-based practices in child welfare services.
- CA intends to increase services available to clients in the three child welfare/home visitation programs identified by the recent WSIPP study:

[1] Children's Administration Response to the 2003 Annual Report of the Office of Family and Children's Ombudsman.

- Nurse-family partnership for low income women
- Home visiting programs for at-risk mothers and children
- Parent-child interaction therapy

- CA is pursuing additional efforts to support and implement evidence based practice:
  - Piloting Multi-systemic Therapy and Functional Family Therapy in two regions
  - CA intends to implement the Child Abuse Potential Assessment to assess the risk of a caregiver physically abusing a child
  - Initiating proposals to implement models of evidence-based therapeutic foster homes
  - Participating in the Children's Mental Health Workgroup to establish evidence-based child mental health services
  - Providing support to increase access to Early Childhood Education and Assistance;
  - Implementing Contract Outcome Initiative to measure effectiveness of all contracted services.

## PROTECTING ADOLESCENTS

### *Ombudsman Recommendation*

Amend state law to clarify that DSHS may not refuse to provide adolescents with child protective services based on their age.

### *Legislative Response*

In the Final Bill Report of Engrossed Senate Bill 5583, the Senate noted that the Ombudsman's 2003 Annual Report noted that the Ombudsman had received complaints that referrals to the Children's Protective Services (CPS) were often screened out or assigned a lower standard of investigation based on the child's age, on the assumption that an adolescent is able to protect himself or herself. Effective July 2005, the Legislature passed a bill "[r]equiring training of children's administration employees concerning older children who are victims of abuse or neglect."

On December 30, 2005, DSHS CA submitted to OFCO a draft of a proposed curriculum entitled "Best Practice in Screening & Assessing Needs for Adolescents" in response to ESB 5583. As required by the law, the proposed curriculum currently includes:

- A review of the relevant laws and regulations related to the screening, assessing and investigation of referrals of CA/N made involving adolescents.
- A review of screening procedures of allegations made related to adolescents with case scenarios and discussion of best practice.
- A review of safety assessment and risk assessment models related to work with adolescents with case scenarios and discussion of best practice.

The Ombudsman reviewed and commented on the proposed curriculum to ensure that it addressed the concerns identified by OFCO in the 2003 Annual Report and the requirements of the law.

***Children's Administration Response*** *(responses are taken verbatim from a CA report from Jan. 2005)*

- CA policy requires all abuse/neglect referrals to be assessed and screened on the basis of risk and not age;
- The CA safety assessment and risk assessment models were reviewed in 2002 to eliminate age as a risk factor;
- CA will strengthen its policy to ensure that adolescents receive CPS services based on their circumstances and not on their age (June 2005);
- CA will provide additional and regular training to CA intake staff related to the screening and response to CPS referrals involving adolescents (February – June 2005 and ongoing);
- CA will implement regular training on safety and risk assessment for all staff. Assessing adolescents safety and risk will be included in this training (February – June 2005);
- CA will implement a new 3-day CPS investigation-training program. The training will include investigation of abuse/neglect referrals related to adolescents (February 2005); and
- CW will review CPS screening decisions related to adolescents on a quarterly basis (April, July, October 2005).

## CHILDREN WITH DISABILITIES

***Ombudsman's Recommendations***

- 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 case worker, Division of Developmental Disabilities (DDD), and mental health services to address placement and service needs of families with developmentally disabled children and children with serious handicaps; and
- Require DSHS to submit to the Legislature a report setting forth protocol to coordinate placement and services for these children.

***Children's Administration Response*** *(responses are taken verbatim from a CA report from Jan. 2005)*

- DDD continues to have statutory authority for services to children with developmental disabilities. The DDD Voluntary Placement Program was capped due to budgetary concerns;
- DDD & CA have implemented an Intra-Agency Agreement for providing services jointly to children with acute needs using existing funds;
- To date 25 children have been placed through this agreement. Most of these children are not IV-E eligible and placement is supported through state funds;

- To date, CA has committed $1.5 million annually to support these placements;
- DDD has submitted a decision package requesting funds for 24 new placements;
- CA is in the process of implementing new performance based contracts for the recruitment of foster homes based on regional needs assessment and resource management plans;
- CA has completed regional service agreements with regional support networks (RSNs) to improve access to children's mental health services for children served by CA, including children with developmental disabilities; and
- CA, Mental Health Division (MHD), and Juvenile Rehabilitation Administration (JRA) are collaborating to develop an improved system for children's mental health services.

## RELATIVE AND KINSHIP CARE

***Ombudsman Recommendations***

- As part of its improvement activities, Children's Administration should develop:
    - A statewide protocol for identifying relative/kinship placement resources;
    - An objective assessment process for evaluating the suitability of relative/kinship placement decisions;
    - Criteria to assist workers in making relative/kinship placement decisions; and
    - A process for promoting family involvement in the agency's case planning process.

***Children's Administration Response*** *(responses are taken verbatim from a CA report from Jan. 2005)*

- CA has developed a new *Practices and Procedures Guide* for relative search and placement. This *Guide* will be implemented in March 2005 and outlines:
    - When relative searches are required; and
    - When activities constitute an adequate search.
- A new relative home assessment tool is in development and is scheduled for implementation June 2005. This will result in all licensed caregivers, including kinship care providers, receiving the same quality of assessments.
- The *Practices and Procedure Guide* includes criteria to guide placement decision-making.
- Kids Come First II has a strong emphasis on family involvement in the case planning process including:
    - New policies, practice guide and training to strengthen the requirement that families be involved the case planning and decision making (October 2005);
    - Development of a strength-based family assessment tool (June 2005);
    - Implementing Family Team Decision Making model

## The 1999 & 2000 Office of the Family & Children's Ombudsman Annual Reports and the Justice and Raiden Robinson Fatalities Review Report by the Family and Children's Ombudsman

### *Ombudsman Recommendation*

In the 1999 Annual Report, the Ombudsman identified as an area of concern the lack of timely and appropriate intervention in chronic child neglect cases. By the 2000 Annual Report, the Ombudsman recommended that the Legislature "[m]odify the statutory definition of neglect by deleting the reference to 'clear and present' danger and clarifying that neglect may result from 'a pattern of conduct.'" This change in definition would permit a court to consider cumulative harm to a child in determining whether the child is dependent.

And then, once again in 2005, in the Report for the Review of the Justice and Raiden Robinson Fatalities, the Ombudsman called for the Legislature to "[m]odify the statutory definition of child abuse and neglect and allow CPS to intervene earlier in an investigation to protect children at risk of abuse or neglect." The deaths of these two children gave a tragic illustration of the need for a change in the law.

### *Legislative Action*

In 2005, the Legislature passed the Justice and Raiden Act (Engrossed Substitute Senate Bill 5922), which will take effect on January 1, 2007 and change the definition of "abuse or neglect" and "negligent treatment or maltreatment" of a child to include language pertaining to chronic neglect for the purposes of an investigation of child abuse or neglect; permit the Department of Social and Health Services (DSHS) to offer voluntary services to a parent to correct the deficiencies that placed the child at risk for child abuse or neglect; and permit the DSHS to file a dependency petition if a parent fails to comply with treatment to correct the deficiencies that placed the child at risk for child abuse or neglect.

## Continued Cooperation

The Ombudsman acknowledges and appreciates the effort of CA to keep the Ombudsman informed of CA's progress with regard to the Ombudsman's recommendations. Without such cooperation, the Ombudsman would have a difficult time tracking which recommendations have been accepted and accomplished, which recommendations have been accepted but not yet accomplished, and which recommendations have been rejected. The Ombudsman looks forward to continued cooperation with CA working in the best interest of the children of the state of Washington.

# APPENDICES

## APPENDIX A - OMBUDSMAN ACTIVITIES

The Ombudsman is charged with promoting public awareness and understanding of family and children services and with identifying systemic issues that need improvement.[1] The office accomplishes this by actively participating on committees established to critically examine such issues; presenting at conferences; reviewing and analyzing proposed legislation, and providing oral or written testimony where appropriate; and conducting site visits of state licensed facilities pertaining to placement, supervision, and treatment of children in the state's care. The following provides a list of the Ombudsman's community outreach and legislative action in 2004 and 2005:

### COMMITTEES/TASK FORCES

Children's Administration Adolescent Work Group

Braam Panel

Child Protective Team Work Group

Joint Task Force on Child Safety established by SHS 2156

Joint Task Force on the administration and delivery of services to children and families established by SSB 5872

Kinship Care Work group[2]

### CONFERENCES

Annual Children's Justice Conference, 2004 & 2005

Children and the Law Conference in Washington DC, 2004

Chronic Neglect Working Conference at Portland State University

Foster Care Assessment Program

Helping Children Affected by Domestic Violence, Burien

Kids Come First II Curriculum Training

Prevention Pays Forum - Evidence Based Services

Region IV Coordinated Response to Child Maltreatment and Domestic Violence Protocol Workshop

United States Ombudsman Conference in Portland, 2004 & 2005

Washington State 2004 Foster Care Conference (FPAWS), Wenatchee

What about Children Conference

[1] RCW 43.06A.010.

[2] The workgroup generated a Kinship Care Report in Response to HB 1397 (codified at RCW 74.13), which directed DSHS to "convene a kinship caregivers working group" to brief the Legislature by November 1, 2002 on "policy issues to be considered in making kinship care a robust component of the out-of-home placements spectrum."

## LEGISLATION

Legislative Children's Oversight Committee

- Testimony on Ombudsman performing statutory duties under RCW 43.06A.

House Committee on Appropriations

- Provided written comments on HB 1551, a bill to provide additional funding to combat methamphetamine abuse.

House Committee on Children & Family Services:

- Testimony on HB 1482, A bill relating to child abuse and neglect

House Committee on Health Care:

- Testimony on HB 1427, a bill relating to postpartum depression

Senate Committee on Health & Long Term Care:

- Testimony on SB 5898, a bill relating to postpartum depression

Senate Committee on Human Services & Corrections

- Testimony to provide overview of the Ombudsman's Office, present the 2003 Annual Report & discuss current OFCO activities
- Testimony on SB 5583, a bill requiring training of children's administration employees concerning older children who are victims of abuse or neglect
- Testimony on SB 5873, a bill to require additional oversight of CPS and CWS employees by the Ombudsman
- Testimony on SHB 5922, a bill changing procedures for investigations of child abuse and neglect (aka "the Justice and Raiden Robinson neglect bill")

In addition to the Ombudsman's actions on these specific bills, the Office also participated in the House oversight hearing on the Braam lawsuit and intervention programs. The Ombudsman also met with numerous legislators and staff to provide expertise and express concerns on subject areas within the purview of these committees.

## PRESENTATIONS

Child Welfare Advocacy Coalition

Children's Justice Conference 2004

Kitsap County Foster Care Association, Silverdale, WA, 2004

Foster Parent Association Board Meeting

King County Child Abuse Network Meeting

Presentation on Foster Parent Retaliation at the Washington State 2004 Foster Care Conference (FPAWS), Wenatchee, WA 2004

United States Ombudsman Association 2004 & 2005 (Director Ombudsman Meinig is co-chair of the Family and Children's Chapter of USOA)

## SITE VISITS

Adolescent residential treatment facility, Spokane

Crisis Residential Center, Spokane

Crosswalk Youth Shelter, Spokane

Safe Harbor Crisis Nursery, Kennewick

St. Anne's Children and Family Center, Spokane

Sally's House, Spokane

Washington School for the Deaf, Vancouver

In addition to site visits of licensed facilities, the Ombudsman participated in ad hoc meetings or informal get togethers with foster parents in both Eastern and Western Washington to hear and address concerns.

## TRAINING

HCSTAT Training on Substance Abuse and Relapse Prevention

Northwest Institute for Children and Families Training on Adolescent Well being, Permanency, and Child Welfare Workforce Recruitment

## WORK IN PROGRESS

- Review and comment on DSHS' proposed curriculum and materials to train staff to appropriately screen and respond to CPS referrals regarding adolescents pursuant to SB 5583.
- Review and comment on DSHS' proposed revisions to CA practices and procedures manual to comply with foster parent retaliation law.

# APPENDIX B - EXPLANATION AND COMPARISON OF CHILDREN'S ADMINISTRATION CHILD FATALITY REVIEWS AND EXECUTIVE CHILD FATALITY REVIEWS

Child Fatality Reviews (CFR) are conducted on any unexpected child fatality if the child's family received any services from the Children's Administration (CA) within 12 months prior to the child's death.

An Executive Child Fatality Review (ECFR) may replace a CFR in situations where the child died of alleged abuse or neglect while the family was actively receiving services from the administration. As an example, an ECFR may be convened when a child dies of alleged abuse or neglect while the family has an open, active child protective services (CPS) investigation case, and/or in a child welfare services (CWS) case where the child is a dependent and living at home, with a relative, or in a licensed facility.

ECFRs are generally convened on these types of cases to provide an independent review by individuals who were not directly involved in providing services to the family. ECFRs bring together individuals who have expertise in disciplines that reflect the specific case dynamics.

| Child Fatality Reviews (CFR) | Executive Child Fatality Reviews (ECFR) |
|---|---|
| A CFR is conducted on any unexpected child fatality when the family received services from the department within 12 months prior to the child's death. | An ECFR may be convened and replace the CFR when the family was actively receiving services at the time of the child's death, and the child died from alleged abuse or neglect. Example: an open, active CPS case or case involving a dependent child who was residing at home, with a relative or in licensed facility at the time of death. |
| Team members are selected by the regional child protective services (CPS) program manager. | The ECFR is convened at the discretion of the Children's Administration (CA) Assistant Secretary who also selects the team members in consult with the regional administrator, the Director of Field Operations, and the CA Office of Risk Management. |
| Review is conducted by a multi-disciplinary team which includes CA staff, service providers, and community stakeholders who have direct knowledge of the case. | Review is conducted by a multi-disciplinary team comprised of community professionals, para-professionals, and CA staff who have no direct involvement in the case. The team should represent the demographic and culture of the community where the fatality occurred and there should be team members who represent the client's ethnic and cultural background. |
| Team members sign confidentiality statements. | Team members sign confidentiality statements. |
| The review is coordinated and facilitated by the regional child protective services (CPS) program manager | The review is facilitated by a chair or co-chairs who are selected by the ECFR team. The regional CPS program manager provides local coordination of materials and logistical support to the team. |
| The CFR team may review the case record, a review of policies, and practice. The review may include interviews. Documents may be developed solely for the purpose of the review and usually include a chronology of the case. | The ECFR team may review the case record, a review of policies, and practice. The review usually includes interviews. Documents may be developed solely for the purpose of the review and usually include a chronology of the case. Additional documents may be provided to the ECFR for their consideration, e.g.) the Gomez ECFR team received documents developed by the Office of the Family and Children's Ombudsman. |

| Child Fatality Reviews (CFR) | Executive Child Fatality Reviews (ECFR) |
|---|---|
| The CFR will be completed within 180 days. The CFR team usually meets for one day. | The amount of time needed for the review is determined by the ECFR team, with a goal of completion by 180 days. Additional time may be requested as needed. |
| Final reports, which identify issues and recommendations, are written by the CPS program manager. The reports are documented in the Administrative Incident Reporting System (AIRS). Once confidential information is redacted, the report is reformatted and submitted to the Legislature per RCW 74.13.640. The report is posted on the web for public review. | Final reports, which include findings and recommendations, are written by the team. Once confidential information is redacted, the report is available to the public. |
| A work plan may be developed to address practice or system issues. | CA provides a response to the report recommendations and a work plan may be developed to address practice or system issues. |

Source: DSHS Children's Administration, Office of Risk Management, 09/29/2005

# APPENDIX C - FATALITY REVIEW MATRIX

| EXPECTED CHILD FATALITIES<br>Type of Case | | CFR* | Executive CFR | No Review Required |
|---|---|---|---|---|
| 1. | Services within 12 months, CA/N alleged | X or | X | |
| 2. | Adoption support, services within 12 months, CA/N alleged | X or | X | |
| 3. | Licensed care (DLR/DCCEL), CA/N alleged | X or | X | |
| 4. | Open case, placement, no CA/N alleged | | | X |
| 5. | Services within 12 months, no CA/N alleged | | | X |
| 6. | Adoption support, no services within 12 months, no CA/N alleged | | | X |
| 7. | Adoption support, services within 12 months, no CA/N alleged | | | X |
| 8. | Adoption support, no services within 12 months, no CA/N alleged | | | X |
| 9. | Licensed care (DLR/DCCEL), no CA/N alleged | | | X |
| 10. | No history, no CA/N alleged | | | X |
| 11. | No history, CA/N alleged | | | X |
| 12. | Open case, no placement, no CA/N alleged | | | X |

| UNEXPECTED CHILD FATALITIES<br>Type of Case | | CFR | Executive CFR | No Review Required |
|---|---|---|---|---|
| 13. | Open case, no placement, no CA/N alleged | X | | |
| 14. | Open case, no placement, CA/N alleged | X or | X | |
| 15. | Open case, placement, no CA/N alleged | X | | |
| 16. | Open case, placement, CA/N alleged | X or | X | |
| 17. | Services within 12 months, no CA/N alleged | X | | |
| 18. | Services within 12 months (includes IO, LRS, HRS), CA/N alleged | X or | X | |
| 19. | Licensed care (DLR/DCCEL), no CA/N alleged | X | | |
| 20. | Licensed care (DLR/DCCEL), CA/N alleged | X or | X | |
| 21. | Adoption support, services within 12 months, no CA/N alleged | X | | |
| 22. | Adoption support, services within 12 months, CA/N alleged | X | | |
| 23. | Adoption support, no services within 12 months, no CA/N alleged | | | X |
| 24. | Adoption support, no services within 12 months, CA/N alleged | | | X |
| 25. | No services within 12 months, no CA/N alleged | | | X |
| 26. | No services within 12 months, CA/N alleged | | | X |
| 27. | Significant history prior to 12 months, CA/N alleged | | | X |

*Shaded cases require a fatality review. RA has option to request review of any case (e.g. Items 24 & 27).*

CFR*–Child Fatality Review

Source: DSHS Children's Administration

# APPENDIX D - ADMINISTRATIVE INCIDENT REVIEW ACTIVITY

<table>
<tr><th colspan="2">Case Status</th></tr>
<tr><td colspan="2">At time of child fatality or critical incident, services are active in Children's Administration (CA) programs;<br><br>OR<br><br>There was an open case that received services from any CA within 12 months prior to child's death or critical incident. Services include "information only" or low risk referrals.<br><br>Services were provided by a CA licensed, certified, state-operated facility or Division of Child Care & Early Learning (DCCEL) home or facility.</td></tr>
<tr><th>Unexpected</th><th>Child Fatality Review (CFR), or Executive Child Fatality Review (ECFR) is Required</th></tr>
<tr><td>Child Abuse/Neglect (CA/N) Fatality</td><td>CFR:<br>• Participation by local/regional staff and/or others appointed by regional administrator (RA). CA may invite community partners who had involvement with and/or provided services to the child's family<br>• CFR prepared and coordinated by regional CPS program manager in Administrative Incident Reporting System (AIRS)<br>• Regional CPS program manager completes review within 90 days or RA may authorize extension<br><br>ECFR*:<br>• Recommended by Director of Field Operations, RA & CA Office of Risk Management.<br>• Convened by Assistant Secretary<br>• Coordinated by Office of Risk Management and regional CPS program manager or other RA designee<br>• The Executive CFR will include statewide, multidisciplinary participants with no direct involvement in services for the child's family. Executive CFR will determine timeline for completion of report.<br><br>*An ECFR may replace a CFR in situations where the child died of alleged abuse or neglect while the family was actively receiving services from the department. As an example, an ECFR may be convened when a child dies of alleged abuse or neglect while the family has an open, active child protective services (CPS) investigation, and/or a child welfare services (CWS) case where the child is a dependent and living at home, with a relative, or in a licensed facility. ECFRs are generally convened on these types of cases to provide an independent review by individuals who were not directly involved in providing services to the family. ECFRs bring together individuals who have expertise in disciplines that reflect the specific case dynamics.</td></tr>
<tr><th>Unexpected</th><th>CFR is Required</th></tr>
<tr><td>Non-CA/N Fatality</td><td>CFR:<br>• Participation by local/regional staff and/or others appointed by RA). CA may invite community partners who had involvement with and/or provided services to the child's family<br>• CFR prepared and coordinated by regional CPS program manager in AIRS<br>• Regional CPS program manager completes review within 90 days or RA may authorize extension</td></tr>
</table>

| Expected | CFR (Optional) |
|---|---|
| Non-CA/N Fatality (e.g. medically fragile, terminal illness) | CFR:<br>• CFR on expected, non-CA/N fatalities are optional.<br>• Participation by local/regional staff and/or others appointed by RA. CA may invite community partners who had involvement with and/or provided services to the child's family<br>• CFR prepared and coordinated by regional CPS program manager in AIRS<br>• Regional CPS program manager completes review within 90 days or RA may authorize extension |
| **Other** | **Administrative Incident Review (Optional)** |
| Other Incidents* | • Requested by Assistant Secretary, Field Operations Director or RA<br>• Coordinated by ORM<br>• May include local, regional, HQ and/or other representation |

*Other incidents that may result in an internal staffing or review include, but are not limited to the following:

- Near-fatalities of children, adults or others that may be CA/N-related where practice, policy or system issues would benefit from review
- Serious CA/N-related injuries on open or recently closed cases
- CA/N issues in state licensed or certified facilities (foster homes, private agency foster homes, child care homes/facilities)
- Other high risk situations or conditions that may have caused harm or potential harm to clients, staff or public
- Provider misconduct

Source: DSHS Children's Administration, Office of Risk Management, 09/29/2005

# APPENDIX E - DELAWARE LAW ON CASELOADS

## Delaware Law Enacted to Ensure Sufficient Caseloads are Funded

§ 9015. Budgeting and financing.

(a) The Secretary, in cooperation with the Department directors and office administrators, shall prepare a proposed budget for the operation of the Department to be submitted for the consideration of the Governor and the General Assembly. The Department shall be operated within the limitation of the annual appropriation and any other funds appropriated by the General Assembly.

(b) Each fiscal year, pursuant to established methodology, the Secretary and the Office of Management and Budget shall review projections on the number of child abuse and neglect cases and the number of child care facilities to be licensed and monitored for the next fiscal year. Based on these projections, the General Assembly shall fund, subject to a specific appropriation, funds and positions for the next fiscal year, beginning each July 1, to the Division of Family Services to provide:

(1) An adequate number of child protection investigation workers so that regional caseloads do not exceed 14 cases per fully functioning worker;

(2) An adequate number of child protection treatment workers so that regional caseloads do not exceed 18 cases per fully functioning worker;

(3) An adequate number of Family Service supervisors so that there is 1 supervisor for every 5 workers;

(4) An adequate number of training positions, but not less than 15, to ensure that fully trained staff are always available to fill vacancies;

(5) An adequate number of licensing specialists for child care centers and family child care homes so that caseloads do not exceed 150 per specialist;

(6) An adequate number of licensing specialists for 24-hour residential child care facilities so that caseloads do not exceed 30 per specialist; and

(7) An adequate number of licensing supervisors so that there is 1 supervisor for every 5 workers.

In the event that regional caseloads exceed the above set standards during any fiscal year, the Office of Management and Budget shall, to the extent monies are available, authorize the use of casual seasonal positions as a temporary mechanism to ensure that caseloads remain within Delaware standards. Fully functioning workers are workers that are employed and working full-time, and do not include workers on extended medical leave, trainees who have not completed training or workers with restricted caseloads.

(c) In order to ensure the standards set forth in subsection (b) of this section are maintained, the Secretary shall submit a quarterly report to the Governor, the Controller General and the

Director of the Office of Management and Budget, with copies to the Chairpersons of the House of Representatives Committee on Health and Human Development, the Senate Committee on Children, Youth and Their Families, and the Child Protection Accountability Commission that details the above information both statewide and on a regional basis.

(d) For the purpose of retaining and attracting experienced investigation and treatment workers in the Division of Family Services, the Division may competitively recruit for Family Crisis Therapists in their investigation and treatment units. Current Division employees who successfully apply for these positions shall have their position reclassified to Family Crisis Therapist. Such reclassifications or reclassifications of vacant positions to Family Crisis Therapist shall be effective upon the approval of the Director of the Office of Management and Budget and the Controller General. The Division is authorized to transfer positions between budget units in order to adjust its complement to ensure the correct number of fully functioning employees are in each functional unit of the Division. The Division shall submit a quarterly report to the Director of the Office of Management and Budget and the Controller General detailing any adjustments to the complement, the number of Family Crisis Therapists hired and retention statistics.

(e) Special funds may be used in accordance with approved programs, grants and appropriations. (64 Del. Laws, c. 108, §§ 1, 14; 67 Del. Laws, c. 398, § 2; 71 Del. Laws, c. 475, § 1; 74 Del. Laws, c. 283, § 1; 75 Del. Laws, c. 88, §§ 20(6), 21(13), 26(2).)

Source: Del.Code.Ann., tit.29 §9015 (2000). Available at http://www.delcode.state.de.us/title29/c090/index.htm.