Office of the
Family & Children's

Ombudsman

An Independent Voice for Families and Children

2009 Annual Report

Mary Meinig, Director Ombudsman
www.governor.wa.gov/ofco

"Though things looked like they were going to work out in that final hour, [the Ombudsman] stayed with it till the very end. A perfect ombudsman."

-Complainant/Parent

"This is the first time I have used this avenue of aid in resolving a case – I was very satisfied with the outcome of this case and the Office of the Family & Children's Ombudsman certainly helped in the final resolution. Thank you."

-Complainant

"It was very helpful to have [the Ombudsman] be a part of our recent meeting to plan for my nieces and nephews placement. I cannot thank [the Ombudsman] enough for caring about them and me."

-Complainant/Relative

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The Office of the Family and Children's Ombudsman:

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December 2009

To the residents of Washington state:

I am pleased to submit the 2009 Annual Report of the Office of the Family and Children's Ombudsman (OFCO). As we enter 2010, we especially appreciate the opportunity to continue to serve the citizens of Washington state. Many state agencies have suffered severe budget cuts and some have been eliminated. The Governor has an almost insurmountable task in balancing budget priorities so that critical services to children and families can be maintained. We have all been asked to do more with less and I want to express my appreciation in particular to the Governor, the legislature and the Department of Social and Health Services and others who have helped us to advance our priorities in the child welfare field during these difficult times.

Much of our activity this year has centered on fulfilling new duties and responsibilities brought about by the enactment of 2SSB 6206 in 2008. This annual report includes the implementation status of child fatality review recommendations, as well as fatality data spanning 2004 to 2008. In July we released "*Patterns in Mandated Reporter Referrals 2006-2008,"* a report that addressed the legislature's interest in further study of DSHS CA's screening and investigation of CPS referrals. A summary of this and other reports completed this year is included in this annual report. We also include the results of OFCO's examination of issues of recurrence and chronicity in child abuse and neglect cases. This was based on notification we now receive from DSHS of the third founded abuse or neglect report received by DSHS within the last 12 months involving the same child or family.

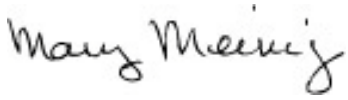
In addition to 2SSB 6206 related work, in May OFCO released its Colville report, the result of a 10-month-long investigation of the child welfare system in the Northeast corner of our state. We identified deficiencies across several systems and made recommendations that have translated into corrective action plans initiated by DSHS. We will continue to monitor implementation.

In the midst of these difficult economic times, DSHS has new leadership. We welcome DSHS Secretary Susan Dreyfus and Children's Administration Assistant Secretary Denise Revels Robinson who have brought new energy and resourcefulness to the agency despite joining DSHS during challenging times. We appreciate the candor and cooperation they have demonstrated to us in their first several months in office.

Along with the change in leadership, OFCO and DSHS entered into an unprecedented inter-agency agreement in November. This new protocol provides greater transparency in the work we do. It also makes DSHS more accountable by requiring the agency to respond to OFCO's findings and recommendations and provide action and implementation plans within specific timeframes.

On behalf of all of us at OFCO, thank you for taking an interest in the work we do and allowing us to give voice to the concerns of families and children across the state of Washington.

Sincerely,



Mary Meinig
Director Ombudsman

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Moses Lake

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Ellen Cady
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Greg Casey
Private Attorney,
Spokane

Patrick Donahue
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Court Appointed Special Advocate,
Spokane

Tara Dowd
The N.A.T.I.V.E. Project/Law Student,
Spokane

Art Harper
Foster Parent Liaison,
Spokane

Kim Kopf
Whitman County CASA,
Colfax

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Spokane

Heike Lake
Lutheran Community Services,
Spokane

*no longer on the Advisory Committee

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Senator Debbie Regala
27th District

Senator Val Stevens
39th District

Representative Ruth Kagi
32nd District

Representative Mary Helen Roberts
21st District

Representative Larry Haler
8th District

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. Ms. Meinig serves as the co-chair of the United States Ombudsman Association, Family and Children Chapter.

OMBUDSMAN

Colleen Hinton is a social worker with broad experience working with children and families. Prior to joining OFCO in 2000, she provided clinical assessments of children in foster care through the Foster Care Assessment Program, and provided training on child maltreatment to community professionals through Children's Response Center (within Harborview Medical Center. Prior to this work, Ms. Hinton helped to establish assessment and treatment services for abused children at Children's Advocacy Center of Manhattan, and worked as a therapist for the Homebuilders intensive family preservation program in King County. She 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.

OMBUDSMAN

Linda Mason Wilgis is a senior attorney who before joining OFCO in 2004 served as an Assistant Attorney General for the State of Washington. 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 law 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. Prior to joining OFCO in 2004, 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 received his MSW from the University of Washington. He is a Licensed Independent Clinical Social Worker.

OMBUDSMAN

Colleen Shea-Brown is a licensed attorney with experience representing parents and other relatives in dependency and termination of parental rights proceedings at Legal Services for New York's Bronx office. She received her law degree from New York University, where she participated in the school's Family Defense Clinic. Ms. Shea-Brown has also worked extensively with victims of domestic violence, advocated for women's rights in India, and served as a residential counselor for a women's shelter in Washington, D.C. Following law school, Ms. Shea-Brown served as a clerk to the Honorable Gabriel W. Gorenstein in the Southern District of New York.

OMBUDSMAN

Corey Fitzpatrick Wood is a licensed attorney with experience representing parents in dependency proceedings, as well as youth in truancy and at-risk youth proceedings. She received her law degree from the University of Washington, where she participated in the school's Children and Youth Advocacy Clinic. Ms. Wood has worked extensively with at-risk youth and currently serves as Board President for Street Youth Legal Advocates of Washington. Prior to law school, Ms. Wood worked for OFCO as an Information and Referral Specialist.

OMBUDSMAN

Megan Palchak first came to OFCO in 2003 as an Information and Referral Specialist/Office Administrator. She left to pursue a Masters degree in Policy Studies from the University of Washington, and soon returned as a Research Analyst to assist with special projects. After graduate school, Ms. Palchak spent a year promoting equity in education as a Communications and Research Specialist at the Governor's Office of the Education Ombudsman, the first state-level K-12 focused ombudsman in the nation. Prior to joining OFCO in 2003, Ms. Palchak worked to secure housing for youth exiting the foster care system. She also coordinated youth development programs in a low-income housing complex, in collaboration with local families, community professionals, educators, and youth.

SPECIAL PROJECTS/DATABASE COORDINATOR

Rachel Pigott holds a Dual Master's degree in Social Work and Education from Boston University. Before joining OFCO in 2005, she worked to improve school attendance by working with families through the Boston Public Schools. She spent a year in the AmeriCorps program working to strengthen families and to connect undergraduate students from Western Washington University to their community by coordinating service-learning projects. She was also a Program Specialist for the Boston Center for Adult Education.

INFORMATION SPECIALIST/OFFICE ADMINISTRATOR

Amy Johnson earned a Bachelor's degree in Communication and Sociology from Pacific Lutheran University. Prior to joining OFCO she worked as a Ticket Sales Coordinator for the Seattle Mariners. She also served as a case aide for DSHS Division of Children and Family Services in 2004. While attending PLU she completed an internship with the Prison Pet Partnership Program within the Washington Correctional Center for Women.

ACKNOWLEDGEMENT

I wish to acknowledge and thank the many people who generously contributed their time and effort over the past year in helping the Office of the Family and Children's Ombudsman (OFCO) complete the work that is reflected in this year's 2009 Annual Report.

Thank you to the community of Colville and the Legislature for bringing to our attention the issues affecting the child welfare system in the Colville area. The community has embraced the recommendations we made and is working hard alongside the Department of Social and Health Services (DSHS) to improve relationships and practice to keep children safe. Thanks also to the many community groups and stakeholders who responded to the recommendations and made helpful suggestions for reform.

The Washington State Institute for Public Policy was instrumental in providing critical analysis in OFCO's "*Patterns in Mandated Reporter Referrals, 2006-2008* report. Analyzing 96,000 referrals received by Child Protective Services is a daunting task and for that, I thank them.

A large piece of this annual report related to implementation of child fatality review recommendations. I want to acknowledge the hard work that DSHS CA does in reviewing these fatalities, which is draining and difficult work. I also want to thank the agency for its cooperation and candor in sharing its views on what is working and what needs improvement to better keep children safe.

Finally, I especially want to thank OFCO staff for their patience, diligence and hard work over the past year in serving complainants and other citizens who contact our office and in researching and writing this annual report. Coinciding with publication of this annual report is the departure of Ombudsman, Linda Mason Wilgis. Linda has been with OFCO for six years. Linda was highly adept at identifying systemic problems to the Legislature and Governor and providing a blunt assessment of necessary improvements. We wish her well as she leaves to join private practice.

Mary Meinig
Director Ombudsman

Tukwila, WA
December 31, 2009

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EXECUTIVE SUMMARY

In 1996, the Washington Legislature created the Office of the Family and Children's Ombudsman (OFCO). Chapter 43.06A RCW empowers the Ombudsman to investigate complaints from citizens involving children and families receiving child protection and child welfare services from a state agency, or any child reported to be at risk of abuse, neglect or other harm. The Legislature also directed the Ombudsman to identify deficiencies in the child welfare system and to make recommendations for improvement to the Governor and the Legislature.

Since 1997 when the office became operational, OFCO has served as a watchdog over the Department of Social and Health Services (DSHS), the main state agency that delivers child protection and welfare services. The Legislature and then Governor Mike Lowry recognized the need for an ombudsman in response to several high-profile incidents involving the safety of children in state care, including ongoing abuse at the OK Boy's Ranch and the death of 3-year-old Louria Grace who was killed by her mother while under state supervision.

THE ROLE OF THE OMBUDSMAN

OFCO is a small cabinet-level state agency located organizationally within the Office of the Governor. The Director Ombudsman reports directly to the Governor. Our agency is independent and separate from DSHS, the main agency whose actions OFCO investigates.

The Ombudsman focuses its resources – 8.5 full-time staff – on complaint investigations, complaint intervention and resolution, and systemic investigations and improvements. Each year we identify issues of concern and report on this, together with our recommendations for necessary change, in our annual report to the Governor, the Legislature and interested stakeholders.

One of OFCO's most important features is its independence. This is essential to OFCO maintaining its reputation for integrity and objectivity. OFCO exercises its independent judgment to determine whether to investigate a complaint and if there is a basis to intervene in a case when OFCO finds that DSHS has not complied with law, policy or procedure.

The Ombudsman acts as a **neutral investigator,** rather than as an advocate, for citizens who bring their complaints to our attention. This neutrality reinforces the credibility of the Ombudsman.

OFCO maintains the **confidentiality** of citizens who contact the Ombudsman to initiate a complaint investigation unless such confidentiality is waived by the citizen. This protection makes citizens, including professionals within DSHS, more likely to contact OFCO and to speak candidly with the Ombudsman about their concerns.

PROTOCOL FOR WORKING RELATIONSHIP BETWEEN OFCO AND DSHS

New this year is an unprecedented interagency agreement between OFCO and DSHS that provides greater transparency in the work of OFCO and DSHS and accountability by DSHS in responding to OFCO findings and recommendations. This went into effect in November 2009.[1] The agreement requires DSHS to provide a status report to OFCO on action plans and implementation plans no less than two times a year to be mutually agreed upon and calls for the department to respond to OFCO report findings and recommendations within 30 days of receiving them and develop an action plan and implementation plan. Prior to this, DSHS was not bound by specific timeframes and had no specific duty to provide OFCO with a status report on action plans and implementation plans.

NEW LEADERSHIP AT CHILDREN'S ADMINISTRATION

In May 2009, the Governor appointed Susan Dreyfus to assume leadership of DSHS. On September 16, 2009, Denise Revels Robinson was named as the new Assistant Secretary for Children's Administration (CA). Both came to Washington from the state of Wisconsin where they worked in the child welfare field. Ms. Dreyfus and Ms. Revels Robinson have brought new energy and excitement to the agency and OFCO has found them to be highly responsive to our agency in these initial months. We are encouraged by Secretary Dreyfus' emphasis on child safety first, her work to improve communication between OFCO and DSHS, and efforts to eliminate intra-divisional barriers within DSHS so that children and families may be better served.

INQUIRIES AND COMPLAINT INVESTIGATION

The Ombudsman responds to the needs of citizens by listening to their concerns, educating them about the child welfare process and either investigating their complaint or referring them to appropriate resources to assist them if a particular issue falls outside the scope of OFCO's jurisdiction. Complaints come from a broad variety of citizens across the state, spanning the six regions over which DSHS conducts its work.

OFCO's reporting year runs from September 1 to August 31. Between September 1, 2008, and August 31, 2009, the Ombudsman received **963** inquiries from citizens who needed information and/or referrals to other resources. Over this time period, the Ombudsman received **728** complaints and completed investigations of **698** complaints. This represents the largest number of complaints investigated by OFCO in a reporting year.[2] In 2009, the greatest number of complaints came from Region 3. The least were from Region 2**.**

The majority of completed investigations were standard, non-emergent investigations. Seventeen percent, or **116** out of **698** complaints, met the Ombudsman criteria for an emergent complaint. These usually involved issues of imminent child safety or well being.

As is typical in other years, the Ombudsman heard most frequently from parents and other family members. Consistent with the historical trend in our office, the top two issues citizens complained to the Ombudsman about were child safety (alleging that the agency did not

[1] It is available on the OFCO Web site at http://www.governor.wa.gov/ofco/interagency_ofco_dshs.pdf
[2] In 2008, OFCO investigated 627 complaints.

respond adequately to reported maltreatment of a child), and family separation and reunification.

OMBUDSMAN IN ACTION

The annual report describes four main categories of Ombudsman action known as "interventions:" inducing corrective action, facilitating resolution, assisting the agency in avoiding errors and conducting better practice, and preventing future mistakes. Our rate of intervention **decreased somewhat in 2009, to 8 percent of complaints – continuing a trend of slight decreases** in the last 3 years (OFCO intervened in 12 percent and 10 percent of complaints in 2007 and 2008 respectively). These interventions **resulted in the complaint issue being resolved in the vast majority of complaints (90 percent).**

This year OFCO added a new category, known as "Ombudsman Assistance," to better capture the results of our investigations and our role in resolving complaints. This category is different from interventions in that the Ombudsman did not necessarily find a violation of law or policy, or a clearly unreasonable action or decision on the part of the agency, but the complaint had validity and warranted Ombudsman's assistance. In 2009, **5 percent of complaints were resolved by the Ombudsman in this manner;** for example, by ensuring that critical information was obtained and considered by the agency, by facilitating timely communication among parties to resolve the problem, or by mediating a compromise.

One in five investigations (20 percent) resulted in an adverse finding against the agency in 2009. Adverse findings fell into three broad categories: the agency violated a law, policy, or procedure; the agency's action or inaction was clearly unreasonable under the circumstances; or actual or potential harm to the child or family had occurred as a result of poor practice on the part of the agency. Most frequently, adverse findings related to child safety issues.

CA launched its much-anticipated new statewide automated child welfare information system – FamLink – in late January 2009. The Ombudsman investigated and made adverse findings in 11 formal complaints received about issues related to FamLink, most involving long delays in foster care payments.

REVIEW OF FATALITIES AND NEAR FATALITIES

The Ombudsman receives notice from DSHS on every fatality and near fatality within the state known to DSHS. This information sharing is a critical step in the Ombudsman's review of cases. OFCO reviews all child fatalities that meet the criteria of children who have been in the care of or receiving child welfare services from the department at the time of or within one year of the child's death, including children who died while in licensed care, *regardless of whether the death was expected.* This report presents data on child fatalities between 2004 and 2008 whose family had an open case with DSHS at the time of death or within a year of the child's death. In 2004, there were 87 such deaths; 71 in 2005; 63 in 2006; 67 in 2007; and 98 in 2008. Data from 2009 is not yet finalized.

EXPANSION OF OMBUDSMAN'S DUTIES

In this reporting year, OFCO's duties have grown as a result of new law. In the 2008 Legislative Session, 2SSB 6206 was enacted. It expanded the duties of OFCO in three important respects:

1. It required OFCO to issue an annual report to the Legislature on the status of the implementation of DSHS's child fatality review recommendations;
2. It required DSHS to notify OFCO if a report of alleged abuse or neglect is founded and constitutes the third founded report received by DSHS within the last 12 months involving the same child or family; and
3. It required OFCO to analyze a random sampling of referrals made by mandated reporters during 2006 and 2007 and report to the Legislature on these referrals, their disposition, any patterns established by DSHS in how the agency responded to such referrals and whether fatalities over this time period involved referrals by mandated reporters.

These provisions reflect recommendations OFCO made to the Legislature that DSHS should pay closer attention to referrals from mandated reporters, improve tracking and implementation of child fatality review recommendations and increase scrutiny of families with chronic referrals. OFCO's fulfillment of these legislative mandates is discussed below under "**Completed Projects in this Reporting Year."**

COMPLETED PROJECTS IN THIS REPORTING YEAR

Colville Report. In June 2008, Robin Arnold-Williams, secretary of DSHS, contacted the Ombudsman regarding child welfare and protection practices and procedures at the Colville Division of Children and Family Services (DCFS). Ms. Arnold-Williams requested that the Ombudsman conduct a review of this office after having been contacted by Joel Kretz, State Representative for the 7th legislative district (includes Colville) with concerns about agency practice in this area. This investigation was completed and OFCO's investigative report, entitled "*Loss of Trust: A Crisis of Confidence in the Child Welfare System in Colville,"* was released in May 2009.[3] In response to OFCO's Colville report, DSHS CA Colville DCFS released 30-day and 60-day corrective action plans. A summary of the report and the agency's response is included in this annual report. *We found child welfare cases in which DCFS did not comply with law or policy, but perhaps even more challenging to address, our investigation revealed a culture of pervasive distrust between parties and stakeholders, poor communication and a lack of collaboration among professionals which infects day-to-day decision making and case planning for dependent children. This culture leads to unnecessary placement changes, delays in permanence for children and ultimately, actions or inaction that put children and families at risk of harm.* **In response to OFCO's report, then interim secretary of CA stated on May 21, 2009, *"We are taking action immediately to improve the practice of the Colville office and reaching out to community partners to better serve the children and families in the area."* DSHS has since issued 30-day and 60-day corrective action plans and a progress report in September 2009.** OFCO will continue to monitor progress. In the meantime, complaints to OFCO from the Colville area are declining.

[3] The Colville report and response of DSHS CA are available at http://www.governor.wa.gov/ofco/reports/colville_investigation_2009.pdf

Patterns in Mandated Reporter Referrals. In July 2009, OFCO released its report, *"Patterns in Mandated Reporter Referrals 2006-2008."* This report was in response to 2SSB 6206, which required that OFCO analyze and report on a random sampling of child abuse and neglect referrals made by mandated reporters to DSHS CA during 2006 and 2007. This report grew out of OFCO and the Legislature's interest in further study of DSHS CA's screening and investigation of Child Protective Services (CPS) referrals. OFCO contracted with the Washington State Institute for Public Policy (WSIPP) to examine whether the source of the referral influenced the response by CPS.[4] A summary of the report is included in this annual report. ***OFCO found that most child deaths were preceded by a referral from a mandated reporter and almost half of the children who died were infants less than 1 year old. WSIPP found that the biggest variation in referral outcome was determined by DSHS region and the history of the individual intake worker, rather than by type of reporter.***

Status of Implementation of Child Fatality Review Recommendations. Included in this annual report is OFCO's report to the Legislature on the status of the implementation of child fatality review recommendations. This was another requirement of 2SSB 6206. This report has four sections:

1. A discussion of law, policy and practice changes that have been implemented in the aftermath of child fatality review recommendations made by OFCO;
2. Data on the status of child fatality review recommendations (approximately 400 recommendations) issued from child fatality review teams convened by DSHS CA as self reported by each of the six regions. OFCO analyzed DSHS CA's reported actions to determine where implementation effort was evident, and to what degree (partial, complete);
3. DSHS CA's categorization of 2005 to 2008 child fatality review recommendations into five subject areas with a description of the agency's implementation activities; and
4. A discussion of barriers to implementation of child fatality recommendations as identified by OFCO (based in part on interviews with each of the six DSHS CA regions) and recommendations for improvement. 2SSB 6206 requires OFCO to continue to report on implementation of child fatality review recommendations annually.

Three Founded Reports within a Year. In 2008, the Legislature enacted law that requires DSHS to notify OFCO of a report of alleged abuse or neglect that is founded and constitutes the third founded report received by DSHS within the last 12 months involving the same child or family. Although this new law does not require OFCO to report specifically on these cases, OFCO viewed this as an opportunity to look at the issues of recurrence and chronicity and to educate stakeholders and the public. We have presented the results of our analysis in this annual report. This is now an ongoing project.

[4] OFCO's report on Mandated Reporter Referrals is available at http://www.governor.wa.gov/ofco/reports/mandated_reporter_referrals_2006_08.pdf

LEGISLATIVE UPDATE

As part of the Ombudsman's duty to recommend systemic change, the Ombudsman reviews and analyzes proposed legislation and testifies before the Legislature on pending bills. This section provides a highlight of those bills on which OFCO provided testimony or those which impact OFCO directly.

APPENDICES

Among the appendices are: letter from CA regarding implementation of DSHS CA review recommendations per 2SSB 6206; supervisor review of case closure or transfer; and fatality grid.

TERMS AND ACRONYMS

Dependent Child	A child for whom the state is acting as the legal parent.
AIRS	Administrative Incident Reporting System
ARS	Alternative Response System
ARY	At Risk Youth
CA	Children's Administration
CAMIS	Children's Administration Care Management Systems
CA/N	Child Abuse and Neglect
CDR	Child Death Review
CFR	Child Fatality Review
CHINS	Child in Need of Services
COA	Council on Accreditation of Services for Families and Children
CPS	Child Protective Services
CPT	Child Protection Team
CWS	Child Welfare Services
DCFS	Division of Children and Family Services
DDD	Division of Developmental Disabilities
DOH	Department of Health
DLR	Division of Licensed Resources
DMH	Division of Mental Health
DSHS	Department of Social and Health Services
ECFR	Executive Child Fatality Review
EFSS	Early Family Support Services
FRS	Family Reconciliation Services
FVS	Family Voluntary Services
OFCO	Office of the Family and Children's Ombudsman
SDM	Structured Decision Making
VSA	Voluntary Service Agreement

ROLE OF THE OMBUDSMAN

The Washington Legislature created OFCO in 1996, in response to two high-profile incidents that illuminated the need for oversight of the child welfare system: the death of 3-year-old Louria Grace, who was killed by her mother while under the supervision of DSHS; and the discovery of years of youth-on-youth sexual abuse at the DSHS-licensed OK Boys Ranch. The establishment of the office also coincided with growing concerns about DSHS' participation in the Wenatchee child sexual abuse investigations. In these instances, 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. The Legislature also authorized the Ombudsman to intervene to induce DSHS to reconsider or change problematic decisions that are in violation of the law or that have placed a child or family at risk of harm, and charged the Ombudsman with the mission of recommending system-wide improvements to the Legislature and the Governor.

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

One of the Ombudsman's most important features is its independence. The ability of OFCO to review and analyze complaints free of political bias and influence allows the office to maintain its reputation for integrity and objectivity. The Ombudsman is located in Tukwila and although it comes under the Office of the Governor, it conducts its operations independently of the Governor's Office in Olympia. OFCO is a separate agency from DSHS.

IMPARTIALITY

The Ombudsman acts as a **neutral investigator** of complaints, rather than as an advocate for citizens who bring their complaints to our attention, or for the governmental agencies investigated. This neutrality reinforces the credibility of the Ombudsman.

CONFIDENTIALITY

OFCO maintains the **confidentiality** of citizens who contact the Ombudsman to initiate a complaint investigation unless such confidentiality is waived by the citizen. This protection makes citizens, including professionals within DSHS, more likely to contact OFCO and to speak candidly with the Ombudsman about their concerns.

CREDIBLE REVIEW PROCESS

OFCO has **a credible review process** that promotes respect and confidence in OFCO's oversight of DSHS. Ombudsmen are qualified to analyze issues and conduct investigations into matters of law, administration and policy. We have collective experience and expertise in child welfare law, social work, mediation and clinical practice, and are trained in the United States Ombudsman Association Governmental Ombudsman Standards.

In November 2009, OFCO and DSHS entered into an unprecedented interagency agreement to improve communication and bring greater clarity to the working relationship between the two agencies.[1]

AUTHORITY

Under chapter 43.06A RCW, the Legislature enhanced the Ombudsman's investigative powers by providing it with broad access to confidential DSHS records and the agency's computerized case-management system. It also authorized OFCO to receive confidential information from other agencies and service providers, including mental health professionals, guardians ad litem and assistant attorneys general (AAGs). The Ombudsman operates under a shield law which allows OFCO to protect the confidentiality of the Ombudsman's investigative records and the identities of individuals who contact the office. This encourages individuals to come forward with information and concerns without fear of possible retaliation by others.

The Ombudsman publishes its investigative findings and recommendations to improve the child welfare system in public reports to the Governor and Legislature. This is an effective tool for educating legislators and other policy makers about the need to make, change or set aside laws, policies or agency practices so that children are better protected and cared for within the child welfare system.

The Ombudsman derives influence from its close proximity to the Governor and Legislature. The Ombudsman director is appointed by and reports directly to the Governor. The appointment is subject to confirmation by the Washington State Senate. The Ombudsman director serves a three-year term and continues to serve in this role until a successor is appointed. 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.

[1] The interagency agreement is available at http://www.governor.wa.gov/ofco

- **Responding to Complaints.** The Ombudsman impartially investigates and analyzes complaints against DSHS and other agencies. We spend more time on this activity than any other. 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 support actions of the agency when it is unfairly criticized for properly carrying out its duties.
- **Taking Action on Behalf of Children and Families.** The Ombudsman intervenes when 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 investigative findings and analyses 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 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 – 8.5 full-time employees (FTEs) and a biennial budget of approximately $1.5 million – to perform these activities.[*] The Ombudsman's work activities are described in more detail in the sections that follow.

[*]In the 2007-09 biennium, the Legislature appropriated resources necessary to fulfill OFCO's additional duties under newly enacted 2SSB 6206, concerning DSHS reviews and reports on child abuse, neglect and near fatalities. This appropriation increased OFCO's biennial budget to approximately $1.5 million and added two full-time employees.

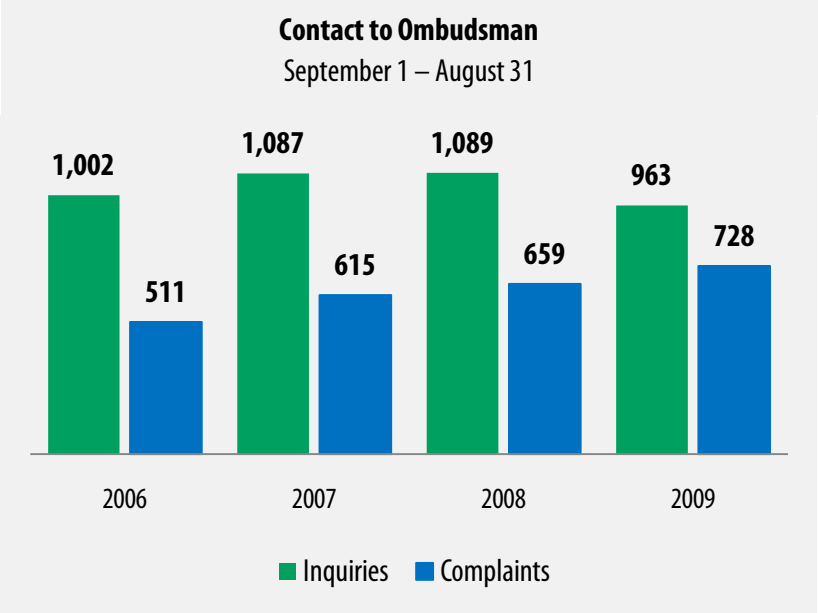
INQUIRY AND COMPLAINT PROFILES

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 Ombudsman's 2009 reporting year.[1] Data from previous reporting years is included for comparison.

CONTACTS TO OMBUDSMAN

Families and citizens contacted the Ombudsman **1,691** times in 2009. These contacts were **inquiries** made by people seeking information. Approximately 43 percent of these contacts were formal complaints seeking an Ombudsman investigation.



Source: Office of the Family and Children's Ombudsman, October 2009

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

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

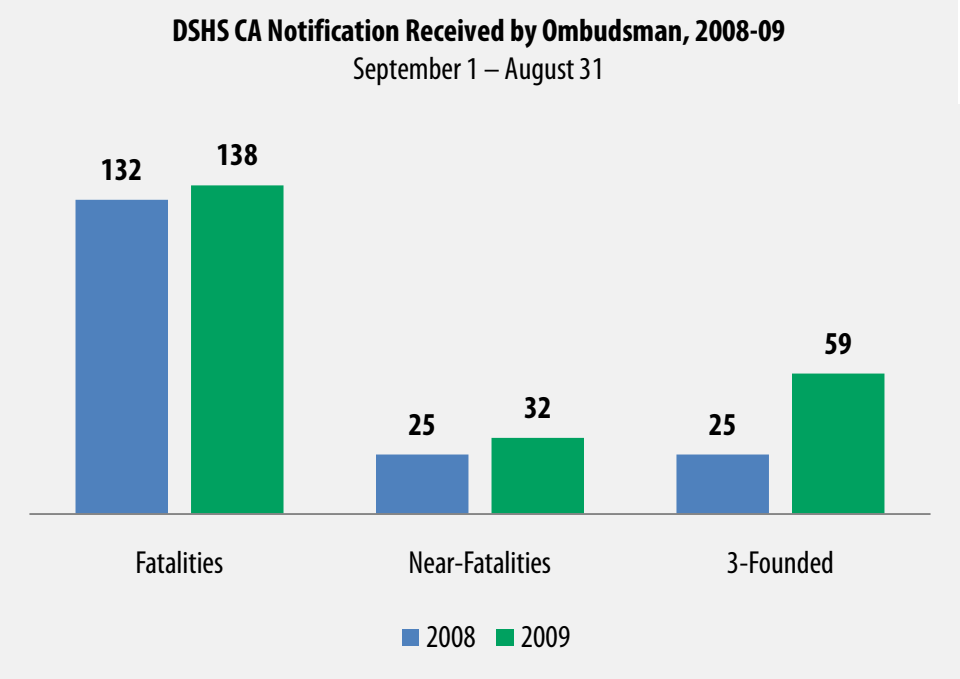
COMPLAINTS. Persons file a complaint with the Ombudsman when they have a specific complaint against the Department of Social and Health Services (DSHS) or other agency that they want the office to investigate. The Ombudsman reviews every complaint that is within its jurisdiction.

[1] The Ombudsman's annual reporting period is September 1 to August 31.

MANDATED NOTIFICATION RECEIVED

Effective June 2008, the Department of Social and Health Services, Children's Administration (DSHS CA) is required to notify OFCO regarding child fatalities, near child fatalities and cases in which there has been a third founded report of child abuse or neglect regarding the same child or family within a one-year period. The graph below describes the number of DSHS CA notifiers received and reviewed by OFCO during the previous reporting period.

Please note that OFCO typically reports child fatalities reviewed based on the calendar year, the graph below reports fatalities based on OFCO's reporting year to describe the increased workload since June 2008. Not all notification of near-fatalities and fatalities are included in OFCO's fatality report.



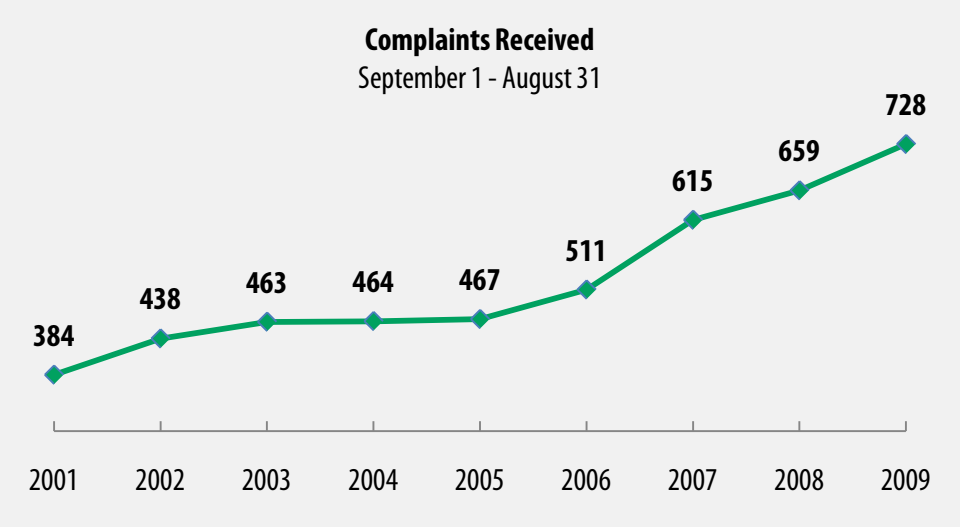
Source: Office of the Family and Children's Ombudsman, October 2009

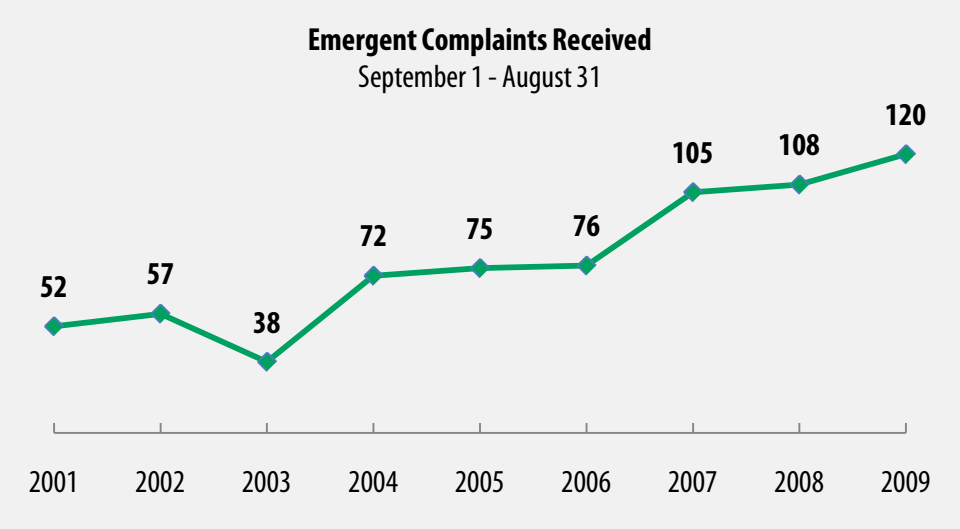
COMPLAINTS HAVE INCREASED

A complaint to the Ombudsman must involve an act or omission by DSHS or other state agency that affects:

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

The graphs below describe the increase in total and emergent complaints since 2001. The Ombudsman received 728 complaints in 2009, an increase of 10 percent over 2008. Total complaints to the Ombudsman have increased by 42 percent since 2006. The Ombudsman received 120 emergent complaints in 2009, an increase of 11 percent over 2008. Emergent complaints most often involved child safety or where timely intervention by the Ombudsman could make a significant difference to a child or family's immediate well-being. Emergent complaints have increased 58 percent since 2006.





Source: Office of the Family and Children's Ombudsman, October 2009

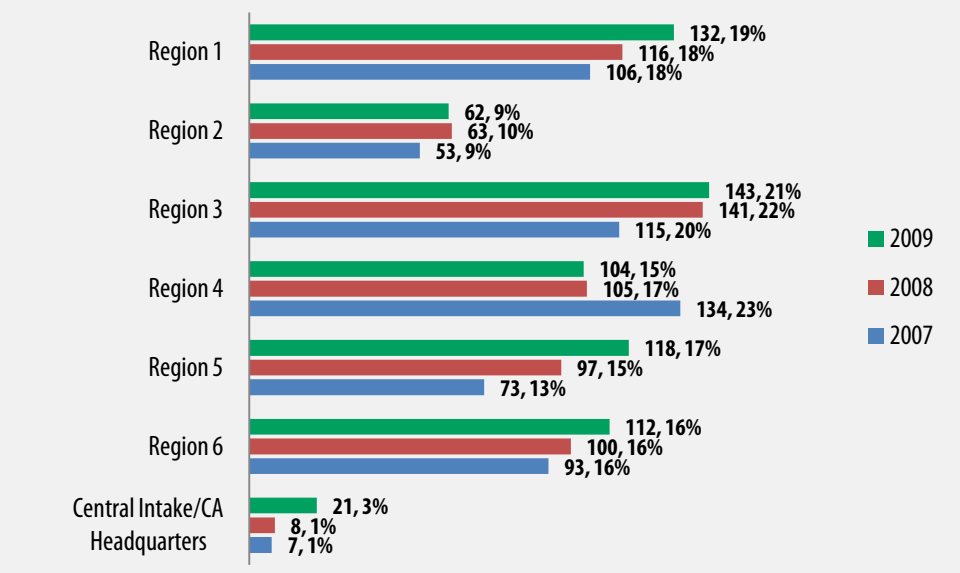
DSHS Regions and Divisions Identified in Complaints

DSHS CA is the state's largest provider of child protection and child welfare services. It is therefore not surprising that the CA was the subject of 95 percent of complaints in 2009.[2]

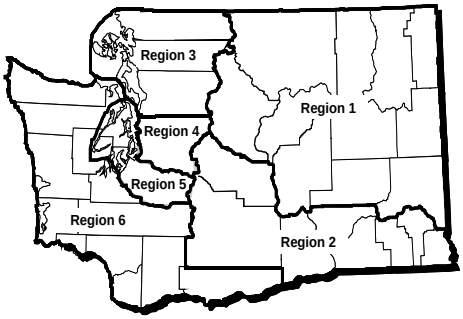
Of the complaints against the CA, 98 percent were directed at DCFS, which includes CPS, Child Welfare and Adoption Services, and Family Reconciliation Services (FRS). A small percentage (2 percent) involved the Division of Licensed Resources (DLR), which licenses and investigates alleged child maltreatment in foster homes, group homes and other residential facilities for children.

During the 2009 reporting year, complaints increased from all regions, except region 2. The largest increase came from Region 5 and CA Headquarters.

Complaints against the Children's Administration by DSHS Region



Source: Office of the Family and Children's Ombudsman, October 2009



Regional Offices	*Population*[3]	*Clients served by Children's Administration*[3]
Region 1 – Spokane	850,635	29,146
Region 2 – Yakima	591,511	22,738
Region 3 – Everett	1,094,902	33,961
Region 4 – Seattle	1,875,519	39,224
Region 5 – Tacoma	1,025,408	31,816
Region 6 – Vancouver	1,111,249	37,208

[2] The remaining complaints were directed against other DSHS divisions (such as Developmental Disabilities [DD] and Mental Health [MH]), Washington Courts, local Court Appointed Special Advocate (CASA)/Guardian Ad Litem (GAL) programs, DSHS contract providers and tribal welfare services.

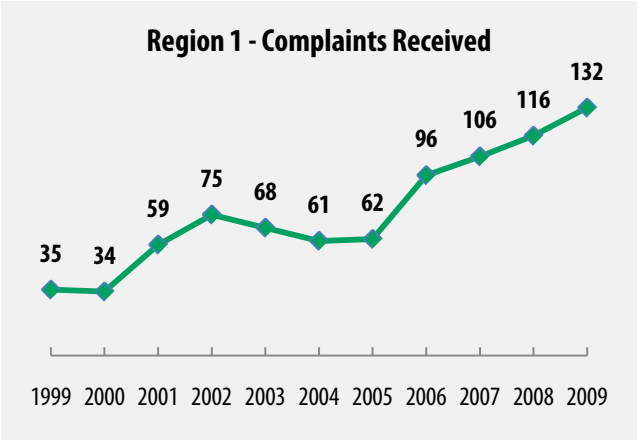
[3] DSHS RDA http://clientdata.rda.dshs.wa.gov/2007/

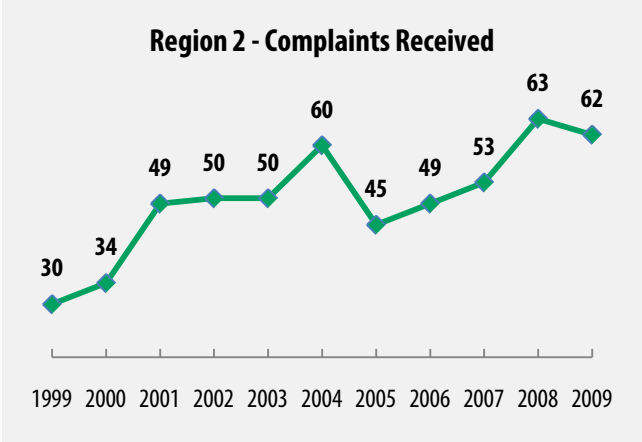
COMPLAINTS BY DSHS REGION

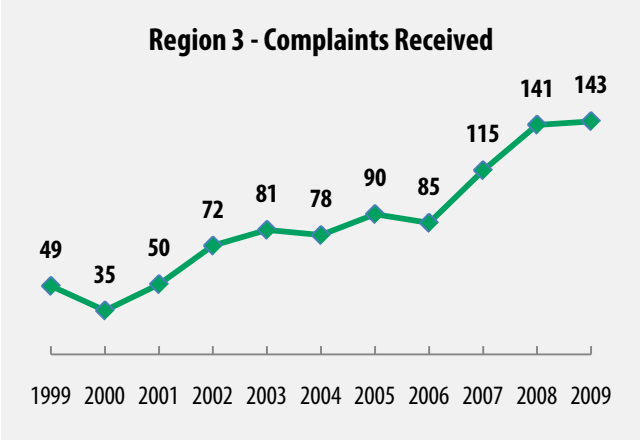
	2008		2009	
	DCFS	DLR	DCFS	DLR
Region 1 Totals	**115**	**1**	**131**	**1**
Spokane	54	1	81	
Colville	23		16	1
Moses Lake	20		17	
Wenatchee	8		6	
Colfax	4		2	
Newport	3		3	
Omak	1		5	
Republic	1		0	
Clarkston	1		1	
Region 2 Total	**62**	**1**	**59**	**3**
Yakima	20	1	17	3
Richland/ Tri-Cities	16		20	
Walla Walla	16		6	
Toppenish	7		4	
Ellensburg	3		6	
Sunnyside	0		5	
White Salmon	0		1	
Region 3 Total	**137**	**4**	**140**	**3**
Everett	39	3	45	3
Bellingham	31		17	
Alderwood/ Lynnwood	20		11	
Arlington/ Smokey Point	16	1	26	
Mount Vernon	15		15	
Monroe/Sky Valley	9		15	
Oak Harbor	7		9	
Friday Harbor	0		2	

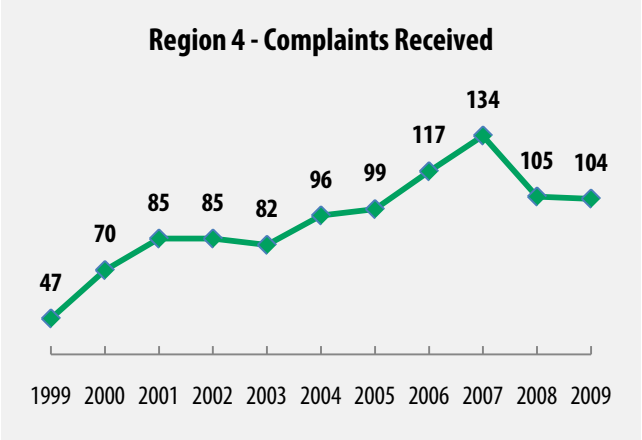
	2008		2009	
	DCFS	DLR	DCFS	DLR
Region 4 Total	**98**	**7**	**101**	**3**
King South/Kent	25	2	16	
Martin Luther King Jr. Office	18		29	
King West	17	1	24	
King East/Bellevue	16		13	
Office of Indian Child Welfare	14		6	
Seattle Centralized Services	3		4	
White Center	3		1	
Seattle Central	2	4	8	3
Region 5 Total	**93**	**4**	**114**	**4**
Tacoma	71	3	90	4
Bremerton/Kitsap	22	1	24	
Region 6 Total	**96**	**4**	**110**	**2**
Vancouver	33	4	31	
Aberdeen	16		11	
Port Angeles	9		9	
Centralia	7		5	
Tumwater	7		10	
Kelso	7		11	
Shelton	6		3	1
Stevenson	3		5	
Lacey/Olympia	3		11	1
South Bend	3		4	
Long Beach	1		0	
Port Townsend	1		8	
Forks	0		2	
Statewide	**8**		**21**	
Children's Administration Headquarters	6		20	
Central Intake	2		1	

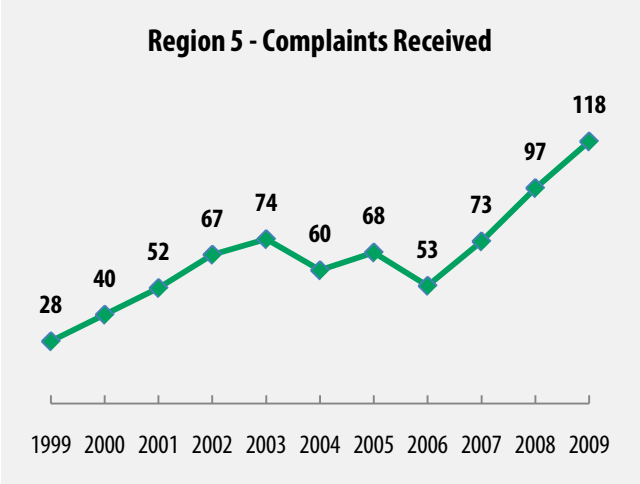
COMPLAINTS RECEIVED 1999-09

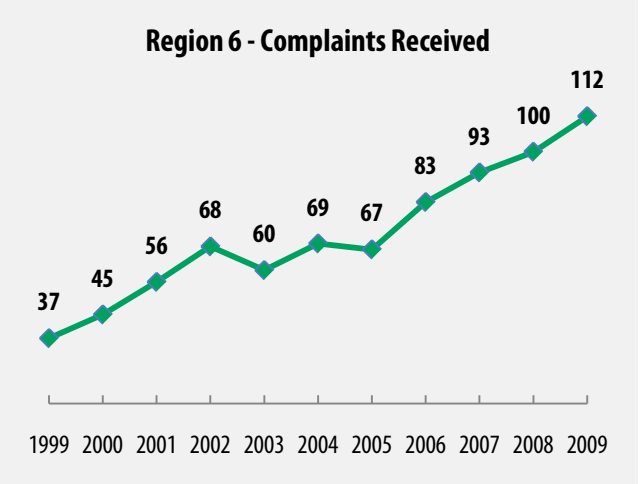










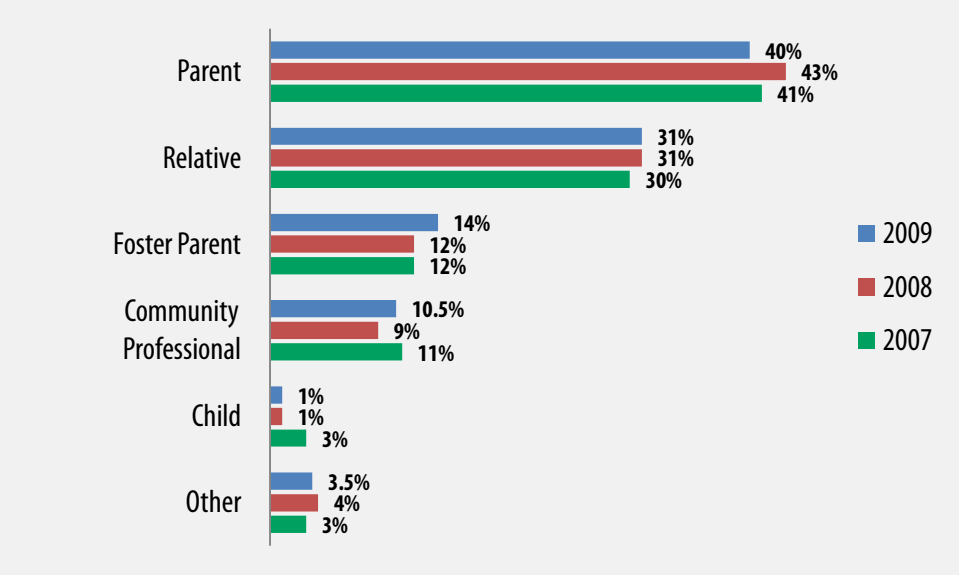


Source: Office of the Family and Children's Ombudsman, October 2009

COMPLAINANT PROFILES

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. We continue to have few children contacting the Ombudsman directly on their own behalf.



Source: Office of the Family and Children's Ombudsman, October 2009

RACE/ETHNICITY OF THE PERSON WHO COMPLAINED

OFCO's complaint form has an optional question asking complainants to identify their race or ethnicity, for the purposes of tracking whether the office is adequately serving and representing all Washington citizens. We include this data here to show which sectors of the community we are reaching and where we need to improve our outreach.

Race/Ethnicity	OFCO 2007*	OFCO 2008*	OFCO 2009*	WA State Census**
Caucasian	80.2%	80.1%	81.2%	84.3%
African American	11.5%	9.7%	8.9%	3.7%
American Indian/Alaska Native	8.5%	6.7%	5.4%	1.7%
Hispanic	2.8%	5.0%	5.9%	9.8%
Asian/Pacific Islander	0.8%	1.8%	2.1%	6.7%
Other	0.5%	1.5%	1.2%	--
Multi-Racial	4.4%	5.5%	5.8%	3.1%
Declined to Answer	2.9%	5.6%	4.5%	--

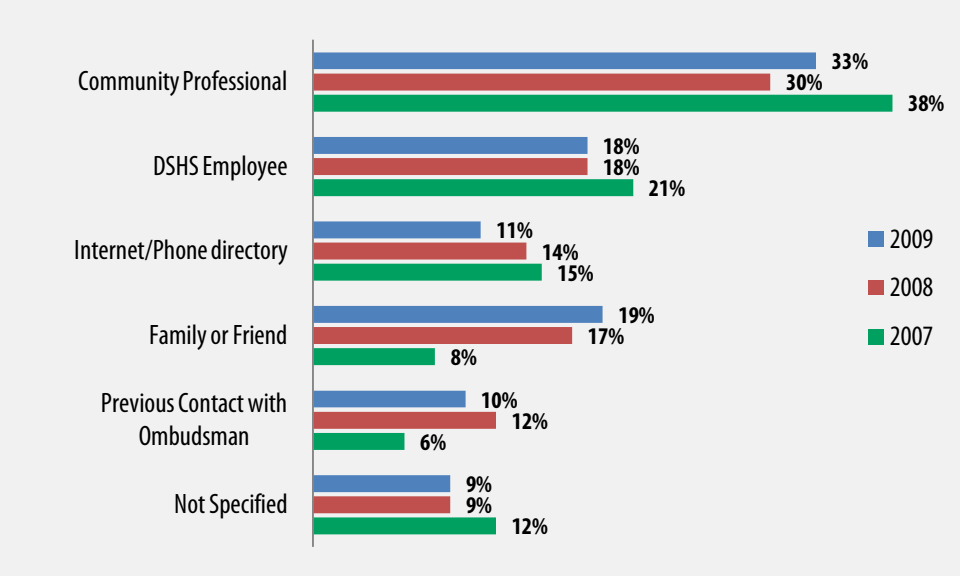
*Data adds up to over 100 percent because our complaint form allows people to select more than one race/ethnicity.
**Taken from US Census 2008 estimates at http://quickfacts.census.gov/qfd/states/53000.html.

As the table above shows, African Americans and American Indians are over-represented in complaints made to OFCO as compared with their representation in state population data,

while Hispanics and Asians are under-represented. OFCO may need to strengthen outreach efforts to Hispanic and Asian population groups. However, when racial data of children who were the subject of our complaints is compared with the population of children served by the CA, OFCO appears to be evenly representing children in the child welfare system.

HOW THEY HEARD ABOUT THE OMBUDSMAN

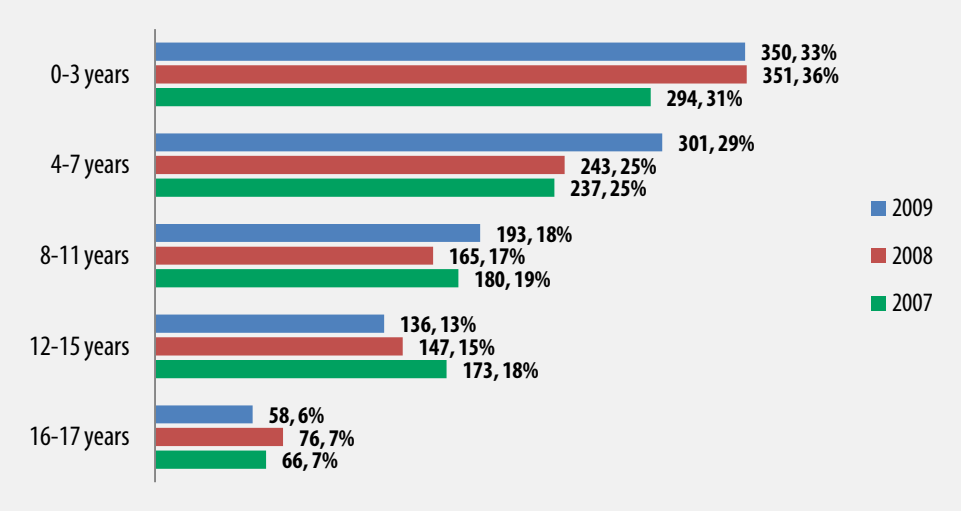
The majority of individuals filing complaints with the Ombudsman indicated that they were referred to the office by someone else. Many individuals reported that they were referred by a **community professional/service provider** (e.g., teacher, counselor, child care provider, doctor, private agency social worker, mental health professional, attorney, CASA/GAL, legislator's office) or **DSHS worker.** A growing number of individuals were referred by a **friend or family member**. Other individuals had **previous contact** with the Ombudsman or stated they found the office via the **Ombudsman Website or telephone directory**. The remaining complainants did not specify how they heard about the Ombudsman.



Source: Office of the Family and Children's Ombudsman, October 2009

AGE OF CHILDREN IDENTIFIED IN COMPLAINTS

As in previous years, most of the children identified in complaints to the Ombudsman were age 7 or younger. Older adolescents continue to be identified in much smaller numbers.



Source: Office of the Family and Children's Ombudsman, October 2009

Note: Some children were counted more than once because they were identified in more than one complaint.
Note: 1 percent of children were 18 years or older in 2009.

RACE/ETHNICITY OF CHILDREN IDENTIFIED IN COMPLAINTS

Because children may be identified with more than one race, it is difficult to accurately measure whether OFCO is representing children of various races proportionately as compared with their representation in the general state population and in the total number of children in placement (as indicated in the table below). However, it does appear that Caucasian and African American children are over-represented in complaints to the Ombudsman, while all other groups are fairly evenly represented. When these figures are compared with the general child population, both children in placement and children who are the subject of complaints to the Ombudsman are greatly over-represented in the African American and American Indian population groups.

Race/Ethnicity	OFCO 2007*	OFCO 2008*	OFCO 2009*	Children's Administration**	WA Population**
Caucasian	76.8%	80.8%	78.8%	60.6%	80.9%
African American	20.0%	17.2%	15.8%	10.1%	4.6%
American Indian/Alaska Native	11.1%	11.3%	12%	12.2%	2.0%
Hispanic	8.7%	12.5%	11.9%	14.4%	14.6%
Asian/Pacific Islander	1.4%	3.5%	4.7%	1.5%	6.8%
Other	1.6%	2.7%	2.0%	3.5%	0%
Multi-Racial	11.4%	15.5%	14.3%	10.7%	6.0%
Declined to Answer	0.5%	0.1%		1.6%	

*Data adds up to over 100 percent because people may self-report more than one race.
**Race of children in placement, taken from Children's Administration Performance Report 2007
http://www1.dshs.wa.gov/pdf/ca/07Report2Intro.pdf

COMPLAINT ISSUES

FREQUENTLY IDENTIFIED COMPLAINT ISSUES[5]

ISSUE	NUMBER OF COMPLAINTS		
	2007	2008	2009
CHILD SAFETY	211	250	247
Failure to protect children from parental abuse or neglect	**122**	**138**	**144**
Physical abuse	37	48	45
Sexual abuse	22	24	27
Emotional abuse	8	13	15
Neglect/lack of supervision	50	53	52
Other	5	0	5
Developmentally disabled child in need of protection	**2**	**2**	**2**
Children with no parent willing/capable of providing care	**18**	**17**	**14**
Failure to address safety concerns involving dependent child in foster care or other substitute care	**58**	**76**	**60**
Failure to address safety concerns involving child being returned to parental care	**11**	**17**	**26**
Safety of children in institutions	**0**	**0**	**1**
DEPENDENT CHILD HEALTH, WELL-BEING AND PERMANENCY	134	165	167
Inappropriate change of child's placement, inadequate transition to new placement	**43**	**45**	**59**
Failure to provide child with medical, mental health, educational or other services, or inadequate service plan	**43**	**52**	**41**
Unreasonable delay in achieving permanency	**--**[7]	**--**	**3**
Inappropriate permanency plan	**33**	**47**	**40**
ICPC[6] issues	**--**[8]	**--**	**1**
Inadequate transition to independent living	**--**[9]	**--**	**3**
Failure to provide appropriate adoption support services/other adoption issues	**7**	**14**	**16**
Inadequate services to dependent/non-dependent children in institutions and facilities	**8**	**7**	**14**

[5] Note that many complaints identified more than one issue.
[6] Interstate Compact on the Placement of Children
[7] Numbers for this category were added to numbers for "inappropriate permanency plan" in 2007 and 2008.
[8] These numbers were not separately tracked in 2007 and 2008.
[9] These numbers were not separately tracked in 2007 and 2008.

ISSUE	NUMBER OF COMPLAINTS		
	2007	2008	2009
FAMILY SEPARATION AND REUNIFICATION	224	309	329
Unnecessary removal of child from parental care	40	40	57
Unnecessary removal of child from relative placement	9	28	28
Failure to place child with relative (including siblings)	54	68	62
Failure to place child with other parent	--[10]	--	3
Other inappropriate placement of child	19	22	34
Failure to provide appropriate contact between child and parent/other family members (excluding siblings)	41	43	44
Failure to provide contact with siblings	--[11]	--	2
Failure to reunite family	51	86	81
Inappropriate termination of parental rights	6	5	5
Concerns regarding voluntary placement and/or service agreements for non-dependent children	2	10	6
Other family separation concerns	2	7	7
COMPLAINTS ABOUT AGENCY SERVICES	13	19	51
Inadequate CPS investigation	0	7	1
Failure to screen in CPS referral	1	3	--
Delay in completing CPS investigation	0	3	4
Unreasonable CPS findings	--	--	31
Failure to notify subject of CPS investigation of CPS findings	2	3	--
Heavy-handedness by CPS worker/unreasonable demands on family	10	3	8
Poor case management, high caseworker turnover, other poor service issues	--[12]	--	7

[10] Not separately tracked in 2007 and 2008.
[11] Not separately tracked in 2007 and 2008.
[12] Not tracked separately in 2007-2008.

ISSUE	NUMBER OF COMPLAINTS		
	2007	2008	2009
OTHER COMMON COMPLAINT ISSUES	**76**	**100**	**110**
Foster parent retaliation	**5**	**6**	**2**
Foster care licensing issues	**--**	**--**	**5**
Lack of support/services to foster parent/other foster parent issues	**16**[14]	**15**	**15**
Retaliation against relative caregiver	**--**[15]	**--**	**2**
Lack of support/services to relative caregiver/other relative caregiver issues	**1**	**4**	**7**
Breach of confidentiality by agency	**3**	**7**	**10**
Unprofessional conduct, harassment, retaliation or discrimination by agency staff	**15**	**9**	**10**
Children's legal issues	**9**	**4**	**1**
Violation of parent's rights	**--**[16]	**--**	**10**
Failure to provide parent with services/other parent issues	**22**	**39**	**11**
Communication failures	**5**	**16**	**7**
FamLink[13]-related issues (mostly delay in payment to foster parents/providers)	**--**	**--**	**12**
Inaccurate agency records	**--**	**--**	**8**

The above table shows the number of times various issues within these categories were identified in complaints.[17] New issue categories were added to the table since last year, and some issue categories were split out and reported separately for enhanced accuracy. As in previous years, issues involving the **separation and reunification of families** (raised in **329** complaints) and the **safety of children living at home or in substitute care** (raised in **247** complaints), were by far the most frequently identified issues in complaints to the Ombudsman. While *child safety* issues were complained about at much the same rate in 2008 and 2009, *family separation* issues **increased slightly in** 2009. Concerns about *children being returned to parental care unsafely* increased by about one-third between 2008 and 2009, while the *safety of children in out-of-home care* was complained about less frequently (a decrease of about 25 percent).

Complaints about family separation and reunification remained similar to 2008 in all categories except for an **increase of almost one-third** in complaints about **unnecessary removal of children from parental care** and **inappropriate placement of dependent children.** Concerns about **children not being placed with a relative or sibling** decreased

[13]FamLink is CA's new computerized database introduced in late January 2009.
[14]This number represented licensing and other foster parent issues in 2007 and 2008.
[15]Not tracked in 2007 and 2009
[16]This category was reported together with the next category in 2007 and 2008.
[17]Many complainants express multiple complex issues, however only the most primary complaint issues are documented in the Ombudsman's complaint tracking database, and reported in the "frequently identified issues" table in this report. Anecdotally, complainants often express concerns about communication failures, unprofessional conduct, retaliation, and inadequate or delayed services.

slightly in 2009, while complaints about **services to parents and violations of parents' rights** decreased by more than one-third between 2008 and 2009.

Also as in previous years, the **welfare and permanency of dependent children** remained our third-highest category of complaints (**167** complaints), and numbers remained similar to last year. Complaints about **inappropriate permanency plans decreased** somewhat, while concerns about **inappropriate changes in placement** or **lack of transition** to new placements **increased by about a quarter**. In 2009, OFCO started tracking complaints about inadequate transition of youth to independent living from foster care.

Patterns or trends in other complaint issues are difficult to identify given their relatively small numbers, but some numbers stand out. Complaints about foster parent retaliation doubled (from six complaints in 2008 to 12 in 2009).[18] Complaints about licensing and other foster parent issues increased by one quarter. Complaints about relative caregiver issues and retaliation against relatives doubled also. Communication failures decreased by half, while FamLink-related issues (mostly long delays in payments to foster parents and private foster care agencies, caused by technical problems with the new computer system) were unique this year.

[18] Foster parent retaliation is discussed in a separate section of this report.

RESPONDING TO COMPLAINTS

The Ombudsman reviews every complaint received to determine whether an investigation is appropriate.[1] Through impartial investigation and analysis, the Ombudsman determines an appropriate response. In cases where the Ombudsman finds that the agency has properly carried out its duties, no further action is taken. In cases in which an adverse finding is made, the Ombudsman may work to change a decision or course of action by DSHS or another state agency.

ANALYZING COMPLAINTS

The objective of a complaint investigation is to determine whether DSHS or another agency has violated law, policy or procedure, or unreasonably exercised its authority. The Ombudsman then assesses whether the agency should be induced to change its decision or course of action.

After initial investigation, the lead Ombudsman presents a report for review by the team, or a senior Ombudsman. Staff may pose questions, test assumptions, identify information gaps, identify problematic policy or practice issues, raise additional issues for investigation or analysis, or offer an alternative analysis by playing "devil's advocate." The investigation continues until it can be determined whether the allegations in the complaint meet one or more of the criteria for intervention by the Ombudsman (see sidebar). If these criteria are not met, no further action is taken and the complainant is notified by telephone or in writing. If the criteria are met, the Ombudsman decides what action to take to address the concerns raised by the specific complaint or any additional concerns uncovered during the course of the investigation. The complainant is informed of the progress and final resolution of the investigation.

Criteria for Analysis by the Ombudsman

The Ombudsman acts as an impartial fact finder and not as an advocate, so the investigation focuses on determining whether the issues raised in the complaint meet the following objective criteria:

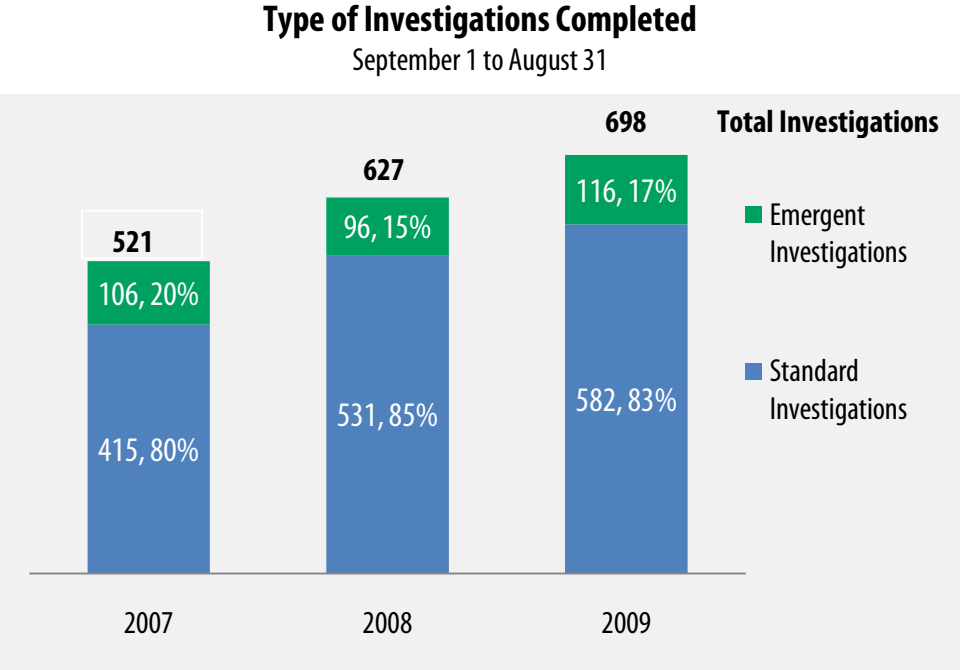
- The alleged agency action (or inaction) is within the Ombudsman's jurisdiction.
- The action did occur.
- The action violated law, policy or procedure, or was clearly inappropriate or unreasonable under the circumstances.
- The action was harmful to a child's safety, health, well-being, or right to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

[1] The Ombudsman may also initiate an investigation without a complaint. During the 2009 reporting period, OFCO initiated 11 investigations. One investigation was closed after the Ombudsman intervened to resolve the concerns. Ten of the OFCO-initiated investigations remained open at the end of the reporting period.

INVESTIGATION OUTCOMES

COMPLETED INVESTIGATIONS

The Ombudsman completed 698 complaint investigations in 2009,[2] representing an **11 percent increase over the previous year**. This increase is attributable to the sharp increase in the number of complaints received by OFCO over this period and OFCO's increased productivity resulting from the addition of two staff in 2008 to meet both the demand for our services and carry out new responsibilities assigned by the legislature. As in previous years, the majority of these investigations were **standard non-emergent investigations** (83 percent). In 2009, slightly less than one out of every five investigations met the Ombudsman's criteria for initiating an **emergent investigation,** i.e. when the allegations in the complaint involve either a child's immediate safety or an urgent situation where timely intervention by the Ombudsman could significantly ease a child or family's distress.

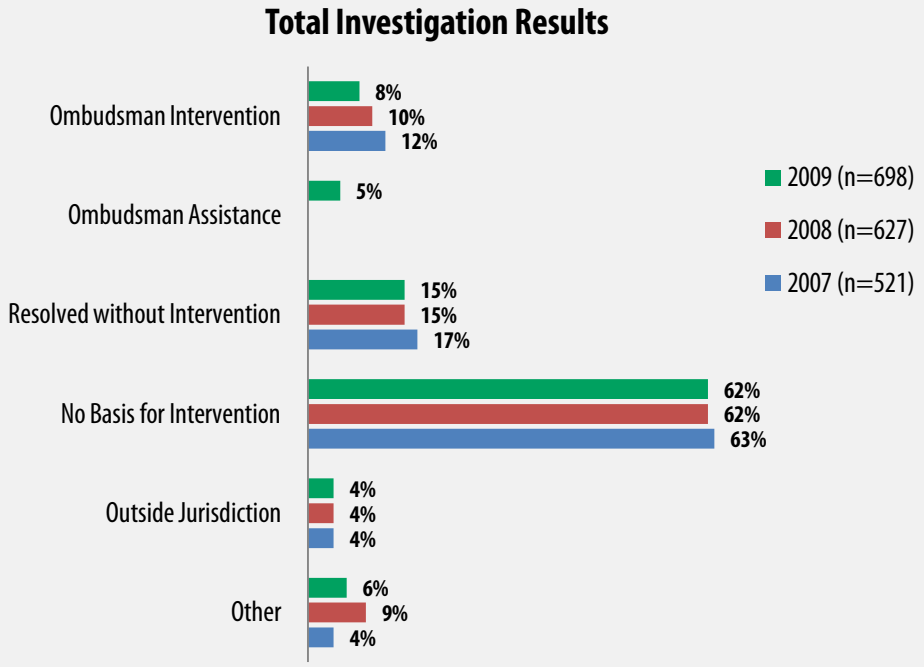


Source: Office of the Family and Children's Ombudsman, October 2009

[2] Of the 2009 complaints, 82 percent were investigations of complaints received during that reporting year, while 18 percent were of complaints received in a previous year. At the end of 2009, 16 percent of complaint investigations remained open. 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 in 2009, including these identical complaints from more than one complainant, was 744.

INVESTIGATION RESULTS

Investigation results remained fairly consistent over the last three years. **Just under two-thirds of complaint investigations (62 percent) found the complaint issue to be unsubstantiated**, i.e. with no basis for intervention. The Ombudsman **intervened to resolve the situation in 8 percent of complaints** in 2009.



Definitions of Investigation Results

Ombudsman Intervention: The Ombudsman substantiated the complaint issue and intervened to correct a violation of law or policy, or to achieve a positive outcome for a child or family.

Ombudsman Assistance: The complaint was substantiated, but the Ombudsman did not find a clear violation or unreasonable action. The Ombudsman provided substantial assistance to the complainant, the agency or both, to resolve the complaint.

Resolved without Intervention: The complaint issue may or may not have been substantiated; the complaint issue was resolved by the complainant, the agency or some other factor.

No Basis for Intervention: The complaint issue was unsubstantiated and the Ombudsman took no further action.

Outside jurisdiction: The complaint was found to involve agencies or actions that were outside of OFCO's jurisdiction.

Other: The complaint was withdrawn, became moot, or further investigation or action by the Ombudsman was unfeasible for other reasons.

Source: Office of the Family and Children's Ombudsman, October 2009

As indicated in the table, in 2009 OFCO added a new category of results of our complaint investigations to better capture our role in resolving complaints. Complaints receiving **"Ombudsman Assistance"** are different from complaints in which the Ombudsman intervened, in that the Ombudsman did not necessarily find a violation or clearly unreasonable action or decision on the part of the agency, but the complaint had validity and could use the Ombudsman's assistance. In 2009, **5 percent of complaints were resolved by the Ombudsman in this manner** by ensuring that critical information was obtained and considered by the agency, by facilitating timely communication among the people involved in order to resolve the problem or mediating a compromise. For example:

> Child Welfare Services (CWS) failed to respond to a request from the relatives of a legally free 7-year-old child to re-establish their lost contact with the child. The child had previously lived with the relatives, and they had been told they would be kept informed of the child's permanency status until adoption. The Ombudsman found the agency's lack of response to the relatives to be potentially harmful for the child and family in terms of losing their connection. The Ombudsman contacted the CWS social worker and requested a response to the relatives. The worker facilitated contact between the relatives and the child's prospective adoptive parents, who agreed to re-establish contact between the child and the relatives.

The number of complaints requiring intervention by the Ombudsman decreased somewhat in 2009, to 8 percent of complaints – continuing a trend of slight decreases in the last three years (OFCO intervened in 12 percent and 10 percent of complaints in 2007 and 2008 respectively). These interventions **resulted in the complaint issue being resolved in the vast majority of complaints (90 percent).**[2]

> For example, CWS modified draft evaluation reports sent to the agency for input by a contracted psychologist hired to conduct a psychological evaluation of a parent. Although it is an accepted practice for CA to provide background information about the client being referred for evaluation, and CA may present specific clinical questions it wants the evaluation to address for case planning purposes, the Ombudsman found that this method of obtaining direct input from CWS undermined the neutrality of the evaluation sought from an independent provider. The Ombudsman contacted the Area Administrator (AA) and requested that the matter be investigated to establish whether this was a more widespread practice in that particular DCFS office, and take appropriate action. The AA and contracts manager for the office found that the practice of caseworkers providing input directly into evaluation reports by contractors was more widespread than this one instance. The AA met with office supervisors to provide guidance on best practices for working with contracted providers conducting evaluations of clients for the agency.

In the remaining 10 percent of complaints in which the Ombudsman intervened, the agency did not change its position and the issue became moot or remained unresolved. The outcomes of these investigations are presented in the next section of this report, titled "Ombudsman in Action."

[2] See the following chapter, Ombudsman in Action, for more examples of interventions.

In 2009, **15 percent of complaints were resolved between the agency and the complainant without significant assistance or intervention by the Ombudsman**. For example:

> CWS refused a request for respite care made by the foster parents of two legally free children. The children had special needs and one of the children required line-of-sight supervision, and the foster parents had four other children in the home. The foster parents had requested respite care two days a week over the summer, or they would be unable to continue caring for the children. The agency was suffering severe budget constraints and considered the following in refusing the request: both foster parents did not work outside of the home; the children would be in a limited summer program through the school; and the foster parents were already receiving respite care when they had medical appointments for the other foster children in the home. The Ombudsman found that the agency had reasonably considered the foster parents' request, and was going a step further in order to avoid another move for these children. It had offered to meet with the foster parents to explore a solution to their need for a break. OFCO contacted CWS prior to this meeting and the agency confirmed its commitment to trying to maintain the placement within budget constraints. During the meeting the agency offered the family some daycare and in-home counseling to assist the foster parents in managing these children's difficult behaviors. The placement was maintained.

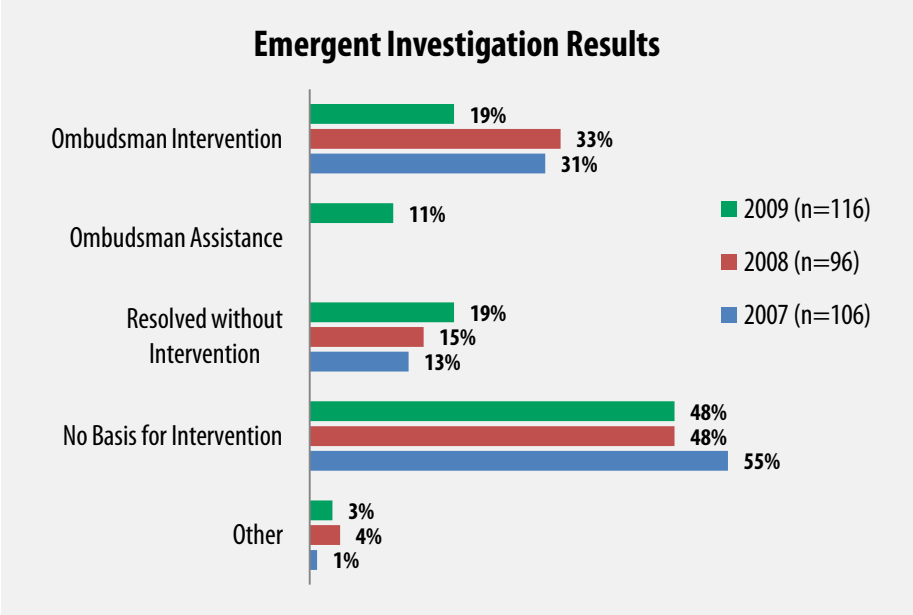
In 2009, just under two-thirds of complaint investigations were closed after the Ombudsman either found no basis for the complaint, or found no unauthorized or unreasonable actions by the agency warranting intervention. In some cases, the Ombudsman may have made an adverse finding regarding a violation of law or policy or an unreasonable action that was not raised by the complainant but was discovered by the Ombudsman in the course of investigating the complaint. However, the adverse finding did not require further action or could not be remedied. For example:

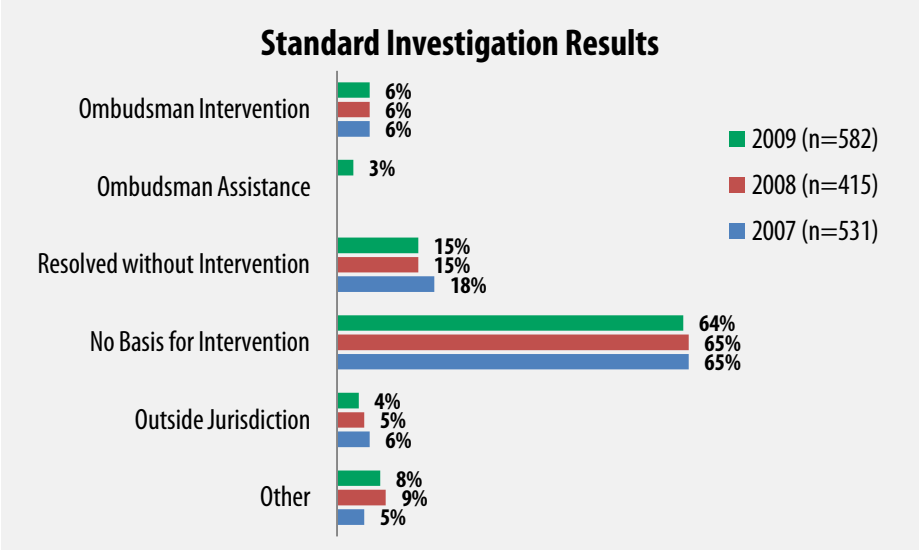
> The Ombudsman found no unauthorized or unreasonable actions by the agency when CWS moved a 4-year-old dependent child from one relative placement to another, after the child had been living with the initial relative for a year and a half. The Ombudsman found that the agency removed the child after it became clear that the relative could not keep the child healthy and safe. The agency had received referrals from mandated reporters expressing concern about recurring episodes of lice and the relative's volatile behavior; when the agency discovered that the child had unauthorized contact with the parent due to the relative's inability to prevent this contact, a Family Team Decision Making meeting was held to discuss the possible need for a change of placement. The parent identified a different relative, who was explored for placement, and the child was moved. The agency arranged phone calls and visits for the child with the former relative placement to ease the transition and maintain the close bond between the child and the relative.
>
> In another example, the Ombudsman found no basis for a complaint alleging that CPS had disclosed the identity of the person who made a referral to CPS to the youth who was the subject of the investigation. While it is true that law and policy dictates that CPS shall make every effort to protect the identity of persons making CPS referrals, the Ombudsman found documentation showing that no such disclosure had occurred. The CPS investigator's record of the interview with the youth documented that the youth had asked about the identity of the referent, and the investigator responded that this was confidential information. Although the Ombudsman shared the complainant's concern that the youth might be unlikely to trust the referent with

sensitive information about the parent's neglectful behavior in the future, the Ombudsman was unable to substantiate the complainant's allegation that the agency had either willfully or negligently disclosed their identity.

Emergent Versus Standard Complaint Investigations

Investigation results differ quite significantly in complaints that are investigated on an emergent basis compared to our standard investigation process (i.e. in 2009, the Ombudsman intervened or provided assistance to resolve concerns in a much larger number of emergent [30 percent] versus standard [9 percent] complaints). The following charts depict the various outcomes for these categories of complaints.





Source: Office of the Family and Children's Ombudsman, October 2009

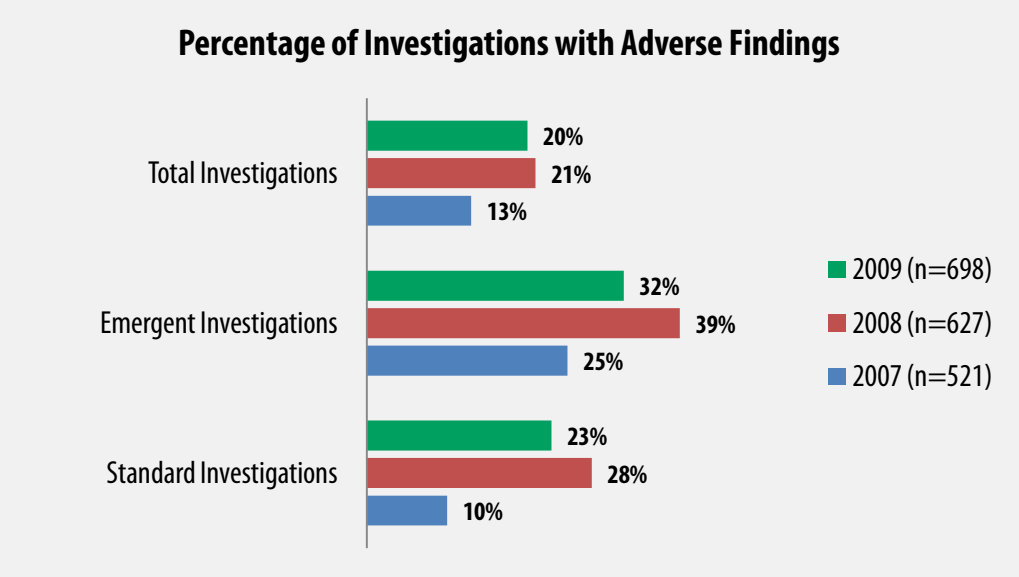
OMBUDSMAN'S FINDINGS

As shown in the graph below, the majority of complaint investigations resulted in **no adverse findings** (555, or **80 percent in 2009**). The number of adverse findings did not change significantly between 2008 (171 findings) and 2009 (175 findings).

One in five investigations (20 percent) resulted in an adverse finding in 2009. It should be noted that a finding by the Ombudsman may or may not be related to the complaint issue(s) raised by the complainant, but rather to other violations or unreasonable actions found by the Ombudsman in the course of investigating the complainant's concerns. The number of adverse findings was also significantly higher in emergent complaints than in standard complaints.

Adverse findings fell into three broad categories:

- the agency violated a law, policy or procedure;
- the agency's action or inaction was clearly unreasonable under the circumstances; or
- no violation or clearly unreasonable action was found, but actual or potential harm to the child or family had occurred as a result of poor practice on the part of the agency.



Source: Office of the Family and Children's Ombudsman, October 2009

The following table shows the various categories of issues in which adverse findings were made. Some complaints had several findings related to different issues that were either raised by the complainant or discovered by the Ombudsman in the course of investigating the complaint.

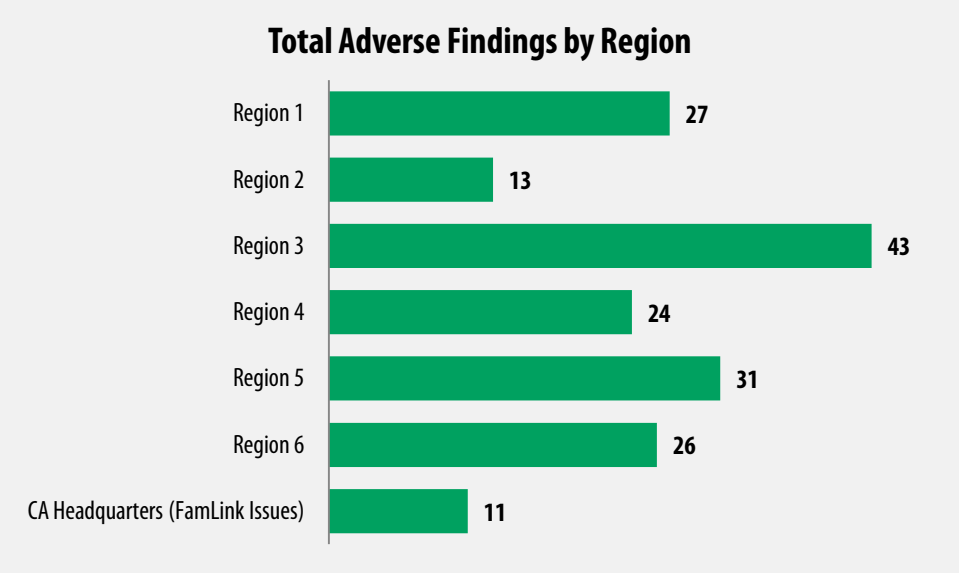
Issue	Number of Findings	
	2008	2009
Child Safety	**68**	**47**
Failure by CWS to ensure/monitor dependent child's safety (examples: failure to conduct health and safety visits; inadequate monitoring of supervised parent-child visits; failure to report child injuries to CPS)	28	20
Failure by CPS to ensure/monitor non-dependent child's safety	16	14
Inadequate CPS investigation/case management	11	5
Failure to screen in CPS referral for investigation/other screening errors	8	5
Inappropriate CPS finding	3	--
Failure by DLR to ensure safety of foster home/facility	2	2
Safety violation by contracted service provider	--	1
Family Separation and Reunification	**20**	**21**
Failure to/delay in placing child with relative	9	11
Failure to provide appropriate contact between parent and child	4	--
Delay in reunification	3	1
Failure to provide visits with siblings	2	2
Failure to provide contact with other relative	2	2
Unreasonable removal of non-dependent child from home	--	3
Unreasonable removal of dependent child from relative caregiver	--	1
Failure to place child with siblings	--	1
Dependent Child Permanency	**19**	**23**
Delay in permanency	15	18
Inadequate permanency planning	3	3
Inadequate preparation of youth aging out of foster care	1	2
Parents' Rights	**18**	**17**
Failures of notification, public disclosure or breach of confidentiality	8	5
Delay in completing CPS investigation	6	7
Failure to provide services to parent	2	1
Other violations of parent's rights	2	4
Foster Parent/Foster Care Issues	**16**	**13**
Poor communication by agency, unreasonable treatment	7	3
Violation of foster parent rights	2	2
Overly lengthy DLR/CPS investigation, inappropriate findings	2	3
Failure to provide foster parent with support services	2	--
Retaliation by agency	2	3
Unreasonable licensing delays/other licensing errors	1	1
Unreasonable DLR/CPS finding against foster parent	--	1

Issue	Number of Findings	
	2008	2009
Dependent Child Health and Well-Being	**13**	**21**
Failure to provide adequate medical care	5	2
Failure to provide appropriate services to meet special needs	3	3
Placement issues (unnecessary moves, delays in placement, lack of availability, inappropriate placement type)	3	7
Failure to meet basic physical needs	1	--
Unreasonable delay in providing Children's Long-Term In-Patient treatment (CLIP)	1	--
Inadequate foster home (non-child safety)	--	4
Failure to support normal activities for foster child	--	1
Traumatic removal/harm by removal	--	2
Other child well-being issues	--	2
Children's Legal Issues	**3**	**2**
Lack of attorney or guardian ad litem for dependent child	2	1
Violations of Indian Child Welfare Act	1	--
Limitation of CASA's access to dependent child	--	1
Poor Casework Practice Resulting in Harm to Child or Family	**10**	**15**
Other poor practice	9	3
Communication failures	1	1
Unprofessional conduct by agency staff	--	1
Inaccurate, incomplete or delayed documentation	--	10
Relative Caregiver Issues	**4**	**3**
Poor communication, poor treatment, lack of support	4	2
Failure to notify caregiver of court hearings	--	1
Adoptive Parent/Adopted Children's Issues	**2**	**--**
Inadequate services for adopted children with special needs	2	--
Inadequate pre-adoption services	--	--
FamLink Issues	**--**	**11**
Failure to provide timely payment	--	10
Failure to close cases in timely manner	--	1
Other Findings	**--**	**2**
Failure to conduct child death review	--	1
Inadequate caseworker training	--	1
TOTAL NUMBER OF FINDINGS[3]	**171**	**175**
Total number of complaints with one or more findings	**131**	**143**

[3] Note that several complaints raised more than one issue and resulted in more than one finding.

Of note in the previous table is that the number of adverse findings for child safety issues decreased by 31 percent between 2008 and 2009, largely due to fewer dependent children found to be in unsafe situations, and fewer inadequate CPS investigations and intake screening errors. Similar to last year, delays or failures to place children with relatives comprised approximately half of the adverse findings for family separation. We found fewer delays in reunification and no instances of lack of parent-child visitation in 2009 (down from 4 such findings in 2008), but saw an increase in unreasonable removals from parents or relatives (4 findings in 2009, none in 2008). Findings regarding delays in permanency for dependent children increased slightly in 2009. More adverse findings related to dependent children's well-being were made, especially related to placement issues, as did findings regarding poor agency practice. A little over 6 percent of the total findings for the year were related to problems with the introduction of the agency's new computer system, FamLink, in late January 2009. No adverse findings were made regarding adopted children this year, down from two such findings last year. Other findings remained similar to 2008 numbers.[4]

The number of adverse findings for each DSHS region is shown below. FamLink-related issues were all attributed to the CA Headquarters (HQ) due to several instances where one foster parent or private agency had children from different regions placed in their care and therefore had different regions attempting to resolve the payment issues. Two regions stand out as having the highest (Region 3) and lowest (Region 2) number of adverse findings by a significant amount: Region 3 totaled 43, or almost a quarter of the total findings, while Region 2 totaled 13, or about 7 percent of the total.



Source: Office of the Family and Children's Ombudsman, October 2009

[4] A cautionary note regarding the above data is that OFCO gathered data regarding adverse findings more meticulously in these last two years, providing limited comparison data showing findings in this kind of detail. Trends and patterns may become clearer once several years of data have been reported.

The following table highlights findings across regions regarding selected issues that were substantiated most frequently. While strong conclusions cannot be drawn from such small numbers, there were some trends in findings in each region. Trouble spots for each region to pay attention to appear to be:

Region 1: Child safety, poor practice issues (see Total Adverse Findings table on page 37 for specifics on poor practice).

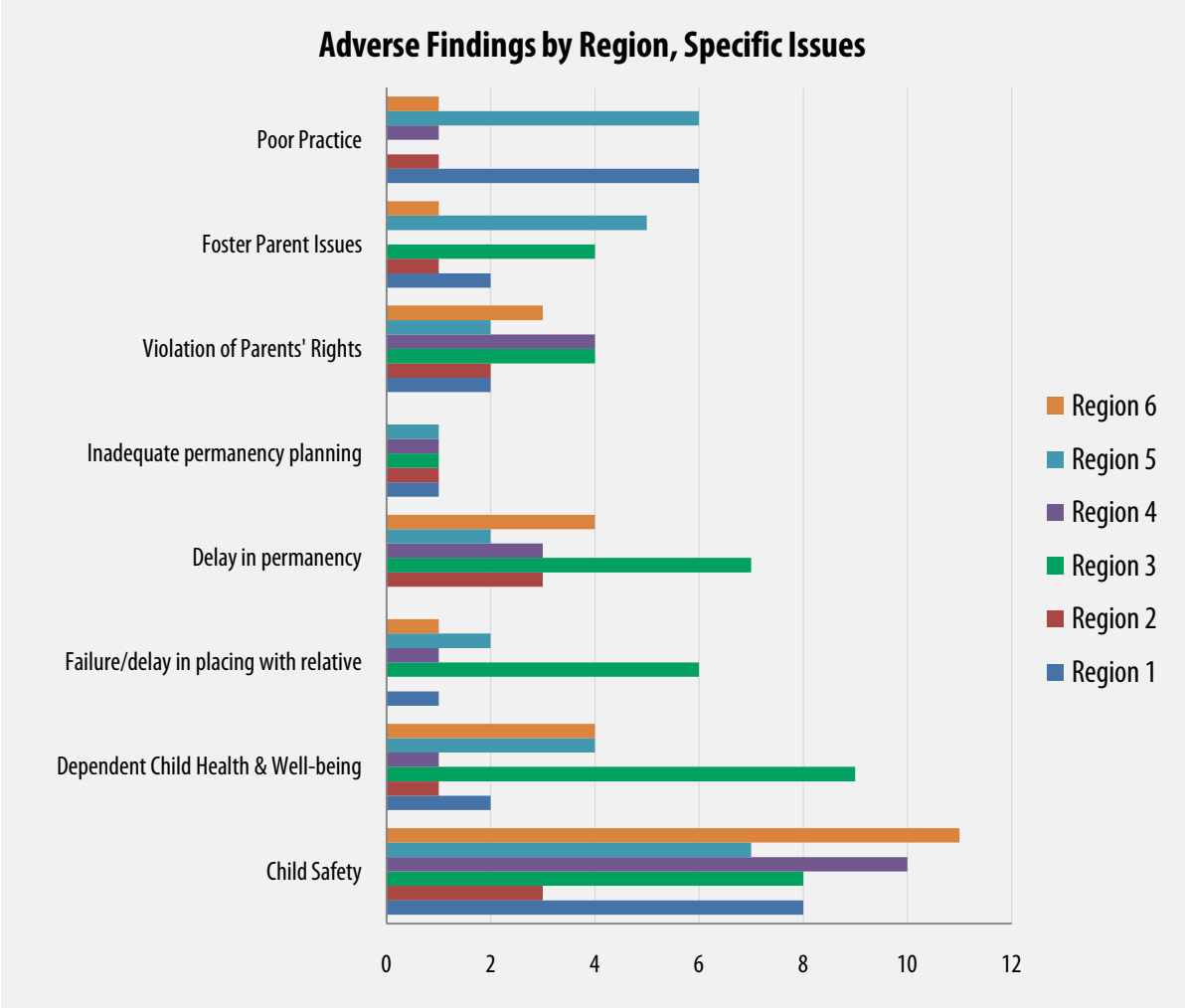
Region 2: Child safety, delay in permanency.

Region 3: Health and well-being of dependent children, child safety, delay in permanency, failure or delay in placing with relatives.

Region 4: Child safety, violation of parents' rights.

Region 5: Child safety, poor practice issues, foster parent issues.

Region 6: Child safety, health and well-being of dependent children, delay in permanency.



Source: Office of the Family and Children's Ombudsman, October 2009

OMBUDSMAN IN ACTION

ADVERSE FINDINGS AND INTERVENTIONS

The Ombudsman takes action when the findings of a complaint investigation indicate that action is necessary to avert or correct a harmful oversight or avoidable mistake by DSHS or another agency.

After investigating the complaint, if the Ombudsman concludes that the agency's actions are either outside of the agency's authority or clearly unreasonable under the circumstances, and could cause foreseeable harm to a child or parent, the Ombudsman intervenes to persuade the agency to correct the problem. The Ombudsman shares the investigation findings and analysis of the problem with supervisors or higher-level agency officials, and may recommend a different course of action or request a case review by higher-level decision makers. In cases where an agency error is brought to the Ombudsman's attention after the fact and corrective action is no longer possible, the Ombudsman brings it to the attention of agency officials so they can take steps to prevent such errors from recurring in the future.

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 by facilitating communication among the people involved. In some cases, the Ombudsman finds that the agency's actions are not in clear violation of law or policy, but rather represent poor practice. In these cases, if the complaint involves a current action, the Ombudsman intervenes where possible to assure better practice. When it involves a past action, the Ombudsman documents the issue and brings it to the attention of agency officials.

As indicated in the previous section, the Ombudsman's investigation resulted in **an adverse finding in 20 percent of complaints in 2009,** slightly down from 21 percent in 2008. As previously noted, sometimes the finding was unrelated to the issue raised by the complainant but was discovered by the Ombudsman while investigating the complaint. For example:

> A foster parent complains to OFCO that the agency is planning to move a foster child from their foster home without justification. The Ombudsman investigates and finds no basis for this complaint, but finds that the child does not have a guardian ad litem or Court Appointed Special Advocate (CASA), and is not receiving mental health services requested by his parent and ordered by the court two months ago. The Ombudsman makes an adverse finding that the agency failed to provide the service in a timely manner and failed to ensure the child was represented in court.

The following tables summarize each complaint in which the Ombudsman made a substantive adverse finding,[1] the action taken by the Ombudsman to address the problem and the outcome. The findings are organized by region and type of intervention taken by the Ombudsman (as in previous reports).

[1] Other adverse findings appearing in summary form in the table in the previous section were more procedural in nature, such as failures of notification, failure to document or failure to complete tasks as required by policy or in a timely manner.

REGION 1

INDUCING CORRECTIVE ACTION

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Lack of guardian ad litem (GAL) for dependent child	CWS failed to ensure that a 10-year-old dependent child had a GAL appointed to represent the child's best interests in the dependency case. The child had been placed in eight different placements in the past 2 ¼ years, was exhibiting serious behavior and mental health problems, and the permanency plan was unclear.	The Ombudsman contacted the Area Administrator to request that CWS seek appointment of a GAL by the court.	A GAL was appointed. Within two months, the child was returned to the parent and the dependency dismissed.
Child safety	CWS failed to conduct monthly health and safety visits to the foster home of a 12-year-old dependent child for seven months, instead seeing the child intermittently (on at least four occasions) at school or at the DCFS office. Agency policy requires that dependent children be visited monthly, preferably in their placement. The Ombudsman did not find the agency's action to be clearly unreasonable, as the foster home was in a remote area that was difficult to access in the winter, the foster home had had no concerns in 10 years, and the child self-reported to be doing well in the foster home during contacts with the social worker.	While the Ombudsman did not find this violation of policy to be clearly unreasonable under the circumstances, given that it was now spring, the Ombudsman contacted the supervisor to request that a worker visit the child in the foster home as soon as possible.	A worker visited the child in the foster home within a week.
Child safety	A private agency contracted to provide Behavioral Rehabilitation Services for DCFS clients violated behavior management guidelines for BRS contractors. The agency directed a foster parent to wrap a foster child in a blanket to restrain the child. The restraint caused injury and restricted the child's breathing.	The Ombudsman contacted CA Headquarters and requested a review of the private agency's policies and internal training and service plans for BRS foster homes.	Following CA's review, additional training was provided to staff in the private agency and a compliance agreement was completed. The specific foster home is no longer licensed.
Inadequate foster home	DLR/OFCL failed to adequately monitor and correct poor hygienic conditions and lack of nurturing in a foster home over several years. The home had a history of 10 CPS referrals or licensing complaints in the last five years, with two valid and two inconclusive findings on licensing investigations. The Ombudsman found there had been no perceptible improvement in the quality of foster care provided by this home over the years.	The Ombudsman contacted DLR to request that it establish a plan for corrective action.	DLR established a compliance agreement with specific dates by which the private agency needed to come into compliance or risk revocation of its license. The agency remains open and is being closely monitored by DLR.

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Failure to place with relative	DCFS failed to conduct a full relative search when an 8-year-old, now-dependent child was placed in foster care. As a result, the agency excluded an interested relative who was unaware the child had been removed from the parent, from participating in case planning and being considered for placement of the child. The relative had contacted the agency upon discovering the child's situation and was told the child was already placed with another relative.	The Ombudsman requested the agency involve the relative in case planning and screen the relative for consideration of visits and possible placement.	The agency invited the relative to a shared planning meeting and arranged for supervised visits with the child. The agency also began the process of considering the relative for placement.
Unreasonable removal of child from relative caregiver	CWS removed two dependent children ages 8 and 7 from their relative caregiver with insufficient evidence that the children were being neglected.	The Ombudsman requested a review by CA Headquarters to consider returning the children to the care of the relatives.	The agency returned the children to the care of the relatives.
Poor practice by agency	CWS unreasonably refused the CASA's request to reschedule a Child Protection Team meeting to assess the reunification plan for 3 dependent children. The CASA was in disagreement with the agency's plan to return the children to the parent and wanted to present CASA's assessment of the plan to the CPT but was unable to attend the meeting as scheduled.	The Ombudsman requested that the agency reschedule the meeting to ensure the CASA's views could be personally presented at the meeting.	The agency rescheduled the meeting to ensure the CASA could participate.

FACILITATING RESOLUTION

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Inadequate permanency planning, dependent child well being	CWS planned to return a 15-year-old dependent youth home despite the youth's strong desire to remain in out-of-home care. While the agency's reunification efforts regarding this youth and three younger siblings were compliant with law and policy, the Ombudsman found that CWS was not taking into account the youth's individual needs in its overall plan for the family. Specifically, the agency appeared to be minimizing the effects of the chronic neglect the youth had experienced in the care of the parents (20 CPS referrals, two founded findings for neglect, multiple inconclusive findings for neglect, physical abuse and emotional abuse), the youth's level of responsibility for caring for the younger siblings if returned home and the unhealthy dynamics between the youth and the parents that had not yet been addressed by therapeutic services offered to the family. Finally, CWS was refusing to allow the youth to visit a school friend for an overnight visit. The Ombudsman found the agency's rationale for this refusal, i.e. that the youth had an unrealistic fantasy of being placed with the friend's family that it did not want to encourage, to be unreasonable.	The Ombudsman contacted the CWS supervisor and requested that a staffing be held with the youth, family, the CASA and all other professionals involved to determine the most appropriate permanency plan for the youth. The Ombudsman also requested that the agency reconsider its refusal to allow the youth overnight visits with a friend and pursue the appointment of an attorney to represent the youth in the dependency proceedings.	The agency began the process of approving overnight visits with a friend, sought appointment of an attorney to represent the youth and arranged a Family Team Decision Making meeting to assist in permanency planning. As a result, the agency began exploring concurrent permanency plans of return home or third party custody by the youth's current relative placement.
Foster parent issues	CWS/Adoptions declined a foster family's request for an updated adoption home study, and recommended that the dependent 5-month-old infant who had been placed in the home since birth as a potential pre-adoptive placement, be removed. The Ombudsman found this to be clearly unreasonable, since Adoptions was basing its position on outdated information about the family's circumstances.	The Ombudsman contacted the adoption supervisor and recommended that a meeting be held with the foster parent to establish the facts about the foster family's current situation.	The meeting was held and it was established that the family's circumstances had changed considerably in the two years since their previous adoption home study. The adoption unit agreed to proceed with a home study. The infant remained in the foster home while permanency planning continued.

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Failure to provide contact with relative	CWS refused to allow contact between a 15-year-old dependent youth and a relative who was the youth's former long-term caregiver. The Ombudsman found the agency's rationale for the prohibition of contact to be unreasonable, i.e. that the agency was concerned that communication between the youth and the relative could undermine the youth's current placement.	The Ombudsman contacted the AA and requested that contact be reconsidered with the relative and youth's agreement that specific ground rules for the contact would be followed.	The agency set up ground rules and allowed the contact to occur. The youth's placement was successfully maintained.

ASSISTING THE AGENCY IN AVOIDING ERRORS AND CONDUCTING BETTER PRACTICE

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
CASA's access to children	CWS limited CASA's access to children they represented, diminishing the CASA's ability to effectively participate in case planning for the children.	Although this action occurred in the past, the Ombudsman identified several issues of concern regarding the relationship between DCFS and the local CASA program, as part of a special investigation into systemic issues in the Colville area.	CA responded to the identified concerns and recommendations with an implementation plan to address these (see section on Colville report).

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Child safety	CPS failed to file a dependency petition regarding a 14-year-old, non-dependent youth with serious mental health and behavioral problems despite the parent's repeated requests for out-of-home placement due to the parent's inability to manage the youth at home and in the community. The family had a long history of DCFS involvement. The youth was currently living at a homeless shelter that was unable to meet the youth's extraordinary needs, and the youth's behavior at times was endangering himself and others. The parent was refusing to take the youth home and other DSHS divisions were either providing insufficient services (Mental Health Division [MHD]) or no services at all (Division of Developmental Disabilities [DDD]). As a result, the youth was being shuttled every few days between various shelters/CRCs, home and juvenile detention. The Ombudsman found DCFS's failure to seek placement of the youth in collaboration with other DSHS divisions was unreasonable given the youth's unstable and unsafe situation.	The Ombudsman contacted the Deputy Regional Administrator to request that a dependency petition be filed and the youth placed in out-of-home care for the youth's protection.	The agency initially responded that it was not responsible for placing the youth in out-of-home care as the youth had not been abused, and furthermore it had no suitable placements. Soon after, a CPS referral was made alleging physical abuse of the youth by the parent. The parent continued to refuse to take the youth home, and 2 ½ months after the Ombudsman's request, the agency filed a dependency petition and placed the youth in a Behavioral Rehabilitation Services (BRS) placement.
Child safety	CPS failed to screen in for investigation a referral alleging physical abuse of an 11-year-old, non-dependent child by a custodial parent. The child reported being "smacked" in the face, pushed up against a wall and kicked out of the home into well-below-freezing winter weather without appropriate clothing for 40 minutes. The Ombudsman found (with verification by the CPS Central Intake Program Manager) that the referral should have been screened in for non-emergent investigation. At least three questions on the intake "sufficiency response" screen had been answered incorrectly based on the information provided in the referral, leading to screening out of the referral.	Since the referral had been received three weeks previously and the non-custodial parent was seeking a change of custody through the family court, the Ombudsman did not request investigation of the referral. The Ombudsman monitored for further referrals regarding the family for two months to ensure appropriate response by the agency.	No further referrals were received.

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Unreasonable removal of child from relative caregiver	CWS removed a 3-year-old, non-dependent child from relative caregivers, filed a dependency petition and prohibited contact between the child and former caregivers. The Ombudsman found the removal and prohibition of contact to be unreasonable, as the agency had found no evidence of abuse or neglect, or high risk for maltreatment.	The Ombudsman requested a review of the case by CA HQ, with a view to reconsidering visitation and return of the child to the relatives.	Following an extensive case review, the agency recommended to the court that visits be re-established and the child returned to the relatives. The child was returned after a period of transitional visits and has since been adopted by the relatives.
Violation of parent's rights	CA failed to expunge outdated screened-out, inconclusive or unfounded CPS referrals regarding a particular family within eight months of new law and policy requiring this (WAC 388-15-077). Although the Ombudsman found this to be a violation of the new law, since the agency was experiencing difficulties with the new FamLink system and the law does not specify a time frame by which these records need to be expunged, the Ombudsman did not find this violation to be clearly unreasonable.	The Ombudsman contacted CA Headquarters in May 2009. CA reported that it had expunged all eligible records by the end of January 2009. However, since the agency's conversion to the new FamLink system at the end of January, no system was in place for continuing to expunge records as they became eligible. CA expected to have a system in place for complying with this law within a year of its coming into effect, i.e. by October 2009.	A follow-up by OFCO with CA in November 2009 indicated that CA is continuing to work on a system for automatic expungements through FamLink. Meanwhile, it is considering individual requests for expungement on a case-by-case basis.

PREVENTING FUTURE MISTAKES

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Child safety	DLR failed to fully investigate previous allegations of abuse and neglect of foster children by a foster parent, by failing to interview the referent who could have provided additional information that would have yielded stronger evidence of maltreatment.	By the time the Ombudsman received the complaint, there had been a subsequent investigation resulting in founded findings of maltreatment. The foster home had been closed by DLR.	The children identified in the complaint had been placed in safe alternative placements.

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Child safety	CPS failed to adequately investigate allegations of medical and physical neglect of a 6-year-old, non-dependent medically fragile child by a non-custodial parent during weekend visits. The Ombudsman found that no collateral calls had been made to the child's medical providers to assess key medically related aspects of the investigation, nor were several of the allegations clearly addressed. The investigation was poorly documented and the summary assessment contained little evidence to support the finding of "unfounded."	The Ombudsman contacted the CPS supervisor to discuss these concerns and request that further training be provided to the worker involved. The Ombudsman also requested that a collateral call be made to the child's medical providers if a new referral was received.	Training was provided to all CPS investigators in the office regarding thorough investigation and documentation. The supervisor agreed to contact medical providers should another referral be received on this child.
Communication failure by agency	In investigating a complaint alleging that CWS was failing to keep the CASA fully informed regarding the details of two legally free children's permanency plan, the Ombudsman found no clear evidence of this but found that a general lack of communication and lack of trust between DCFS and the CASA had hindered case planning and delayed permanency for these children.	Since the court had halted adoption proceedings for the children to allow the CASA and children an opportunity to discuss the adoption plan, intervention by the Ombudsman was not necessary.	Further disagreement between professionals involved in this case hindered the outcome intended by the court. The children's adoption was finalized three months later.
Unprofessional conduct by agency staff	A DLR licensor behaved unprofessionally in a meeting with a foster parent.	The Ombudsman contacted the DLR licensing supervisor and found that appropriate action had already been taken. The supervisor had given the licensor a written reprimand and was monitoring the licensor's work more closely.	Upon later follow-up by the Ombudsman, the licensor's communication with clients was reported to be improved following the reprimand.

REGION 2

INDUCING CORRECTIVE ACTION

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Delay in permanency, services to parent	CWS failed to follow ASFA timelines for filing a petition to terminate the parental rights of parents of a 3-year-old dependent child. The child had been in out-of-home care for 3 ¼ years and the parents had made minimal progress in remedying the conditions leading to placement. Furthermore, CWS had failed to provide the parents with services to promote reunification.	The Ombudsman requested a review of the case by the AA.	A termination petition was filed but was not granted by the court. The Ombudsman monitored the child's situation and safety for a year after receiving this complaint. The child was ultimately returned to one of the parents.

FACILITATING RESOLUTION

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Violation of parent's rights	CWS failed to invite a parent to a Child Protection Team (CPT) review meeting to decide whether to reunify a 5-year-old dependent child with the parent. CPT procedures specify that "the family, if appropriate, shall be invited" to participate in CPT meetings. The Ombudsman found that there was no evidence to suggest the parent's participation would be inappropriate.	The Ombudsman contacted the CWS supervisor, who agreed to arrange a Family Team Decision Making (FTDM) meeting so the parents could hear directly from professionals and others involved in the case about perceived barriers to reunification. The supervisor also agreed to invite the parents to the next quarterly CPT meeting.	The Ombudsman observed the FTDM. The parent reported having greater clarity regarding issues affecting reunification following the meeting.

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Inadequate permanency planning	CWS petitioned the court to move three legally free siblings, ages 10, 9 and 6, from their pre-adoptive foster home where they had been living for two years. The petition was based on CWS' mistaken belief that it was obligated to follow the Local Indian Child Welfare Act Committee (LICWAC) recommendation to move the children without further assessment of their safety and welfare. By policy, the agency could have sought further review of the placement to determine the best course of action. The Ombudsman's investigation revealed that part of the reason for the LICWAC recommendation to remove the children was a perception that the foster parents were reluctant to adopt the children. In fact, the foster parents were seeking specific information about adoption that CWS was unable to provide.	The Ombudsman contacted the CWS supervisor and recommended that the case be transferred to the adoption unit to provide the needed information and expedite the adoption of the children.	The case was transferred to the adoption unit.

ASSISTING THE AGENCY IN AVOIDING ERRORS AND CONDUCTING BETTER PRACTICE

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Child safety	DLR maintained the foster care license of a foster home that had a history of 42 referrals alleging either maltreatment or licensing violations over a period of 10 years. The Ombudsman found the pattern and chronicity of referrals to be concerning. Although all of the CPS investigations were unfounded and many of the licensing investigations resulted in invalid findings, the Ombudsman found that the same licensor had investigated all licensing complaints, bringing into question the objectivity of the investigations. For example, during the most recent investigation, one youth in the foster home was interviewed by the licensor and denied allegations made by another youth in the home that the foster parent was leaving the children home at night without adult supervision. The youth later affirmed these allegations after being placed in another foster home.	The Ombudsman contacted the DLR licensing supervisor and requested that the recanting foster youth be re-interviewed and the licensing file be reviewed to assess the chronic number and pattern of referrals on this foster home.	DLR agreed, but the youth was never re-interviewed and the licensing complaint was closed as invalid. The foster home remains open. The Ombudsman monitored the foster home for any new referrals and the agency's response for six months. No new referrals were received.

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Delay in permanency	CWS failed to follow Adoption and Safe Families Act (ASFA) timelines for filing a petition to terminate parental rights regarding a 9-year-old dependent child with special needs. The child had been in out-of-home care for 24 months (nine months longer than the ASFA mandate for filing), and the parent had only recently shown a brief period of stability after a 9-year-long history of instability and chronic neglect of the child. The Ombudsman found that despite these factors, the agency did not engage in concurrent planning nor did it present compelling reasons to the court for delaying filing a termination petition.	The Ombudsman contacted the supervisor and requested that the agency consider filing a termination petition.	The supervisor agreed to send a TPR referral to the Office of the Attorney General (AGO) by the end of the following month. Five months following that date, the child's permanent plan was established and in process.
Health care for dependent child	CWS failed to arrange for medical coverage of a 7-year-old legally free child prior to sending the child to an out-of-state treatment facility. As a result, certain medical evaluations and treatments were delayed and the child had to be seen in the emergency room for any needed medical care.	The Ombudsman contacted CWS who acknowledged the oversight and reported on its efforts to obtain coverage for the child.	The Ombudsman monitored the case until the medical coverage issues were resolved six weeks later.

PREVENTING FUTURE MISTAKES

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Child safety	CPS improperly returned a 2 ½-year-old, non-dependent child to the care of a parent who had revoked a Voluntary Placement Agreement (VPA) and was out of compliance with services. The child had suffered serious physical abuse (beating and strangling) at the hands of the parent's companion. Days prior to the parent's revocation of the VPA, the CPT had recommended against returning the child to the parent and had asked to re-staff the case in a month. CPS returned the child home without re-staffing the case with the CPT nor consulting with the Regional Administrator (RA) as required by policy when the agency decides not to follow a placement recommendation made by a CPT.	This finding was made during OFCO's investigation of a complaint involving these children three years after this CPS action had occurred. By that time, the agency was aware of its poor management of this case in the past.	

ADVERSE FINDING WITH NO INTERVENTION

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Foster parent issues	DLR/OFCL took one year to complete the foster care licensing process for a formerly licensed relative caregiver of a 17-year-old dependent youth. The Ombudsman found that although the delay was attributable largely to difficulties in getting acceptable fingerprints from the applicant, the year-long delay had resulted in an undue financial burden on the caregiver. Although DLR eventually issued an administrative waiver to allow foster care payments to be made until the fingerprint issue was resolved, the Ombudsman found that a waiver could have been granted much earlier.	No further action was necessary because the license had been issued.	
Unreasonable removal of child from parent	CPS failed to present sufficient evidence to support filing a second dependency petition regarding a newborn infant alleging neglect by the parent. The parent had three older children in out-of-home care, and the first petition (and removal of the infant) was based on the parent's CPS history and lack of progress in services with regard to the three older children. The court dismissed this petition three months later. CPS then filed a second petition and pick-up order. The court quashed the pick-up order and again dismissed the petition. The Ombudsman found there was no new information in the second petition supporting the need for removal of the infant.	These actions had already occurred.	The agency's actions caused the parent to leave the jurisdiction with the infant without further contact with the agency, potentially placing the infant at higher risk of harm.

REGION 3

INDUCING CORRECTIVE ACTION

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Delay in placing with relative	CWS delayed in exploring placement of a 2-year-old, non-dependent child who had been placed in foster care with an out-of-state relative. The Ombudsman found that the agency's rationale for delaying the process, i.e. that it needed to wait until dependency was established as to both parents, was not supported by law or policy. The child was in foster care for 6 months without an Interstate Compact on the Placement of Children (ICPC) home study being requested on the available relative.	The Ombudsman contacted the CWS supervisor and the CA program manager for the ICPC and verified that there was no need to wait for establishment of dependency on both parents before requesting a home study on the relative through the ICPC process.	The ICPC home study request was submitted two months later. The child was placed with the relative after spending a little over a year in foster care.
Health care for dependent child, placement issues, foster parent retaliation	1. CWS failed to provide appropriate medical care to a 1-year-old dependent child in foster care. The Ombudsman found that despite its knowledge of scheduled medical procedures well in advance, and despite frequent reminders from the caregiver about these appointments, CWS failed to obtain the required parental consent for the procedures. As a result, the child's treatment was delayed for approximately 3 months. 2. CWS moved this child and two siblings from the foster home abruptly and unnecessarily after the foster parents complained about the delay in medical care, resulting in separation of the siblings, further multiple placements of the children and disruption of their schooling. The Ombudsman found the move to be in violation of law and policy (including the Braam settlement agreement) on all of these counts. Furthermore, although the agency stated that the children were moved because of an allegation made by one of the older siblings about the foster home, the Ombudsman found little credibility to this rationale and found the move to be suspicious for retaliation against a foster parent by the department (see Foster Parent Retaliation, page 86).	1. The Ombudsman requested immediate action to obtain the required medical procedure. 2. The Ombudsman contacted the deputy regional administrator and CA assistant secretary prior to the children's removal to request a review of the decision to move the children.	1. The child's medical appointment was rescheduled after the agency obtained parental consent, resulting in a three-month delay in treatment. 2. CA management upheld the decision to move the children and the move occurred.

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Inadequate child fatality review	CA failed to do an adequate fatality review of the death of a 10-year-old dependent child in a fire that occurred in a foster home. During the investigation, another foster child in the home claimed to have started the fire. This fatality received a regular fatality review (where abuse or neglect is not suspected) and therefore CA did not include anyone from outside the agency in its review team. The cause of the fire remained unclear in the fatality review report. The Ombudsman found that due to the need for investigation of possible negligent treatment (lack of supervision of this child) by the foster parents, the agency should have conducted an executive fatality review, which would have included statewide, multidisciplinary participants with no direct involvement in services for the child's family or the foster home.	The Ombudsman contacted CA HQ several times and requested that the agency convene an executive fatality review of this child's death.	As of November 2009, CA decided to convene a second fatality review to include non-CA entities such as law enforcement, the fire department and the Ombudsman.

FACILITATING RESOLUTION

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Foster parent issues, violation of foster parent's rights	DLR/CPS failed to complete an investigation of a referral on a foster home in a timely manner, making a finding 28 months later. Furthermore, DLR failed to communicate the concerns identified in the investigation until almost three years after the fact, when it requested anger management evaluations of the foster parents. The Ombudsman found that this request so long after the fact to foster parents who had provided many years of good foster care service to the agency and were unaware of the agency's concerns, represented poor service to one of the agency's most valuable resources. The Ombudsman found a critical lack of documentation in the licensing file, lack of effective communication between the agency and the foster parents, and bureaucratic errors had contributed to the loss of this resource.	The Ombudsman contacted the DLR Area Administrator to discuss these findings and requested that the agency acknowledge its errors to the foster parents and clearly explain its basis for requesting the anger management evaluations.	The DLR Area Administrator did so in a meeting with the foster parents and followed up with a letter.

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Delay in permanency, dependent child well-being	1. CWS inappropriately pressured the pre-adoptive foster parent of a 5-year-old legally free child to allow visits between the child and the biological parent. Although an open adoption agreement had been drafted allowing for an annual visit between parent and child, the agreement was not yet in effect as the adoption had not been finalized. Furthermore, the parent was not in compliance with conditions specified in the agreement for the annual visit to take place and the child's therapist was recommending against a visit at this time. 2. CWS delayed implementation of this child's permanency plan. The child had been in this identified permanent placement for most of the child's life and had been legally free for nine months. The Ombudsman found the delay to be partially attributable to the fact that CWS had lost the case file (including the adoption home study) of the pre-adoptive foster family.	1. The Ombudsman contacted the CWS supervisor who reported that the AA and other key parties to the case were consulting to clarify legal and other issues to decide whether visits were in the child's best interests at this time. 2. The foster parents had meanwhile provided the agency with their copy of their home study. The Ombudsman urged the agency to expedite the adoption.	The child was adopted by the pre-adoptive foster parents two months after the Ombudsman contacted the agency.
Delay in reunification, services to dependent child	CWS maintained the foster care placement of four dependent children, ages 3 through 7, out-of-region despite growing evidence that their distant placement was precluding services and parent-child visitation necessary to achieve reunification. Moreover, the agency failed to ensure the children's participation in trauma-focused, cognitive-behavioral treatment as recommended by the mental health professional who evaluated them. This was especially unreasonable given that the availability of this specialized treatment out of region had been a major reason for selecting this placement. The children received no treatment for nine months.	The Ombudsman contacted the AA to request that the agency consider moving the children closer to the parent and that therapy be arranged as soon as possible.	CWS continued exploring alternative placements in-region, but six months later the children remained in the same foster home. At that point, the court ordered their return home, over the recommendation of the CPT to move the children closer to the parent but maintain out-of-home placement to allow the parent to achieve greater stability. The Ombudsman monitored the agency's management of this case for eight months to ensure that the input of the many professionals involved (including the CASA, the CPT and the children's therapist) was being solicited in decision making.

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Inadequate permanency planning	CWS planned to move a 9-year-old dependent child from a long-term, foster-adopt placement to another potential adoptive placement due to the current foster parent's concerns about the financial implications of adopting the child. The child had exceptional needs that would likely need future treatment. The Ombudsman found that the foster parent had not been provided with concrete information about adoption support and other possible permanency options for the child. The potential alternative placement would not have been appropriate for this child given the child's special needs and the number of other children with special needs in that home, and the lack of services in the community in which the alternative placement was located.	The Ombudsman contacted the CWS supervisor to request that the move be reconsidered, and the foster parent be provided with full information needed to make an informed decision.	The child remained in this placement. A shared planning meeting was convened, attended by the Ombudsman, in which the foster parent and CWS agreed to work together to address barriers to adoption.
Delay in placing with relative	CWS planned to move a 2 ½ -year-old dependent Native American child from the foster-adopt placement the child had been in since shortly after birth, to a relative who was caring for the child's older sibling. The Ombudsman found that relative placement options should have been explored much earlier in the case, to avoid a traumatic move after the child had developed a strong bond with the foster family. Furthermore, CWS's communication with the foster parents and parties to the case appeared to be adding confusion and conflict rather than clarity and cooperation during the decision process, making the process more traumatic for the child.	The Ombudsman requested a review of the case by CA HQ to assess whether the change in placement was in the child's best interests. The Ombudsman also requested that all parties to the case receive complete information regarding court hearings and the status of the placement decision, and that the agency present a motion to change the child's placement, to the court.	HQ reviewed the case and concurred with the plan to move the child to a relative. The court later approved this plan.

ASSISTING THE AGENCY IN AVOIDING ERRORS AND CONDUCTING BETTER PRACTICE

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Placement issues, services to dependent child, delay in permanency, delay in placing with relative, foster parent retaliation	1. CWS planned to move three dependent children, ages 8, 7 and 7, from their long-term foster home to another foster home, despite the children doing well in the home. The children had been living in the foster home for two years, and the decision appeared to be fueled by the escalating conflict between the foster parent and the agency rather than concerns about the safety or well being of the children. 2. DCFS was considering placing the children with relatives from whom they had been removed due to neglect. 3. CWS delayed in obtaining evaluations and services for the children. Neuropsychological evaluations, recommended by the Foster Care Assessment Program to provide effective treatment and permanency planning for the children, took over a year to be arranged and were ultimately arranged by the foster parent. 4. CWS delayed in filing a petition to terminate parental rights in this case despite frequent assurances to the Ombudsman that it planned to do so. Two of the children had been in out-of-home placement for three years by the time they became legally free. Part of the delay may have been attributable to the high turnover in caseworkers and supervisors (four and three respectively during the Ombudsman's two-year monitor of the case). Each change brought a new perspective and "start-over" mentality to the case. 5. CWS delayed in exploring relatives for possible placement of the children. Although the children were initially placed with relatives, after they were removed and placed in foster care the agency did not explore other suitable relatives until it ruled out the foster home as a permanent option two years later. 6. The Ombudsman found that the actions taken by DLR against this foster home were suspicious for retaliation, in the absence of other evidence that would provide a clear rationale for these actions (see separate section on Foster Parent Retaliation, page ? for details.)	The Ombudsman intervened in this case several times by requesting a review of decisions that lacked a rational basis, asking that evaluations and services be arranged and urging that permanency be expedited.	The children were not placed with the relative from whom they had been removed and were not moved from the foster home until other permanency plans were implemented. Two of the children were placed with different relatives after they had been living in their foster home for 28 months. They have since been adopted. The other two children were reunified with the parent.

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Delay in placing with relative	CWS delayed for seven months the conduction of a home study on a relative who had requested placement of a 1-year-old dependent child. The relative passed the home study but by this time, CWS believed the harm to the child of a move from the caregivers the child had been with since birth outweighed the benefits of placement with a relative. Although agency policy does not specify which factor should have priority in permanency planning, placing a child with a relative vs. leaving a child with long-term, non-relative caregivers, the Ombudsman found that the delay in completing the home study had unfairly tilted the decision in favor of leaving the child in the current placement.	The Ombudsman requested a review of the case by the AA to ensure decision making about placement reflected the best interests of the child.	The AA directed CWS to pursue placement with the relative. CWS began the process, including making a referral to the Foster Care Assessment Program to carefully assess the permanency needs of the child. By the time OFCO ended its monitoring of the case, the child was being carefully transitioned to the care of the relative.
Inadequate foster home	DLR failed to take effective action to assess and correct chronic allegations of neglect and lack of nurture/care in a licensed foster home. A recent referral alleged that an 8-year-old dependent child placed in the home reported not being allowed to bathe daily, being cold and hungry in the home and arriving at a parental visit so dirty that the parent took the child to a laundromat to clean the child's clothes. This referral was being investigated as a licensing complaint. The Ombudsman found that these allegations should have been screened in for investigation of possible neglect by DLR/CPS.	The Ombudsman contacted the child's CWS worker and the DLR supervisor, and CWS made a CPS referral that was accepted for DLR/CPS investigation. The CPS investigation was unfounded, but the investigation noted numerous concerns about the pattern of referrals on this foster home. OFCL made a finding of "not valid" regarding the licensing complaint, even though the visiting supervisor corroborated the neglected state of the child and took the unusual step of moving the visit to the laundromat. OFCL was taking no corrective action. The Ombudsman contacted the OFCL supervisor to request a review of the license and a corrective action plan for this home.	The supervisor concurred with the concerns about the foster home but ultimately did not take corrective action. The supervisor flagged the concerns so that if another referral was received, corrective action could be taken. The Ombudsman monitored for further referrals for nine months. No new referrals were received.

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Unreasonable removal of child from parent	CWS filed a dependency petition and sought removal of a 5-month-old, non-dependent child without credible allegations of maltreatment and without imminent risk of harm to the child. The Ombudsman found that the petition was based on one parent's arrest history and the other's involvement with DCFS regarding an older child age 7. Furthermore, the infant was placed with the relative caregiver for the older child over the parents' objections, due to their ongoing concerns about the relative's suitability that they had repeatedly reported to CWS. The relative was reported to be abusing alcohol and prescription drugs, and neglecting the 7-year-old. When the infant was returned home by the court, the parent had to take the child to a doctor for hygiene issues.	By the time the Ombudsman received this complaint, the court had returned the infant to the parents' care at a shelter care hearing. A referral regarding the relative caregiver was being investigated. The Ombudsman monitored the investigation.	The 7-year-old was removed from the relative placement over two months later.
Delay in permanency	CWS failed to file an early petition to terminate the parental rights of a now 19-month-old dependent child who had been in foster care since birth, despite no involvement of either parent in services or visits since birth and previous termination of their parental rights to older siblings. Under these circumstances, the agency could have petitioned for TPR earlier than timeframes specified by ASFA, but it did not refer a petition to the OAG until the child was 15 months old.	The termination referral had been submitted to the OAG by the time the Ombudsman investigated this complaint. The Ombudsman monitored the case to ensure that permanency planning occurred in a timely manner.	The child became legally free and was adopted just prior to the child's second birthday.
Child safety	CPS failed to adequately monitor a family on which it had an open case and a safety plan in place to protect two non-dependent children, ages 7 and 3, from unsupervised contact with their 17-year-old sibling who had sexually abused another sibling and was perceived as a threat to the safety of younger children. The family had a history of nearly 30 CPS referrals, including the founded finding of child-on-child sexual abuse. Lack of supervision and/or neglect were repeated concerns in these referrals. The Ombudsman found CPS's safety plan for the family inadequate as it relied too heavily on the parent and youth's cooperation, which had been lacking in the past, especially given the vulnerable ages of the two younger children in the home.	The Ombudsman requested that the agency consider obtaining a mental health evaluation of the youth to better assess the risk level in the home. CPS agreed and obtained a psychological evaluation, which concluded that the youth was at high risk of sexually re-offending and required close supervision. CPS closed the case with an agreement from the parent to not allow unsupervised contact between the youth and the children, again relying on the parent whose past supervision of the children was in question. The Ombudsman continued to monitor the case for further referrals.	CPS received four further referrals from mandated reporters (including the youth's probation officer) alleging that the youth was not attending school, may be having unsupervised contact with the younger children, that the 7-year-old came to school with injuries disclosing being hit with a bat by a sibling while the parent was sleeping, and that the parent was using drugs and alcohol and leaving the children home alone with the 17-year-old. None of these referrals were screened in for investigation. A fifth referral was screened in, a new case opened and a dependency filed on the youngest child.

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Violation of parent's rights	CPS delayed in obtaining a second medical opinion as part of its investigation of allegations of physical abuse of a 4-month-old, non-dependent child by the parents. The medical opinion was sought over four months after the agency agreed to obtain it, and the alleged perpetrator was required to live outside the home until the investigation was completed. Although the second opinion agreed with the original medical evaluation that the child had suffered an unexplained injury, it also concluded that the parents had provided good care to the child. CPS made a finding of "unfounded" for physical abuse, but requested that the parents undergo psychological evaluations. The Ombudsman found this to be unreasonable, given that the parents had no identified psychological concerns and had already completed parenting assessment at the agency's request with favorable results.	The Ombudsman contacted the RA and requested that the agency reconsider its request for psychological evaluations.	The RA agreed that psychological evaluations were not needed, but decided that an additional parenting assessment should be obtained to assess any remaining risk to the child. The parents ultimately agreed to participate in a further assessment.
Delay in placing with relative	CWS failed to place a 2-year-old dependent child with relatives upon removal of the child from a fictive kin placement. The Ombudsman found that although the agency was aware of the relative, had no reason to believe they were unsuitable and the relative had an existing relationship with the child, CWS failed to explore the relative placement and instead placed the child unnecessarily in foster care for a month.	The Ombudsman contacted CWS who was aware of this oversight and was in the process of considering the relative for placement.	The child was placed with the relative after a month in foster care.

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Child safety, relative placement issues, dependent child well being	CWS failed to identify concerns about the relative caregivers of a legally free 3-year-old child that would jeopardize their adoption of the child, per the agency's permanency plan. The Ombudsman found several errors in case management that led to the removal of the child after over 2 ½ years of placement with the relatives, just before the child was to be adopted. CWS had failed to complete a relative home study at the time of initial placement. A year later, the relatives were issued a foster care license. However, the licensor conducting the home study failed to make collateral contacts to verify certain information provided by the relatives. Two foster children were placed in the home. CWS failed to make all the required health and safety visits to the three dependent children (two foster children and one relative child) in the home, failed to inspect the home and therefore may have missed key evidence that the children's safety and well being was being compromised. An adoption home study conducted 2 ½ years later was about to be approved when the agency received troublesome information about the relative's character and behavior, ultimately resulting in removal of the relative child. The remaining foster child who was placed in the home at the time was moved to a relative placement. The Ombudsman found that the manner in which the relative child was removed was deceptive to the child and relatives and traumatic for the child. Finally, CWS did not conduct a relative search prior to moving the child, even though it had time to do so, resulting in the child being placed in an unnecessary foster placement before being placed with another relative.*	Since there had been no abuse or neglect of the children by the relatives and the related child had been in their care since the age of 8 months, the Ombudsman contacted the AA to request that the agency explore the possibility of a corrective action plan to restore the relative placement. The Ombudsman monitored the case for six months and intervened with the agency several times to ensure effective case management.	Given numerous concerns subsequently discovered by the agency and revocation of the family's foster care license, DCFS decided it could not recommend adoption by the relatives. The child was placed with other relatives. The court ultimately granted both sets of relatives a motion to intervene in the dependency, and the court will decide who should adopt the child.
Delay in permanency	CWS failed to oppose a relative's motion to intervene in the adoption of a 10-year-old legally free child whose permanency plan was for adoption by a different relative (the current caregiver). The Ombudsman found that the agency's failure to oppose the motion caused further delay in permanency for the child and financial hardship to the relative caregiver, who had to hire an attorney to represent them in the contested adoption. Moreover, the agency's inaction was unreasonable because the court had previous ordered removal of the child from the relative filing the motion and this relative would likely not have passed an adoption home study.	The Ombudsman contacted the AA to discover the agency's rationale for its decision not to oppose the motion to intervene. The agency explained that it was attempting to be fair to both sets of relatives because the current relative caregiver had not yet completed an adoption home study.	The court ultimately allowed the other relative to file a competing petition for adoption of the child. In the time it took to resolve the legal issues, the child's permanency had been delayed by approximately one year. The child is now in the process of being adopted by the current relative caregivers.

* OFCO corrected an inaccuracy in this summary on April 8, 2010. The correction does not affect the substance of OFCO's findings.

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Delay in permanency	CWS failed to file a petition for termination of parental rights regarding a 3-year-old dependent child within timeframes specified by law and policy. The Ombudsman found that several factors should have prompted the agency to expedite permanency planning in this case: the child was born drug-affected and had been placed in foster care at birth; both parents were incarcerated with lengthy sentences; and the parents had no contact with the child and were not engaged in services. Despite these major impediments to speedy reunification, the child had been in the current foster home for over 2 ½ years with no progress toward permanency.	The Ombudsman contacted CWS who explained that part of delay in permanency was attributable to poor legal representation of one of the parents. CWS reported that the parent had recently been assigned a new attorney.	The agency stepped up permanency planning efforts and a termination petition was filed.

PREVENTING FUTURE MISTAKES

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Inadequate social worker training	The Ombudsman was unable to substantiate a complaint that a CWS social worker entered a parent's home when the parent was not home. The Ombudsman found that CWS does not provide adequate training to workers regarding citizens' Fourth Amendment rights to privacy, leaving workers vulnerable to situations in which the correct course of action is unclear. In this instance, the employee contract specified that this new worker would be accompanied by a supervisor or mentor when conducting home visits. This had not occurred.	The Ombudsman contacted CA's Training Academy to inquire how this topic is covered in the training curriculum. The trainer informed that workers are trained to leave a business card when clients are not home and should use "common sense" which should be reinforced through on-the-job training by supervisors.	

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Child safety	CWS failed to develop a safety plan for a 12-year-old dependent child with history of sexually abusing another child when placing the child in a foster home with other children. The child later sexually abused another child in the home. During the DLR/CPS investigation that ensued, the foster parents stated they had not been informed of the child's past sexually aggressive behavior. DLR found no written evidence that they had been informed, although the DCFS placement coordinator stated that the foster parents had been verbally informed. The Ombudsman found that the failure to provide this information in writing was a violation of policy. The lack of a specific safety/supervision plan to address these behaviors may have contributed to sexual abuse of a child in foster care.	The Ombudsman followed up with the AA regarding the apparent lack of clarity about procedures for informing foster parents about children's behavioral and other history at the time of placement.	The administrator later reported that the region had developed a new policy/procedure requiring that foster parents receive a document containing comprehensive information about a foster child's history and needs at the time of placement in their home.
Child safety	A DCFS employee left two dependent children, ages 11 and a 5-week-old infant, in a car for a few minutes while on agency business. The lack of direct adult supervision was mitigated by the employee asking a responsible adult in the vicinity to monitor the children from a distance and not wanting to expose the children to below-freezing temperatures outdoors.	The Ombudsman contacted the supervisor to verify that that appropriate action was being taken.	The agency took disciplinary action with the employee.

ADVERSE FINDING WITH NO INTERVENTION

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Child safety	CPS placed two non-dependent children, ages 8 and 6, in the care of a non-custodial parent who was under CPS investigation through a different case. The parents' companion's 7-year-old child had recently been removed from the home by CPS due to allegations of physical abuse and neglect. The parent (of the 8 and 6-year-olds) was prohibited from having contact with the 7-year-old. The Ombudsman found that the these factors and the fact that the parent had a founded finding for neglect two years previously indicated safety risks that should have precluded placement of the children in this non-custodial parent's care.	Soon after the Ombudsman began investigating this complaint, the court ordered that the 8-and 6-year-old children be placed with their custodial parent.	

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Delay in permanency	CWS failed to achieve permanency for a 13-year-old legally free child who had been in and out of out-of-home care since the age of 1 and legally free for five years. The Ombudsman found that the child had been living in a foster home offering no possibility of permanency for four of those five years, in clear violation of ASFA. CWS also failed to maintain contact between the child and two legally free siblings.	At the time the Ombudsman was reviewing this case, the youth had been moved to a pre-adoptive home in another state. This placement failed prior to the adoption being finalized.	The youth is in group care awaiting an adoptive home. CWS is actively recruiting a potential home.
Child safety	CPS failed to provide specialized equipment required by a 9-year old, non-dependent child with a medical condition when it removed the child from home. The Ombudsman found this was caused by human error but resulted in the equipment not being delivered to the relative caregiver's home until 48 hours later, negatively affecting the child's sleep and placing the child at risk of seizures for two nights.	Since the agency had already corrected this error, no further action was necessary.	
Child safety, violation of parent's rights	CPS failed to inform a parent and the alleged perpetrators that CPS was investigating alleged physical abuse of an 11-year-old, non-dependent child and that the child had been interviewed. The Ombudsman found that by law and policy, this information should have been provided as soon as possible after the initiation of the investigation. Instead, the parent and subjects were only informed over three months later. The subjects of the allegations were only interviewed four months after the referral was received, by a different investigator, potentially affecting the integrity of these interviews and the investigative finding.	This had already occurred by the time the Ombudsman investigated the complaint.	

REGION 4

INDUCING CORRECTIVE ACTION

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Violation of parent's rights	CWS modified draft evaluation reports sent to the agency for input by a contracted psychologist hired to conduct a psychological evaluation of a parent. Although it is an accepted practice for CA to provide background information about the client being referred for evaluation and CA may present specific clinical questions it wants the evaluation to address for case planning purposes, the Ombudsman found that this method of obtaining direct input from CWS undermined the neutrality of the evaluation sought from an independent provider.	The Ombudsman contacted the AA and requested that the matter be investigated to establish whether this was a more wide-spread practice in that particular DCFS office, and take appropriate action.	The AA and contracts manager for the office found that the practice of caseworkers providing input directly into evaluation reports by contractors was more widespread than this one instance. The AA met with office supervisors to provide guidance on best practices for working with contracted providers conducting evaluations of clients for the agency.
Child safety	CWS failed to remove from home the 12-year-old, non-dependent sibling of a youth who had been taken into protective custody following allegations of severe maltreatment by the parents. Furthermore, the victim was not being adequately protected from contact with the perpetrator.	The Ombudsman contacted the AA and requested a review of the decision to leave the sibling in the home and the safety plan in this case.	The agency filed a dependency on both children and collaborated with law enforcement to establish appropriate contact boundaries between family members.
Failure to place and provide contact with relative	CWS failed to place a dependent 3-year-old child with relatives. The child had been in their care much of the child's life and the relatives had no history of child maltreatment or other concerning history. Furthermore, the agency was refusing to allow visits between the child and the relatives. The Ombudsman found the agency's rationale for these decisions, i.e. that: (a) the parent was opposed to visits and placement and the agency was following law and policy by respecting parental preference; and (b) that it believed the parents would not support reunification was: (i) insufficient to justify depriving the child of a primary attachment relationship for the 18 months the child had been in foster care; and (ii) was unsupported by evidence.	The Ombudsman requested a review of the case by CA HQ with a view to reconsidering both visits and placement with the relatives.	The agency changed its position and after reinstating visits between the child and the relatives, the child was gradually transitioned from foster care to the relatives who later adopted the child.

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Violation of parent's rights	DLR/CPS delayed in completing an investigation into allegations of abuse and neglect of two non-dependent youths by their adoptive parents (who were also licensed foster parents). Although supervisory approval was granted for the investigation to remain open beyond 90 days in compliance with law and policy, the investigation took a year to complete. The Ombudsman found that while the investigation had been extensive and complicated, involving multiple alleged perpetrators and victims and coordination with law enforcement, CPS's investigation had been largely completed within 90 days and the agency was merely awaiting the completion of the police investigation. The Ombudsman found that the agency could have reached its findings much earlier without relying upon or interfering with the investigation by law enforcement. The year-long delay in informing the subjects of the founded findings and the corresponding delay in DLR's decision to revoke the foster care license was unreasonable.	The investigation had been open for over 10 months by the time the Ombudsman began investigating this complaint. The Ombudsman contacted the DLR/CPS supervisor to request that the investigation be completed and the subjects notified of the findings as soon as possible.	DLR completed its investigation within a month.
Child safety	CWS failed to report an accidental injury to a 5-year-old dependent child in a relative placement. The child had been hit by a car while running across the street. Policy requires agency staff to report any injuries to dependent children within 48 hours to allow for prompt investigation. The Ombudsman found that although CWS had taken steps to ensure the child's safety, the accident had still not been reported for CPS investigation six days after the accident had occurred.	The Ombudsman contacted CWS the same day this complaint was received to request that a CPS referral be made immediately.	The CWS caseworker made a referral the same day. The referral was investigated by CPS promptly.

FACILITATING RESOLUTION

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Delay in permanency	CWS failed to file a petition to terminate the rights of the parents of two dependent children, ages 2 and 4, after the children had been in out-of-home care for over 2 ½ years and despite the parents' non-compliance with services. The children had been living in a stable foster home that was willing to adopt them. The Ombudsman found that the delay in permanency was partly attributable to the CWS worker's plan to move the children to pre-adoptive home that matched the children's race (unlike the current home). The Ombudsman found that this case plan could violate the intent of federal law prohibiting denying an adoptive placement on the basis of race.	The Ombudsman contacted the AA to request a review of the case to address whether race may be playing a role in permanency planning for these children. The AA found that race was being inappropriately considered in placement planning.	The administrator directed CWS to file a termination petition and actively explore all relatives. No suitable relatives were found and CWS began concurrent planning to either return the children home (one of the parents had recently begun complying with services) or facilitate their adoption by their long-term foster parents.

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Inadequate transition to independent living	CWS failed to adequately prepare a 17-year-old youth for exit from foster care at age 18. Specifically, the Ombudsman found that the agency failed to hold a shared planning meeting, failed to provide the youth with a social security card and birth certificate, and failed to set up needed independent living services.	The Ombudsman contacted the CWS caseworker and supervisor to request that the youth be assisted with independent living services. No action was taken. The Ombudsman then contacted the Independent Living Services program manager at HQ who facilitated a referral to the regional ILS contact.	The youth was provided with the needed assistance.
Failure to place with sibling, supporting sibling relationships	CWS failed to place a dependent 9-month-old infant with an older sibling who had been adopted by a foster family. Although there are competing priorities under the law governing placement in such cases, the Ombudsman found that the agency's prioritization of placement in a foster home closer to the parent's home in order to facilitate visitation, was puzzling in light of the parent's history. The parent had lost custody, and in some cases, parental rights to four older children and had a history of chronic non-compliance with court-ordered services. Furthermore, the parent moved soon after the infant was placed, negating the original intent behind the placement. Finally, the sibling's adoptive parents had been willing to facilitate parent-child visits by providing transportation of the child if placed with them. The Ombudsman found despite these factors, CWS was largely unresponsive to the sibling's parents' ongoing efforts to be considered for placement of the child. CWS had agreed in writing to arrange visits between the siblings and failed to do so.	The Ombudsman discussed these findings with CWS, who acknowledged poor practice in managing this case. The Ombudsman discussed the visitation issue with the child's CASA who had a good working relationship with both sets of foster parents, and the CASA volunteered to assist them in arranging visits between the siblings, as the agency and all parties were in support of this.	The infant remained in the original placement.
Violation of parent's rights	CPS failed to complete an investigation within 45 days without the required supervisory approval for an extension of time. The investigation had also not been documented as required by policy. While this is a violation of policy, the Ombudsman found that the CPS investigator had 62 open investigations, far exceeding the agency's policy regarding caseload size (18 cases), making it impossible for the caseworker to comply with investigation standards.	The Ombudsman was in the process of investigating concerns about the alarmingly high workload of caseworkers and supervisors in this particular DCFS office. The Ombudsman contacted agency officials up the management chain to urge resolution of this problem.	The Secretary of DSHS initiated a full review of the problems experienced by workers in this office.

ASSISTING THE AGENCY IN AVOIDING ERRORS AND CONDUCTING BETTER PRACTICE

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Child safety	CPS failed to intervene effectively to prevent chronic and serious maltreatment in a family with two non-dependent children, ages 5 and 4, over a 2 ½ year period. CPS had received 18 referrals alleging physical abuse and neglect, and non-intensive services that had been provided were ineffective in protecting the children from further maltreatment. The service providers themselves were making many of the referrals to CPS, advocating for stronger protective action by the agency.	The Ombudsman contacted the AA and requested that the case be staffed at with the CPT.	The case was staffed, and the CPT recommended specific services and a re-staffing of the case with the CPT in 2 months. The family made good progress when these additional services were provided. The Ombudsman monitored the case for eight months, during which no new CPS referrals were received and the family continued to make good progress.
Child safety	CPS exhibited bias in investigating a referral alleging long-standing physical abuse of a 16-year-old, non-dependent youth by a parent. CPS prematurely concluded that the abuse was unfounded after interviewing only the alleged victim. CPS then communicated skepticism about the allegations when interviewing the referent, telling the referent the subject would be interviewed but the finding would be unfounded and the case closed. The Ombudsman found that the agency's failure to obtain collateral information, including medical records, and complete all interviews before reaching a finding was contrary to policy and poor practice.	The Ombudsman contacted the AA to express concern about the quality of the investigation and the dismissive communication with the referent who was trying to secure assistance for the youth.	CPS conducted a thorough investigation, including collateral contacts to medical providers, an extended family member and thorough interviews with both parents. The investigation resulted in an unfounded finding.

PREVENTING FUTURE MISTAKES

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Child safety	CPS failed to communicate effectively with law enforcement during an investigation of allegations of physical abuse of a 7-year-old dependent child. CPS failed to inform law enforcement of the child's test results on a test for a sexually transmitted disease. As a result, the child had ongoing (though supervised) visits with the perpetrator of sexual abuse and there was a two-month delay in establishing the identity of the perpetrator. The Ombudsman found that CPS should have informed law enforcement about the full results of the child's medical exam upon receipt of the results.	This action had occurred some time ago by the time the Ombudsman investigated the incident. The Ombudsman contacted CPS to discuss how this oversight had occurred. The communication error was partly attributable to the number of jurisdictions involved and the number of different caseworkers/units.	
Child safety	CPS failed to monitor the safety and well-being of an 11-year-old, non-dependent child after it made a founded finding for negligent treatment against the parents for locking the child in a room with no escape access and leaving the child home alone while locked up. After completing the investigation, CPS referred the family to community resources for counseling services and closed its case. The Ombudsman further found that disclosures the child made during the investigation about being deprived of food were not adequately assessed. Inadequate assessment of risk to the child and premature closure of the case without any monitoring or follow-up resulted in chronic and severe maltreatment of the child for three more years before the agency had another opportunity to intervene.	The Ombudsman reviewed this three-year-old CPS investigation as part of a critical incident review.	Since the agency was already conducting its own review, the Ombudsman shared the findings of OFCO's review with CA HQ.
Delay in permanency	CWS delayed in filing a petition for termination of parental rights as to the parents of a 2½ -year-old dependent child. Although the child had been in out-of-home care and the same foster home since the age of two weeks, and the parents had had minimal contact with the child and were not engaging in services, the agency had not yet filed a termination petition to expedite the child's permanency plan. The Ombudsman found that high caseworker turnover and resulting poor case management contributed to the delay in permanency.	Soon after the Ombudsman's investigation began, CWS filed a termination petition. The case had been transferred to a new worker, who quickly completed delayed tasks to ensure the child's well being and expedite permanency.	The child is now almost 3½ years old, is legally free and in the process of being adopted by the foster parents.

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Child safety	CPS intake inappropriately screened a referral alleging that a registered sex offender was living in a home day care, as a licensing complaint rather than for CPS investigation. The Ombudsman found the screening decision to be inappropriate due to the potential for child abuse occurring under these circumstances.	When the Ombudsman received this complaint, CPS had received a second referral alleging similar and additional information and had screened in the second referral for investigation.	The Ombudsman monitored the investigation to ensure appropriate action was taken to protect all vulnerable children. The home is no longer licensed.
Delay in permanency, dependent child well being	CWS left three legally free children, ages 15, 11 and 4, in a pre-adoptive placement with a relative who was ultimately unable to pass an adoptive home study. CWS removed the children from this four-year-long placement, during which the agency had growing concerns about the suitability of the relative. The Ombudsman found that the harm to the children resulting from the removal from a long-term placement was considerable, and was exacerbated by the agency having to separate the children in new placements. The agency's delay in accurately assessing the suitability of this placement resulted in a significant delay in permanency for these children.	Since the children had already been removed, the Ombudsman monitored the agency's permanency planning for these children for over a year.	The oldest youth successfully petitioned for reinstatement of the biological parent's parental rights and returned home. The middle child is in a stable foster care placement but plans to do likewise. The youngest remains in foster care while the agency continues to seek a permanent placement.
Child safety	CPS conducted an inadequate investigation into allegations of abuse and neglect of six non-dependent children, ages 1 through 9, by their non-custodial parent. CPS interviewed the children all together, in the presence of the custodial parent who was suspected of coaching them. As a result, CPS focused exclusively on the allegations involving the non-custodial parent while missing abuse and neglect that was later founded against the custodial parent.	The Ombudsman reviewed CPS's management of this case over the prior year as part of its review of cases in which three founded findings have been made regarding a family, per the Legislature's request. For further information regarding that systemic investigation, see separate section of this report, page 174 (three founded cases).	

REGION 5

INDUCING CORRECTIVE ACTION

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Placement issues	CWS placed a 1-year-old legally free child with a relative who had a criminal conviction listed by law and policy as a "disqualifier" for providing care for children. The relative wanted to adopt the child.	The Ombudsman contacted the CWS and Adoption Unit supervisors involved (the relative was undergoing an adoption home study at the time) to request that this error be resolved.	The relative, who passed all other aspects of the adoption home study aside from the criminal background check, was able to get the conviction vacated. The adoption process continued.
Child safety	DLR tolerated non-compliance with licensing regulations by a contracted child-placing agency over a seven-year period without a corrective action plan in place to bring the agency into compliance. The Ombudsman found that DLR investigated 16 reports alleging 35 licensing violations during this period, resulting in 11 valid and eight inconclusive findings. While DLR provided technical assistance to correct the lack of compliance over the years, DLR failed to enter into a formal compliance agreement to correct the agency's problems.	The Ombudsman contacted DLR to request that it establish such a plan.	DLR established a compliance agreement with specific dates by which the private agency needed to come into compliance or risk revocation of its license. The agency remains open and is being closely monitored by DLR.
Child safety	CPS intake failed to screen in for investigation multiple referrals alleging neglect of two medically fragile non-dependent children, ages 2 and 6 months. The Ombudsman found that the screening decisions were clearly unreasonable given the high number of referrals, the parents' chronic history of domestic violence, drug use and mental health problems, the high level of risk posed by the children's young age and special needs, and the parents' lack of cooperation with voluntary services in the past.	The Ombudsman contacted the AA and requested a review of the two most recent screening decisions.	The AA agreed to change the screening decision to allow for referral of the family for public health nursing services.

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Placement issues, unreasonable CPS finding against foster parent, foster parent retaliation	1. CWS removed a 12-year-old legally free child from a foster home in which the child was doing well due to the private licensing agency's concerns that the child was sharing a bedroom. The child had special needs and had experienced six placements in 5½ years of out-of-home care, including a recent failed adoptive placement. The child expressed a strong desire to remain in the home and the placement was supported by the CASA and all other service providers for the child. However, the private agency was concerned about the risks of the child sharing a bedroom with 15- and 16-year-old foster children, given the child's past sexually reactive behavior with younger children. CWS was in the process of trying to resolve these issues when a referral alleging neglect by the foster parent was received (see #2 below). CWS immediately moved the child with no transition. The Ombudsman found the move to be unreasonable, as the sleeping arrangements could have been resolved and none of the professionals involved (including CWS) believed the child's safety or well-being had been jeopardized by the reported incident (below). 2. DLR/CPS made a founded finding for neglect of this child by the foster parent that was clearly unreasonable. The foster parent had allowed the child to go trick-or-treating in the immediate neighborhood together with 15- and 16-year-old foster siblings. The child's supervision plan required adult supervision in the community, but the adult whom the foster parent had arranged to supervise the children had a last-minute family emergency and with no other adults immediately available, the foster parent allowed the children to go. The older children were fully aware of the 12-year-old's supervision needs. The Ombudsman found that the agency could have made a licensing finding for lack of supervision instead of the much harsher CPS finding of neglect, which would result in revocation of the foster care license. The foster home had an exemplary record of care for children with special needs with no history of referrals. 3. The Ombudsman found that the actions taken by DLR against this foster home were suspicious for retaliation in the absence of other evidence that would provide a clear rationale for these actions (see separate section on Foster Parent Retaliation, page 86 for details.)	1. After investigating CWS's initial threat to remove the child due to the private agency's concerns, the Ombudsman contacted the CWS supervisor and DLR regional licensor to urge efforts to resolve the barriers to maintaining this placement. The Ombudsman participated in case staffings arranged for this purpose. 2. The Ombudsman requested a review of this finding by CA HQ and a review of the decision to screen this referral for CPS investigation rather than as a licensing complaint.	1. CWS moved the child. The Ombudsman monitored the child's well being in two further placements before the child was placed in a pre-adoptive home. 2. The finding of neglect was overturned by CA HQ. CA's review of this and other DLR cases requested by the Ombudsman has resulted in systemic changes in policy and practice. For example, the agency is reviewing its requirement for 24/7 supervision of some foster children by foster parents, to develop a more reasonable supervision requirement.

FACILITATING RESOLUTION

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Relative caregiver issues	CWS failed to include the relatives of an 11-year-old dependent child in permanency and case planning for the child. The relatives were the pre-adoptive caregivers for the child's younger sibling and the subject child's pre-adoptive placement with other relatives had recently failed. The sibling's caregivers wanted to be considered for placement and to actively support the older child. CWS was sharing limited information with the relatives, limiting their visits with the child (with the rationale that this would allow the child's new temporary foster placement to stabilize) and was unwilling to consider the family for placement without objective criteria (i.e. an adoptive home study). The Ombudsman found that CWS appeared to be creating unnecessary roadblocks to a true collaboration with family members and professionals invested in the child to share all available information and develop an optimal service and permanency plan for the child.	The Ombudsman contacted the CWS supervisor to request that more information be shared with the relatives and that they be fully included in case planning.	The relatives began attending case planning meetings and actively participating in obtaining services for the child to stabilize the child's behavior. The Ombudsman monitored the case for over three months. The child was transitioned to the relatives with a plan for adoption.
Placement issues	CWS failed to plan a transition for a 10-year-old dependent child who was moved from one foster home to another to ease the child's adjustment. The Ombudsman found that the agency's rationale that the move needed to occur immediately due to a scarce resource (an open bed in a BRS placement) becoming available, and its decision to carry out a sudden move of the child with no transitional support, did not take into account the child's mental health needs – the bond the child had developed in the 1½ year-long placement with the current foster parents.	The Ombudsman contacted the CWS supervisor and requested that a transition plan be developed with the input of the current foster parents and the child's CASA. CWS did so and a transition plan was developed that allowed for phone contact and some weekend visits to the child's former foster home and an opportunity for the child to say goodbye to school classmates. However, the Ombudsman later learned that the plan was not adhered to, necessitating several more interventions to ensure phone contact and visits were arranged.	A visit was finally arranged almost seven months after the child moved.

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Inadequate transition to independent living	CWS failed to plan appropriately for a suitable placement for a 17-year-old legally free youth upon imminent release from jail. CWS was planning to petition the court to dismiss the dependency and emancipate the youth so the youth could access adult services due to the many restrictions of the youth's probation once released. The Ombudsman found this to be clearly unreasonable given the state's responsibility for a dependent youth in need of services to transition to independent living.	The Ombudsman contacted the CWS supervisor and requested that a suitable placement and services be arranged.	CWS contracted with a private agency to provide a suitable placement and services for the youth. The plan was finalized the day before the youth was released.

ASSISTING THE AGENCY IN AVOIDING ERRORS AND CONDUCTING BETTER PRACTICE

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Child safety, dependent child well being, supporting sibling relationships	1. CWS continued an in-home dependency of a 7-month-old infant despite the parent's partial compliance with court-ordered services and conditions and the parent having placed the infant in a risky situation. 2. CWS recommended to the court that visits continue between this parent and two older children, ages 4 and 2, despite serious behavioral and emotional disruptions exhibited by the children after visits, including unexplained weight loss in the 2-year-old. One child had experienced severe physical abuse in infancy (17 fractures) while in the parent's care and the other child had witnessed it. The Ombudsman found that while the agency's stance that it needed to provide persuasive information to the court to request decreasing or ceasing the visits was not clearly unreasonable, the agency was not making strong efforts to obtain this information. Instead, it was the foster parent who obtained letters from the children's pediatrician, therapist and child abuse specialist who had seen the children when they were removed from home, to present to the court. 3. CWS failed to provide visits or contact between these three dependent children who were placed in different foster homes. The Ombudsman found that the agency was relying upon the foster parents to arrange visits and no contact had occurred for approximately eight months.	1. The Ombudsman contacted the CWS supervisor to request increased monitoring of the in-home dependency. 2. The Ombudsman asked the agency to present the letters from the children's providers directly to the court. 3. The Ombudsman contacted the caseworker and urged active facilitation of visit arrangements.	1. CWS did so. Less than two months later, it was discovered the parent was having unauthorized contact with the other parent of the child, who had a history of violent behavior, and the parent tested positive for drugs. The infant was removed. 2. The court followed professionals' recommendations that visits be suspended for three months to monitor any changes in the children's physical and mental health. Marked positive changes were observed and the court ultimately recommended that visits not resume. 3. The children began having regular visits.

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Inadequate foster home	CWS failed to adequately assess the well being of a 13-year-old dependent child who was living under a guardianship with foster parents whose two younger foster children had been removed after a licensing investigation made a valid finding for lack of nurture and care of the children. The foster home had seven prior facility complaints, with four inconclusive findings and three findings of "not valid." CWS believed the 13-year-old, who had many special needs, was doing well in the guardianship and advocated with DLR for the foster care license to remain open. The Ombudsman found that the agency did so without seeking any collateral information to fully assess the child's well-being.	The Ombudsman contacted the AA to request a thorough review of the appropriateness of this guardianship for the older child, given the licensing findings and removal of the foster children. The Ombudsman requested that the agency make collateral contacts to fully assess the child's progress and well being.	The agency conducted a review, contacting collaterals involved with the child. No significant concerns were reported. The information was reported to the court at an annual review hearing, and the court ordered that the child remain in the home for another year pending further review. DLR and DCFS held a joint staffing and decided to reduce the capacity of the foster home to accommodate just this child.
Child safety	CPS failed to protect five non-dependent children, ages 9 months to 10 years, from chronic neglect by a parent. The family had a history of nine CPS referrals, with one founded finding for neglect. Each CPS investigation found the home to be unsuitable for the care and safety of young children, and in each case, services were provided or the family was asked to correct the problems. At the time of the Ombudsman's investigation, a recent investigation had been closed as unfounded but noted ongoing concerns regarding the marginal physical condition of the home. A new referral by a medical provider concerned about one of the children's untreated anxiety (medical neglect) had been referred to ARS. The parent was historically unresponsive to ARS services.	The Ombudsman contacted the AA to request follow-up with ARS (not usually done per policy) to ensure the parent's engagement with services.	The AA followed up several times, as ARS made multiple contacts to engage the parent. A 10th CPS referral was investigated and unfounded. When an 11th referral was made by law enforcement after the parent was arrested on criminal charges, CPS appeared slow to assess the safety of the children who had been left in the home with a relative. The Ombudsman requested that CPS consider placing the children in out-of-home care which it did.
Child safety	CPS failed to file a dependency petition regarding a 3-year-old, non-dependent child who had a history of abuse and neglect by the parents and had been previously placed in foster care for two years. Furthermore, one of the parents had relinquished parental rights to three older children and had a history of physically abusing two of those children as infants. Instead, upon investigating a new referral alleging neglect after the child was taken into protective custody by law enforcement, the agency entered into a voluntary placement agreement with the parents.	The Ombudsman contacted the AA requesting that consideration be given to filing another dependency rather than relying on a voluntary agreement by the parent for placement of the child.	The AA acknowledged that the full history of the parents had not been taken into account in the current case plan and the agency filed a dependency petition.

PREVENTING FUTURE MISTAKES

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Delay in permanency	CWS failed to file a petition to terminate the parental rights in the dependency case of a 3-year-old child that had been in out-of-home care for 27 months. The child had been in the same foster home all this time and was strongly attached to the foster parents. The Ombudsman found that the agency failed to document a compelling reason for not filing a TPR petition after 15 months of foster care as required by ASFA. Another year went by before one of the parents was making sufficient progress and the CPT recommended return home of this child and two siblings with specific services in place.	The Ombudsman monitored the case for five months after reunification to ensure that the agency adequately monitored the in-home dependency given the risks to the children.	The agency provided appropriate services and monitored the in-home dependency adequately. The court dismissed the dependency six months later.
Delay in placing with relative	CPS failed to place a 2-year-old dependent child with relatives immediately upon removal from home. The Ombudsman found that although the agency was aware of the relatives and had no reason to believe they were unsuitable, CPS failed to follow new policy allowing children to be placed with relatives on an emergent basis via an abbreviated screening process (as opposed to a full home study). Placement did not occur until three weeks later.	Since this action had already occurred, the Ombudsman contacted the supervisor to discuss this oversight. The supervisor did not return the call.	
Child safety	CPS failed to protect three non-dependent children, ages 13, 5 and 2 ½, from life-long chronic maltreatment by their parent. The 13-year-old had been identified as a victim in 20 CPS referrals beginning while in utero alleging neglect, physical abuse, sexual abuse and exploitation, and emotional abuse. CPS had made at least one founded and three inconclusive findings for neglect. The agency had recently filed a dependency regarding all 3 children. This was the third dependency for the 13-year-old and the second for the younger children, with the children being returned home each time. Referrals had been made through the years by medical professionals, mental health professionals, educators, neighbors, family members, friends, the landlord, CPS workers and law enforcement. The Ombudsman found that intervention and services by DCFS in the past was ineffective in protecting the children from repeated maltreatment.	The Ombudsman verified that the children had been placed in out-of-home care and services were being provided.	By the time the Ombudsman closed this complaint, the agency was evaluating the oldest child's other parent for suitability for placement of the child. The younger children were in a foster placement with a concurrent plan of reunification or adoption.

Adverse Finding with No Intervention

Key Issue	Investigative Finding	Ombudsman Action	Outcome
Delay in placing with relative, foster parent issues	CWS failed to make active efforts to place a 6-year-old dependent Native American child with relatives or with the tribe for almost two years after the child's placement in out-of-home care, despite both the tribe and relatives contacting the agency soon after the child's removal from home to indicate their availability for placement. As a result, the child was moved to a relative placement after a two-year-long placement in the same foster home, disrupting the strong bond that had developed between the child and foster family. Moreover, the Ombudsman found that CWS failed to adequately communicate with and support the foster parents regarding the child's change of placement.	This had already occurred by the time the Ombudsman investigated the complaint.	

REGION 6

Inducing Corrective Action

Key Issue	Investigative Finding	Ombudsman Action	Outcome
Child safety	CPS intake failed to screen in a referral alleging neglect of a 13-year-old dependent child in foster care. The referral alleged that the child was having unauthorized contact with a parent, during which the child was exposed to drug abuse. The Ombudsman found that the referral should have been screened in for DLR investigation of the foster parent's alleged failure to comply with the court order which specified only limited and supervised contact between the child and parent.	The Ombudsman contacted CPS intake and requested that the screening decision be reconsidered for investigation by DLR/CPS.	A DLR/CPS investigation was conducted. Although information gathered during the investigation indicated that the foster parent was allowing the unsupervised contact in violation of the court order and the agency's instructions, DLR's finding was unfounded on the basis that the foster parent denied allowing the contact. The Ombudsman found this to be a problematic finding.

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Child safety	CPS failed to screen in for investigation a referral made by a mandated reporter, reporting a sudden, potentially life-threatening deterioration of a 5-year-old, non-dependent child who had a seizure disorder. The child and two siblings, ages 7 and 3, had a history of many unexplained illnesses and consequent CPS involvement. The Ombudsman discovered this referral five weeks later when mandated reporters made another referral with similar allegations, but were concerned that this referral may too be screened out. The Ombudsman found the screening decision on the five-week-old referral to be clearly unreasonable, given the family's history, the level of prior CPS intervention, a dependency had been filed on the 5-year-old which had later been dismissed, and the seriousness of the allegations.	The Ombudsman contacted the Area Administrator and requested a review of the screening decision and consideration of immediate protective action.	The AA agreed that the earlier referral should have been screened in for investigation and in response to the current referral, took immediate action to have CPS file a dependency petition and place all three children in out-of-home care. The case was referred to a Practice Specialist at CA HQ for further assistance with case planning. The Ombudsman monitored the safety and progress of the children for four months.

FACILITATING RESOLUTION

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Child safety	FRS planned to close a case referred by CPS after CPS made a founded finding for neglect of 7 non-dependent children, ages 3 to 17, due to drug use by their parent. The parent had failed to engage in FRS services. The Ombudsman found that closure of the case without assessing the risk to the children of further neglect was poor practice. Furthermore, one of the teen children had called CPS requesting assistance with filing a Child in Need of Services (CHINS) petition and possible out-of-home placement. The Ombudsman found that DCFS had failed to respond to this request.	The Ombudsman contacted the FRS and CPS supervisors and requested re-assessment of the family's situation and the risk of further abuse or neglect of the children. The Ombudsman also requested that the agency respond to the youth's request to file a CHINS petition.	The case was re-assessed by CPS, who found that the parent had been participating in drug treatment and the 2 oldest children were living with a relative. DCFS never responded to the youth's request for court intervention.

ASSISTING THE AGENCY IN AVOIDING ERRORS AND CONDUCTING BETTER PRACTICE

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Child safety	CPS failed to effectively intervene to prevent medical neglect of an 8-year-old, non-dependent child by a parent and unsanitary home conditions for this child and two siblings, ages 5 and 10. After reaching a finding of "founded" for medical neglect of the child's dental decay, the agency failed to monitor and ensure the parent's compliance with the agreed-upon care plan. Consequently, the 8-year-old child was still in need of significant dental work (and in pain) several months later and conditions in the home had not improved. At that point, CPS filed a dependency petition regarding the two youngest children who were placed in foster care. CWS later returned the children home without adequately checking the home's conditions and without services that had been recommended by the CPT to occur prior to reunification. CPS continued to receive referrals alleging medical and other neglect. Community professionals were deeply concerned about the well being and safety of these children and felt their concerns expressed to CPS over the years had yielded little improvement in the children's welfare.	Much of this case activity had already occurred by the time OFCO received a complaint. The Ombudsman intervened at various points over the course of monitoring the case for a year to ensure the children were receiving needed medical care and attending school.	The children are living at home in an in-home dependency being monitored by CWS and reportedly doing satisfactorily. One new CPS referral was received during the Ombudsman's year-long monitoring of the case. The investigation resulted in finding of unfounded.
Child safety, delay in permanency	CWS failed to accurately report to the court regarding the lack of progress made by the parents of a 4-year-old dependent child and failed to clarify its safety concerns regarding reunification at that time. Furthermore, the Ombudsman found that CWS had failed to file a petition for termination of parental rights in compliance with ASFA despite the parents' lack of participation in services and failure to visit the child for a period of two years.	Since a court hearing to decide whether to return the child home was imminent, the Ombudsman contacted CA HQ and requested a prompt review of the case to ensure the court was fully apprised of the parents' circumstances and the agency's concerns.	CWS amended its report to the court and requested that reunification be delayed for a further 90 days to allow greater progress by the parent. The court ordered immediate reunification despite the agency's concerns about safety. The Ombudsman monitored the case for four months.

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Delay in placing with relative, relative caregiver issues	CWS delayed placement of a 6-month-old, non-dependent infant with a relative based on concerns that the relative would not cooperate with the case plan. The Ombudsman found that these concerns were not based on objective facts. The relative had expressed concerns about CPS's reliance on a voluntary agreement with the parent that the parent and infant would remain in an in-patient drug treatment program, despite evidence that the parent had left in-patient treatment several times in the past. CWS characterized the relative's concerns as non-cooperation with the case plan. In fact, the parent did leave the treatment facility with the infant, relapsed and caused a car accident that endangered the life of the infant. CWS filed a dependency and placed the infant in foster care, requesting a psychological evaluation of the relative before it would consider placing the infant with the relative. CWS then interpreted the evaluator's recommendations incorrectly and required the relative to engage in therapy for several months in order to consider placement. The psychologist provided an addendum to the evaluation report clarifying that she had no concerns about immediate placement of the infant in the relative's care.	The Ombudsman contacted the AA and RA to request that the psychologist's addendum to the evaluation be presented directly to the court.	The court ordered placement of the infant with the relative.
Placement issues	CWS planned to move a 9-month old dependent infant from a foster home where the infant had been placed for over seven months, back to the foster home who had provided care for the first two months of the infant's life. The Ombudsman found that this was an unnecessary move, as the infant was bonded with the current caregivers who were willing to adopt the child if this became the permanent plan.	The Ombudsman contacted the AA and requested a review of the decision to move the infant.	The agency did not change its position, reasoning that the plan had been to return the child to the original foster home but the implementation of the plan took longer than anticipated. The infant was moved to the former foster home.

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Child safety	CPS delayed in protecting two non-dependent children, ages 2 and 4, from serious domestic violence during an open CPS investigation. CPS learned that the victimized parent had moved back in with the abusive parent out-of-area and transferred the case to another office. The Ombudsman found that the case was mistakenly showing as closed in the agency's computer system (CAMIS) and the parent had not been located, nor had the children's safety been verified. The Ombudsman called CPS to request appropriate action. Soon after, CA converted from CAMIS to its new FamLink system. The family's referral history and case documentation did not successfully transfer to FamLink and when relatives and law enforcement contacted CPS following another domestic violence incident and alleged physical abuse of the 4-year-old, intake mistakenly reported that the family had no CPS involvement. The children were therefore not taken into protective custody until two days later when they were brought to the DCFS office by a relative and CPS workers with knowledge of the case responded.	The Ombudsman verified that CPS filed a dependency petition.	The children were placed with relatives. See page 85 for an update on the status of FamLink, which the Ombudsman continues to monitor.
Placement issues	CPS placed three non-dependent children ages 3, 1, and 4 months, in a relative placement that posed risks to their health and well-being. The parents strongly objected to the placement, stating that there were aggressive animals, black mold and other toxins in the home, and offered alternative placement options but the agency refused to consider moving the children. Even after a home study on the relative was denied because of the mold issue, CPS left the children in the home. The Ombudsman found the agency's action to be clearly unreasonable.	Prior to the completion of the home study, the Ombudsman contacted the CPS supervisor to request that CPS carefully assess the health and safety risks of the relative's home and consider moving the children.	CPS declined to move the children, with the rationale that the relative was being evicted and was seeking alternative housing. The parents filed a motion for change of placement with the court, which was granted. The children had remained in this unsafe placement over the parents' objection for five months.

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Child safety	CPS failed to screen in repeated referrals made by both mandated and non-mandated reporters, alleging physical abuse of a 14-year-old non-dependent youth by a parent. The agency had received nine referrals, three of them within the last three months. The referrals alleged that law enforcement had been called to the home during some of these altercations. Although the youth was disclosing similar acts each time, the agency did not screen in most of the referrals on the basis that no injury was reported and the allegations did not meet the legal definition of abuse. While the Ombudsman found that the agency was technically correct, CPS could have used its discretion to screen in any of the more recent referrals, at minimum for referral to the Alternative Response System (ARS) if not for CPS investigation, based on the chronicity of referrals and the consistency of the youth's reports.	The Ombudsman contacted the CPS intake supervisor to request a review of the pattern of referrals received regarding this youth. The Ombudsman also requested that intake make a collateral call to law enforcement to obtain more information about their assessment of the risk to this youth.	The supervisor agreed to obtain collateral information from law enforcement but no such call was documented. A new referral was received a month later alleging a new incident of physical abuse. This was screened in for alternative response and a letter was sent to the parent offering services. The parent did not respond. The case was closed.

PREVENTING FUTURE MISTAKES

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Child safety	CWS failed to conduct all required health and safety visits to a 4-year-old dependent child who had been returned home. CWS failed to assess the step-parent who was participating in care giving and failed to develop a plan to address several risk factors noted in the reunification risk assessment. Finally, CWS failed to make a CPS referral after receiving information alleging the parent's symptoms of serious depression and neglect of the child.	The Ombudsman made these findings after OFCO's review of the death of the child.	This fatality occurred prior to the passage of Sirita's Law, which requires the agency to assess other caregivers in the home for risk factors. The agency's fatality review identified recommendations to improve practice (see http://www.dshs.wa.gov/pdf/ca/CFR2qtr2008.pdf (pages 150-152).

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Inadequate foster home	DLR/OFCL took 13 months to decide whether to renew the foster care license of a home that had been licensed for over 15 years. The renewal had been put on hold due to a DLR/CPS investigation being conducted at the time of the application for renewal. This investigation was completed (and unfounded) within six weeks, but a licensing complaint was then received and investigated. The licensing investigation took over five months to complete and was closed with valid findings. The license remained in "pending" status for 13 months after the renewal application had been received, and children continued to be placed in the home. At that point, DLR informed the foster parents that it planned to revoke the license. The Ombudsman found that leaving this foster home in limbo while ongoing concerns were being investigated and DLR's plan to revoke the license after continuing to place children in the home, to be incongruous and clearly unreasonable.	The Ombudsman found that there is no policy regarding time limits for DLR to take action under such circumstances. The Ombudsman contacted the DLR deputy administrator to discuss whether any policy or procedural changes needed to be considered to prevent this from occurring in the future.	The foster parents met with CA HQ staff and the plan to revoke the license was changed. The family was permitted to withdraw their application. DLR stated that this was an isolated case that did not require a change in policy or procedure.
Child safety	CWS failed to follow policies mandated for children missing from care regarding a 13-year-old dependent youth who ran away from a placement. Although CWS was taking steps to locate the youth and discussed these at a weekly staffing for all youth missing from care, the following policy requirements were not met: professionals and other people involved in the youth's life were not invited to attend (including the youth's guardian ad litem); and the search process was not documented weekly (CA Practices and Procedures Guide, 45504).	The Ombudsman brought these issues to the attention of the CWS supervisor who reported that the area administrator was aware of them also.	The Ombudsman followed up with the administrator who reported that further training (including FamLink training) and changes in practice (such as conducting FTDMs) have improved documentation in such cases and resulted in more inclusive staffing of cases.

ADVERSE FINDING WITH NO INTERVENTION

KEY ISSUE	INVESTIGATIVE FINDING	OMBUDSMAN ACTION	OUTCOME
Violation of parent's rights	CPS inappropriately screened in an anonymous referral for investigation, alleging a parent who used drugs was seen in a verbal argument with other adults while the parent's 2- and 5-year-old children were present. The anonymous referrer reported that the children were crying and the parent was holding the 2-year-old throughout the argument. The law requires CPS to investigate anonymous referrals if they allege a criminal act or a serious threat of substantial harm to a child or if a member of the household has had a founded finding for abuse or neglect in the prior three years. The Ombudsman found that none of these conditions applied in this case.	The referral had already been screened in and investigated when the Ombudsman received this complaint.	The investigation was closed as unfounded.
Services to dependent child	CWS failed to comply with a court order specifying that a 6-year-old legally free child receive mental health therapy with a particular provider at least three times monthly. The Ombudsman found that the agency's rationale that it had arranged for the child to see a different provider did not justify its failure to follow the court order for two months. The agency should have either followed the order or requested the judge to modify the order in a timely manner.	Since a court hearing was imminent and the child's guardian ad litem planned to ask the judge to hold the agency to the original order, the Ombudsman did not intervene.	The court did not accept the agency's petition for modification of the original order. The agency arranged the therapy immediately.

DSHS Response to Adverse Findings

Pursuant to the new Interagency Agreement between OFCO and DSHS,[2] OFCO provided its adverse findings in writing to DSHS ahead of publication of this report to allow the agency to review the findings and respond. The following response was received from the DSHS Secretary, Susan Dreyfus, on December 14, 2009.

> *Thank you for the Office of the Family and Children's Ombudsman (OFCO) preliminary adverse findings report for 2009. We are currently reviewing those cases, but given the volume of 101 cases it will take some time to review each case and the outcome. As part of our review, themes and patterns are also being identified. After we review these cases, we will provide a written response to you.*
>
> *The Interagency Agreement that we just signed between our agencies establishes a better process for responding to OFCO's findings for the future. I understand that OFCO will now send notice to our staff both in the field and here in Olympia when your office believes we have violated a law or not followed a policy or acceptable practice. We can then respond to each case and OFCO's finding in a timely manner.*
>
> *There are always lessons to be learned in these cases and it's important that those lessons provide learning opportunities for our staff as we all have a strong commitment to ensuring quality services and good outcomes for the children and families we serve. We will be tracking OFCO findings to evaluate patterns or trends in practice that need to be addressed in training or to determine if policy changes or clarification are needed.*
>
> *Again, thank you for helping to ensure best practice standards and accountability in our work.*

FamLink

Children's Administration launched its much-anticipated new statewide automated child welfare information system (SACWIS), FamLink, in late January 2009. Almost immediately, OFCO began receiving a flurry of calls and complaints about technical problems, ranging from errors in the transfer of data from the previous information system (CAMIS-GUI) to problems with closing cases and paying providers. Some of these problems had been expected by management, while others were not. For the next several months during OFCO's routine contacts with agency staff, widespread frustration was expressed across the board – from caseworkers to supervisors and higher-level managers, as well as clients and other stakeholders of the child welfare system. Concerns were voiced that the new system had multiple unforeseen technical glitches and that data management had – contrary to expectations and promises – made staff's jobs harder instead of easier.

The Ombudsman investigated and made adverse findings in 11 formal complaints received about issues related to FamLink. All but one of these complaints involved long delays (up to three-four months) in foster care payments to foster parents or private foster care agencies, to the point where providers were having to consider discontinuing care for children (although OFCO did not hear of any actual instances in which children were moved due to non-payment issues). One complaint involved high workloads resulting from caseworkers struggling to enter data accurately in

[2] See http://www.governor.wa.gov/ofco/interagency_ofco_dshs.pdf

FamLink and consequent risks to child safety due to high caseloads and workers' inability to process information efficiently and in a timely manner.

OFCO referred all of the specific cases involved directly to the CA assistant secretary. All of the payment issues were eventually resolved.

CA has dedicated considerable resources to resolving problems with FamLink and much progress has been made. For example, OFCO is no longer hearing about payment problems. However, we continue to hear a high level of concern from line staff and managers alike regarding technical problems with data entry and retrieval and the impact that this has on their ability to do their jobs effectively. OFCO is also hearing from parents whose CPS cases have not reached resolution (i.e. an investigative finding) and are remaining open indefinitely due to technical problems associated with FamLink.

Foster Parent Retaliation

RCW 74.13.333(4) allows any foster parent who believes they have been retaliated against by the department or a supervising agency to file a complaint with OFCO, when that retaliation is believed to be because:

(a) The foster parent made a complaint with the office of the family and children's ombudsman, the attorney general, law enforcement agencies, the department or the supervising agency, provided information or otherwise cooperated with the investigation of such a complaint;

(b) The foster parent has caused to be instituted any proceedings under or related to Title 13 RCW;

(c) The foster parent has testified or is about to testify in any proceedings under or related to Title 13 RCW;

(d) The foster parent has advocated for services on behalf of the foster child;

(e) The foster parent has sought to adopt a foster child in the foster parent's care; or

(f) 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.

This law was amended[3] effective July 26, 2009 to further provide that "upon the conclusion of its investigation, the ombudsman shall provide its findings in written form to the department." The department is then required to notify the ombudsman of any personnel action taken or to be taken with regard to the department employee involved. OFCO is required to include its recommendations regarding retaliation complaints in its annual report to the Governor and the Legislature, and "shall identify trends which may indicate a need to improve relations between the department or supervising agency and foster parents."

[3] ESSB 5811, Chapter 491, Laws of 2009 §11.

OFCO's 2005 Annual Report presented in detail the complexities involved in investigating allegations of retaliation.[4]

As described in that report, the Ombudsman developed an analytical framework to guide these investigations, consisting of three primary questions:

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

As discussed in our 2005 Annual Report, OFCO has found that it is extraordinarily difficult to "prove" a causal connection between an adverse action against a foster parent and a particular activity engaged in by the foster parent. There is no easy way to find the "truth" that lies somewhere between the vastly different perspectives offered by the foster parents and agency staff in their accounts of what happened to lead to the high level of conflict that exists when accusations of retaliation are being made. Although the law implies that a retaliatory act should be attributed to an individual employee in order for the Ombudsman to induce the agency to take corrective action with that employee, in a system that utilizes team decision making to manage risk and strive toward excellence in child welfare practice, the alleged retaliatory actions often involve several agency staff. This also makes it difficult to identify a motive for the retaliation. It should be noted that although OFCO does not make any of its adverse findings against the agency without careful deliberation, given the potential consequences of a finding of retaliation – not only for agency staff (who may face disciplinary action) but for all parties to the case – these findings in particular are made with the utmost diligence.

It should also be noted that allegations of retaliation are not made by foster parents alone. Similar complaints are received from relatives, parents and others who believe they have been wronged by the agency. As shown earlier in this report,[5] in 2009 OFCO received two complaints alleging retaliation against a relative caregiver and 10 complaints from parents or others alleging harassment, discrimination, unprofessional conduct or retaliation by agency staff.[6] For the purposes of this section, our reporting on retaliation is limited to complaints received from foster parents based on OFCO's statutory mandate to do so.

In 2009, OFCO received 12 complaints from foster parents alleging retaliation by the agency, about double the number received in 2008 (6) and 2007 (5). Retaliation was "substantiated," to the best of OFCO's ability, in three of these complaints (see section below).

The following excerpts from complaints filed by foster parents and quotes noted during the course of investigating foster parents' complaints illustrate the deep distress and ill-will bred by foster parents' perceptions of poor communication and unresponsiveness on the part of agency staff. These perceptions of mistreatment, often by both sides, can quickly escalate to outright adversarial behavior and high levels of conflict between social workers and foster parents. The following quotes also demonstrate the negative effects these conflicts can have on children caught in the fray.

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[4] See http://www.governor.wa.gov/ofco/reports/ofco_2005_annual.pdf, pp. 72-76.

[5] See section titled "Inquiry and Complaint Profiles," table of "Frequently Identified Complaint Issues," page 24.

[6] The latter category remained similar to the number of such complaints in 2008 (9 complaints), a drop since 2007 (15 complaints). There are no numbers for retaliation against relative caregivers for those years, as OFCO only began tracking these numbers separately in 2009.

- "[The social worker] got upset, raising her voice and stated, 'Foster homes should not be making more money than me! I'm the one with the college degree!' From that point on, she has been hassling."
- "When licensors come to foster homes to investigate allegations, the foster parent is made to sign the state's form whether or not it is true. If you disagree, you are told that if you refuse to sign, they will revoke your license, remove all of the children forthwith and you'll never have another foster child in your home…"
- "[The social worker] admitted she was mad at me and our situation – she took it personally… she wouldn't work with my husband and I, she knew we were the best place for [child] … [social worker]'s actions/feelings toward me was harmful for [child] having a secure and happy home with us."
- "[The licensor] knew my license was due to expire [the next day] so she didn't need to revoke it the day before. I can only interpret this as another form of harassment. The final straw was when she personally served me the revocation papers the evening before our big meeting…the fact that she was grinning when she handed them to me just confirmed to me that it was act of pure retaliation [and] spite ..."
- "[The licensor] would not respond to our contact attempts unless we contacted her supervisor or [our] Foster Parent Liaison…"
- "[The licensor]'s lack of follow through directly coincided with an ongoing dispute we had with [foster child's social worker who worked in the same office as the licensor], of which [the licensor] had first-hand knowledge."
- "We have faced scorn, abuse and contempt from the DLR licensors… based solely on an "inconclusive" finding [several] years old…"
- "To see the children's little hearts ripped apart, to see them torn from the only family they have known since they were 4 and 5 years old, the loss of their pets, their extended family, their church family…their social activities, their community projects which they are so proud of, and their future plans and goals that they have worked toward – it tears me apart…"

Adverse Findings for Retaliation in 2009

In 2009, the Ombudsman made adverse findings in three complaints alleging retaliation. These findings for retaliation are summarized in detail below, illustrating the nuances involved in analyzing the actions of the agency and foster parents to make a determination whether these actions constitute retaliation. More often than not, rather than making a clear finding of retaliation, OFCO is only able to conclude that the actions taken by the agency were "suspicious for retaliation".

Finding #1

OFCO received a complaint that DCFS/CWS was failing to provide needed medical care to a 13-month-old dependent child in foster care. Upon investigating, the Ombudsman found that the agency's records indicated that it was fully aware of scheduled medical procedures the child was to undergo well in advance of the appointments. Despite this knowledge and despite the foster parents repeatedly reminding the caseworker of the appointments and need for parental consent, the agency

failed to obtain the required consent necessitating the cancellation of the scheduled procedures. The foster parents expressed (via numerous e-mails) frustration regarding department's lack of response and concern about the child's health. During a Family Team Decision Making meeting, the children's mother also expressed frustration regarding the agency's lack of action, stating that her consent had not been requested until just prior to the appointments. This contradicted what the agency had told the Ombudsman about why consent had not been obtained. The Ombudsman intervened to ensure that immediate action was taken by DCFS to obtain the medical care. By the time it was actually provided, the child's treatment had been delayed by approximately three months. The Ombudsman also requested that DCFS obtain medical documentation regarding the potential adverse impact on the child attributable to the delay in obtaining treatment. The agency did not provide such documentation.

A few days after the medical appointments were cancelled, the foster parents were informed that the subject child and two older siblings placed in their home would be moved to a different foster home. CWS's rationale for the move was that it believed the children's safety was in jeopardy, as the oldest sibling (age 11) had recently disclosed that after accidentally breaking her eyeglasses, she had been grounded and told she would have to do chores to earn money for a new pair. Also that she had to "earn" the privilege of going to church activities and that the child appeared anxious and stressed. The Ombudsman found this rationale to be outweighed by the following factors:

1. CWS's referral to CPS intake regarding the 11-year-old's statements was screened as a licensing complaint and referred for investigation by the foster home licensor, indicating that the child's safety was not determined to be at risk. No investigation of the child's statement had begun when CWS decided to move the children, including no consultation with the 11-year-old's therapist who might have provided clarifying information about the basis for the child's statements and advice about whether a move was appropriate. The foster home had no history of concerns in the 3¼ years it had been open.
2. Law and policy[7] mandates that siblings be placed together if at all possible. The abrupt move necessitated the siblings being separated due to limited placements being available at short notice.
3. Law and policy[8] mandates that foster children have the fewest possible placements. In this case, the two older children had been in four different placements in ten months; the 13-month-old had been in five placements and would need to be moved at least once more.
4. Law and policy[9] requires that continuity of schooling for foster children be preserved whenever possible. In this case, the two older children started a new school one week before CWS moved them and due to the distance of their new placement, they would likely need to change schools again once a permanent placement was established. The children did later change schools.

The Ombudsman therefore contacted the AA to obtain more information about the rationale for moving the children. The AA stated that in addition to the concerns the agency had about the statements made by the 11-year-old, an adoptive home had been identified for the children (their

[7] See RCW 74.13.290, as well as the *Braam* settlement agreement [Braam v. State of Washington Final Settlement, July 31, 2004, available at: http://www.braampanel.org/SettlementAgreement.pdf
[8] See RCW 74.13.290 and *Braam.*
[9] See RCW 74.13.550 and *Braam*

current placement was not a permanent placement). Shortly thereafter, the Ombudsman discovered that the children were being moved to an interim foster home after all, not a permanent placement. The Ombudsman contacted the deputy RA and later the CA director of field operations to express concerns about this apparently unnecessary move and requested that the move be reconsidered. The agency did not change its position and the children were moved with no transition and without having an opportunity to say good-bye to the foster parents. OFCO found this to be an abrupt and unnecessary change of placement which led to separation of the siblings, multiple subsequent placements and disruption of the children's schooling. The licensing investigation of the foster home resulted in a finding of "not valid" for discipline and the foster home remains open.

In addition to making an adverse finding regarding the agency's failure to provide timely medical care for the 13-month-old, the Ombudsman found the removal of the children to be suspicious for retaliation under subsection (d) of RCW 74.13.333(1),[10] based on its timing, shortly after the foster parents communicating their frustrations with CWS over the delay in facilitating the child's medical care, and lack of reasonable justification. The foster parents were informed of this finding.

FINDING #2

OFCO received a complaint that CWS was considering moving a 12-year-old legally free child from her foster home due to the private foster care agency's concern that the child did not have her own bedroom. The child (who had mental health problems including an attachment disorder) had already experienced multiple placements, including a two-year placement in a residential treatment facility and a failed pre-adoptive placement with a relative. The current foster care placement was intended to be an indefinite placement while an adoptive home was sought. The child had made noticeable behavioral progress in this placement, although she had only been there for almost two months by the time the private foster care agency requested that she be moved. The child was expressing a strong desire to remain in the home and her GAL and all service providers (attachment therapist, pediatrician, sexual behavior therapist, school personnel) were in unanimous support of her remaining in the placement. CWS too was in support of the child remaining in the placement, but DLR and the private agency felt the placement was too risky given her history of sexually reactive behaviors with other children since she was sharing a bedroom with two 15-year-old female foster youth.

In light of the professional disagreement about the child's best interests in this situation and the fact that law and policy[11] dictated that another move should be avoided if possible, the Ombudsman intervened by requesting that CWS and DLR collaborate together to explore whether a compromise could be agreed upon regarding the licensing issues which were preventing the private agency from approving this placement as a longer-term placement than initially planned. CWS consulted with the child's sexual behavior therapist, who approved her sharing a bedroom with the older girls with a safety precaution in place, given her progress in therapy and lack of sexualized behaviors in recent years. The private agency was still not entirely comfortable with the placement but said it would approve it if DLR approved. DLR would not do so, placing the onus back on the private agency. At that point, a DLR/CPS referral was made (see below) and CWS made the decision to remove the

[10] Subsection (d) constitutes one of the protected activities foster parents may engage in without retaliation, i.e. "the foster parent has advocated for services on behalf of the foster child."
[11] RCW 74.13.290 and *Braam.*

child, despite the fact that nobody involved felt that the child's safety or well-being had been jeopardized by the reported incident.

The DLR/CPS referral was made after one of the foster parents reported to the private agency that she had allowed the child to go trick-or-treating on Halloween along with the three older female youths in the home, ages 15 and 16, without an adult present. The private agency instructed her to report this to DCFS because the child was supposed to have adult supervision around other children. DLR/CPS investigated and made a finding of founded based on the foster parent's knowledge of the child's supervision plan developed by her sexual behavior therapist requiring the child to have adult supervision around younger children. The foster parent had planned for an adult to be present with the youths, but when that adult cancelled at the last minute due to an emergency and neither foster parent was available to accompany the youths, the foster parents decided to allow the youths to go unaccompanied. The rationale for the foster parent's decision, as described to the DLR investigator, was that the youths were limiting their trick-or-treating to about an hour visiting houses in the lane in their small, close-knit community; the foster parents' responsible and mature 16-year-old daughter was present; and all youth were aware of the 12-year-old's "rules" for contact with younger children and would immediately intervene if these were broken. The 12-year-old had been eagerly anticipating this typical holiday activity and would have been crushed if she was left out. No problems occurred during the outing. When the foster parent made the referral to CPS, it was initially screened as a licensing complaint for lack of supervision by a foster parent. However, the DLR/CPS supervisor decided to staff the referral with DLR/CPS HQ and the screening decision was changed to be accepted for DLR/CPS investigation into neglect.

The DLR/CPS investigator found no evidence of neglect. The foster parent admitted her awareness of the child's therapist's recommendation for adult supervision in the community (although neither the private agency nor DCFS had provided the foster parent with a written supervision plan for the child as required by policy when special supervision is needed) and had taken this into account in making her decision to allow the youth to participate in the activity. Finally, there had been no negative consequences on the outing in question. The investigator also took into consideration that the foster home had been licensed as a specialized Behavioral Rehabilitation Services home for over three years, had only one prior licensing complaint that was found not valid for failure to report, no previous CPS referrals and no reported problems. These foster parents were reported to have provided excellent care of several foster youth in the past. The investigator therefore made a finding of "unfounded" for neglect. After submitting the investigative summary to the supervisor, the investigator was instructed to change the finding to "founded." The foster parents were informed that their license would be revoked.

OFCO found this finding to be clearly unreasonable given the evidence gathered during the investigation and intervened to request a review of the finding by the DLR Administrator. The Administrator upheld the finding. OFCO then contacted the CA Assistant Secretary requesting review at a higher level. After an extensive review of the investigation, the Assistant Secretary directed the finding to be changed to "unfounded."[12] The foster home remains licensed.

[12] See end of this section for a discussion of action taken by the department to address the systemic problems identified in this case.

OFCO found specific actions taken by DLR to be suspicious for retaliation under subsections (a), (d) and (f) of RCW 74.13.333 (1),[13] given either lack of a clear rationale for these actions or the rationale provided being clearly unreasonable:

Action 1: DLR's support for moving the child and its resistance to considering and facilitating other options identified by the child's team to address surmountable licensing concerns (no separate bedroom) to allow a foster child to remain in an effective, stable placement where she was doing well.

OFCO's basis for finding this action to be clearly unreasonable:
DLR and the private foster care agency overseeing the foster home stated its belief that there were major safety risks in allowing this child to share a bedroom with the older girls in the foster home based on her history of sexual behaviors. However, all the professionals providing services to the child, including her sexual behavior therapist, attachment therapist, DCFS social worker, pediatrician, GAL, and her former relative caregiver who knew the child and her history intimately, all stated that they believed the safety risks were minimal. In spite of this information, DLR did not actively consider alternative measures to ensure the safety of everyone in the foster home.

Action 2: DLR's decision to screen the referral regarding the Halloween incident as a DLR/CPS investigation of neglect rather than a licensing violation for lack of supervision.

OFCO's basis for finding lack of a clear rationale for this action:
This screening decision was discretionary and could have been (and initially was) screened in as a licensing violation – a much less serious allegation – while remaining well within reasonable interpretation of the RCW/WAC governing screening of such referrals. OFCO has seen numerous referrals regarding foster parents' failure to follow a supervision plan for a child (with or without negative consequences) investigated as licensing complaints. Although DLR quoted the definition of negligent treatment in statute as its rationale for changing CPS's initial screening of this referral from a licensing complaint to an investigation into neglect, it did not explain why this referral was different from other such referrals which are not typically screened this way.

Action 3: DLR's clearly unreasonable finding of "founded" for neglect by the foster parents and subsequent plans to revoke the foster care license.

OFCO's basis for finding this action to be clearly unreasonable:
As described in detail in OFCO's findings in this case, the evidence found by the DLR/CPS investigator did not support a finding of neglect by the foster parents.

A further question to be considered when OFCO is investigating an allegation of retaliation is whether there is an identifiable motive for retaliation on the part of the agency. Again, a motive is difficult to "prove" and in the absence of an admission by the agency, possible motives can only be

[13] These subsections list the protected activities foster parents may engage in without retaliation, in this case: (a) the foster parents provided information or otherwise cooperated with the investigation of a complaint by the office of the family and children's ombudsman; (d) the foster parents advocated for services and placement on behalf of a foster child; and (f) the foster parents discussed or consulted with [anyone] regarding their rights.

speculated at best. In this case, the Ombudsman considered the following factors as heightening the possibility that the agency's actions and decisions could be seen as retaliatory:

- The foster parents were receiving exceptional payments for the children in their care and it was reported to (but not verified by) OFCO that statements have been made by agency staff to or about the foster parents that "they are in [foster care] for the money."
- Some caseworkers who have had children placed in this foster home have described the foster parents to OFCO as wanting to "do things their way" instead of the agency's way.
- The foster parents reported that the private agency staff they dealt with regarding this matter expressed increasing annoyance over the way the 12-year-old's placement in this home came about and the child's team's (including DCFS's) advocacy to keep her there.
- The foster parents were consulting with a foster parent advocate throughout this process who advocated for them directly with CA HQ. The advocate and the foster parents began to question the amount of money the private agency was receiving for the children placed in this home, compared to the amount of money the foster parents were receiving directly, and questioned why few of the support services usually provided to Behavioral Rehabilitation Services placements were actually offered for these children.

FINDING #3

OFCO received a complaint that CWS planned to move three dependent siblings from a stable foster home that was a potential permanent placement where they were making excellent progress, to a relative from whom they had been previously removed due to neglect. Other issues raised in the complaint were that CWS was not providing needed services and was delaying permanency. OFCO monitored this case for almost two years and intervened several times to request corrective action and ensure better practice.

The Ombudsman made a number of adverse findings against the agency in the course of this lengthy investigation/case monitor. The foster parent disagreed with the agency's decision or position regarding each of these issues and advocated vociferously for what she believed the children needed and their expressed desires. The foster parent also contacted entities outside of DSHS (including OFCO) to garner assistance.

1. CWS was planning to place the children with relatives who had a founded finding for neglect, whom it later prohibited from having unsupervised contact with the children. The Ombudsman intervened by requesting that this plan be reconsidered and the children remained in the foster home.
2. CWS failed to set up recommended evaluations and services for the children in a timely manner. For example, neuropsychological evaluations recommended by the Foster Care Assessment Program took over a year to be provided and were eventually set up solely by the foster parent who had great difficulty getting approval and payment for this service. CWS did not attend the meeting with the neuropsychologist to discuss the results and recommendations. Counseling for the children was also delayed.

3. DCFS planned to move the children from their long-time foster home to a temporary foster home despite reports from the children's service providers and school that they were making good progress in placement and vocally expressing their desire to be adopted by the foster parent. The agency's rationale for the move, that the foster parent was interfering with reunification efforts, was not supported by the evidence OFCO found in its investigation and appeared to be motivated largely by the hostile relationship that had developed between the foster parent and the agency. OFCO contacted the RA to request a review of the decision to move the children and the children remained in the foster home for several more months until another permanency option was available.

4. There was a clearly unreasonable delay in exploring all available relatives for placement of these children. The children were originally placed with relatives but had to be removed due to neglect. They were then in the same foster home for over two years before other relatives were identified as a placement option.

5. CWS failed to file a petition to terminate parental rights after the children had been in out-of-home care for over 2.5 years, despite the fact that the parent continued to show a level of instability necessitating the filing of a dependency on the fourth (youngest) sibling who had been in the parent's care. Although the Ombudsman urged that permanency be expedited for these children early on in its investigation and the agency promised to file a petition, more than a year went by before it did so. Ultimately, three years elapsed between the children's original placement date and establishment of permanency for two of the children and 3½ years for one of the children, well over timelines specified by law.[14] This delay was attributable in large part to the high turnover of caseworkers and supervisors on the case. During OFCO's two-year long monitor of this case, there were four different caseworkers and three supervisors. Each change brought a new perspective and "start over" mentality to the case.

6. Specific actions taken by the agency were suspicious for retaliation against the foster parent under subsections (a), (d) and (e) of RCW 74.13.333 (1).[15] Threats and an actual plan to move the children fell into this category (see discussion in #4 above). In addition, there were a number of referrals made or possibly caused to be made to CPS by CWS that could be viewed as retaliatory. A total of eight CPS referrals were made in the six months prior to the children being moved from the foster parent. Allegations ranged from the foster parent not dressing the children appropriately for cold weather, not feeding the children appropriately, not treating the children for lice they had contracted, not giving the children water to drink with their breakfast, discussing adoption inappropriately with the children, being argumentative with a relative of the children, using respite care on one occasion that was not pre-approved by the agency and finally, inappropriately taking photos of the home of the relative with whom the children were to be placed. The referral regarding the failure to treat for lice was screened for DLR/CPS investigation and resulted in an unfounded finding. The other referrals were all investigated by the foster home licensor as licensing complaints. All but two of the complaints were found to be "not valid." One finding was inconclusive

[14] The Adoption and Safe Families Act of 1997 ("ASFA"), Pub.L. No. 105-89, 111 Stat. 2115, amending 42 U.S.C. §§671-675.

[15] These subsections list the protected activities foster parents may engage in without retaliation, in this case: (a) the foster parent provided information or otherwise cooperated with the investigation of a complaint by the office of the family and children's ombudsman; (d) the foster parent advocated for services on behalf of a foster child; and (e) the foster parent sought to adopt these foster children.

regarding whether the foster parent had failed to inform a respite care provider of one of the children's need for line-of-sight supervision. The finding was inconclusive despite the foster parent showing the licensor the supervision plan she had provided to the respite provider and that the respite provider had signed. The final complaint was found to be "valid" for character.[16] The corrective action plan developed by DLR in response to this finding was for the foster parent to undergo a psychological evaluation.

There were no concerns on record about this foster home prior to the high level of conflict that developed between the agency and the foster parent over its case management of these children. In fact, the foster home and the children's care and progress in general had received glowing reports. The foster parent had educational and work experience that made her a highly skilled foster parent for children with special needs (as these children had). The foster parent had a collaborative and positive relationship with the DCFS and DLR office in whose jurisdiction the foster home was located and who provided courtesy supervision of the placement; the children's DCFS case was assigned to a different office. The courtesy supervision worker reported excellent care of the children, strong advocacy on the part of the foster parent to ensure the children's needs were met and a high level of cooperation between the foster parent and the children's health care providers, educators and counselor.

Because these three findings occurred prior to the July 2009 amendment to the foster parent retaliation statute requiring the Ombudsman to notify the agency of a specific finding of retaliation in writing, OFCO has included these findings as part of its overall adverse findings in complaints in the 2009 reporting year. The secretary of DSHS has informed the Ombudsman that the agency will be examining these adverse findings and taking action as appropriate (see letter from Susan Dreyfus, page 148).

With regard to OFCO's findings in the second complaint described above that the DLR/CPS finding of neglect was clearly unreasonable following OFCO's request for a review of the finding by the CA Assistant Secretary and the consequent change of the finding to "unfounded," DLR convened a meeting to review best practice with regard to findings of negligent treatment in licensed foster homes related to lack of supervision.[17] The meeting included DLR management, field staff, an AAG representative and OFCO. The workgroup examined sample cases involving findings for negligent supervision to consider whether action would be warranted to change current practice. The workgroup recommended that CA examine practice around the development of supervision plans, particularly with regard to supervision plans that set an expectation that foster parents provide line-of-sight supervision. DLR leadership was informed that the issue of findings on negligent treatment had been raised. DLR will include information regarding supervision plans in the annual assessment newsletter to foster parents. The group also agreed to revisit the issue in the future.

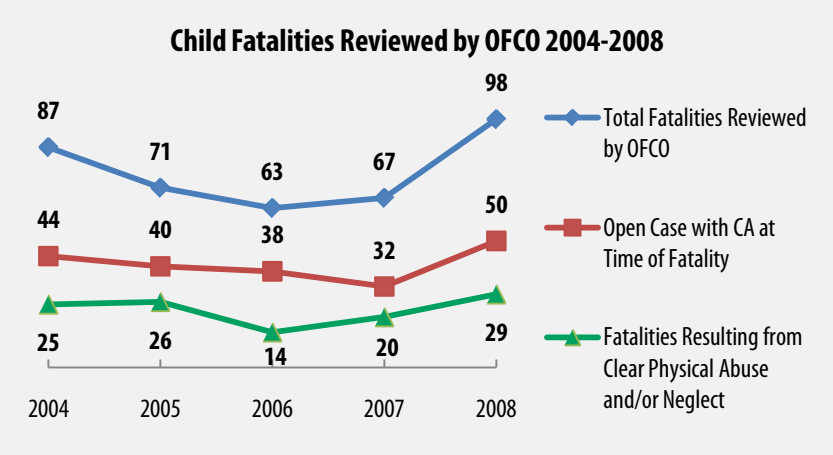
[16] WAC 388-148-0035 lists the personal characteristics required to provide care for children. Subsection (5) states: "You must have the ability to furnish the child with a nurturing, respectful, supportive, and responsive environment."
[17] Communication with Darcey Hancock, December 18, 2009.

SUMMARY AND DISCUSSION OF 2004-08 CHILD FATALITIES EXAMINED BY OFCO

In its capacity as a watchdog of the child protection and welfare system, OFCO routinely reviews child fatalities across the state in cases where the child was in the care of, or receiving child welfare services from, DSHS CA at the time of death, within one year of his or her death or who died while in state licensed care. CA conducts its own review of fatalities using the above criteria but limits such reviews to *unexpected* fatalities.[1] All further discussion of "fatalities" in this section refers to fatalities reviewed by OFCO.

In OFCO's 2004-05 Annual Report, we presented results of our compilation and analysis of 87 child fatalities that occurred in 2004. Our purpose in reviewing all 2004 child fatalities was to identify critical factors and patterns, 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 in safeguarding children. In 2005, OFCO conducted a thorough review of the Justice and Raiden Robinson and Sirita Sotelo[2] child fatalities. Advocacy efforts following the deaths of these children, the reviews conducted by OFCO and the Executive Fatality Reviews convened by DSHS resulted in significant changes in child welfare law and policy.

The following data describes the profile of child fatalities reviewed by OFCO between 2005 and 2008, using 2004 as a point of comparison. Fatalities declined steadily after 2004, until 2008 when they sharply increased to reach an all-time high of 98. About half of the child fatalities continue to occur in families with cases that are open to DSHS CA at the time of death. This has remained consistent since 2004. OFCO plans to produce a separate report with a more in depth discussion of child fatalities in 2010.



Source: Office of the Family and Children's Ombudsman, October 2009, based on analysis of DSHS CA data

Note: Based on OFCO's review criteria, OFCO typically reviews approximately 9-13 percent of all child deaths in Washington state. The total number of child deaths statewide was 719 in 2005, 683 deaths in 2006, 700 deaths in 2007 and 777 deaths in 2008.[3]

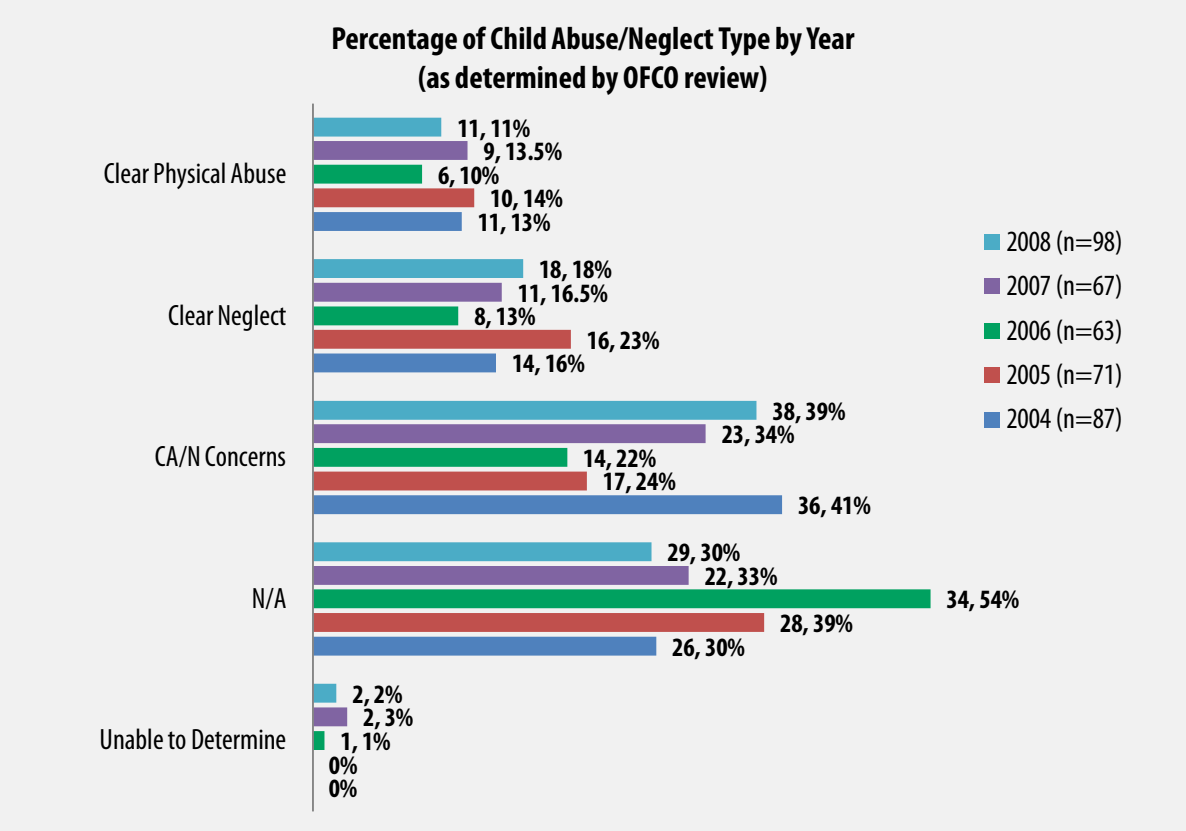
[1] Per RCW 74.13.640, Child Fatality Reviews are required on unexpected deaths of children in Washington state who are in the care of or receiving services from CA. For CA's most recent data on child fatalities, see http://www.dshs.wa.gov/pdf/ea/CFWS0509.pdf

[2] For OFCO's 2004 Fatality Report, see http://www.governor.wa.gov/ofco/reports/ofco_2004_fatality.pdf

[3] Total child deaths derived from CA's fatality data for 2005-08 found at http://www.dshs.wa.gov/pdf/ea/CFWS0509.pdf. Data presented includes information on the youth population in

CHILD ABUSE AND NEGLECT CONCERNS

Using the same methodology as in 2004, the Ombudsman reviewed fatalities from 2005 to 2008 to determine if child abuse and/or neglect contributed to the fatalities, and if so, how. A number of fatalities can be clearly attributed to abuse or neglect (see definitions below the next graph). However, a larger number are determined by OFCO to be fatalities in which abuse or neglect concerns *contributed to the fatality*. While CA and OFCO usually agree on the number of cases involving "clear physical abuse" or "clear neglect," OFCO independently categorizes fatalities with "child abuse/neglect concerns" after reviewing these cases. Examples of fatalities which were determined by OFCO to be the result of "clear physical abuse," "clear neglect," or having "child abuse/neglect concerns" as a contributing factor are presented here. Further examples and discussion of OFCO's review process will be presented in our upcoming report.



Source: Office of the Family and Children's Ombudsman, October 2009, based on analysis of DSHS CA data

WA state, referrals for Child Abuse/Neglect (CA/N), referrals accepted for intake and investigation, fatalities in WA state, fatalities requiring Child Fatality Review, fatalities on open case, child abuse related fatalities and open case fatalities attributed to CA/N.

Definitions

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. Developed in 1989, CAMIS is a computerized database and the primary system used by CA to document the services it delivers to children and families statewide. CAMIS was replaced by FamLink in January 2009. OFCO had access to CAMIS and now has access to FamLink.

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 or 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 or neglect of the deceased child or 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 find the concerns to be 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.)

Unable to Determine: In a small number of fatalities, there either was not enough information to make a determination or investigations into the fatality were not complete.

Case Examples

Clear Physical Abuse

A 5-year-old dependent, legally free child died while in placement with a relative caregiver. The medical examiner determined the manner of death to be unknown or undetermined, caused by "traumatic bodily injury." Five days prior to the child's death, the child had been hospitalized with a skull fracture and subdural hematoma. The caregiver reported that the child had slipped in the bathtub. Reports from other relatives contained inconsistent information regarding how the injury occurred. CA had not completed a background check or home study of the relative prior to placement. Once the agency did complete a background check, it did not follow up on criminal history that would have disqualified the relative from passing a home study. **Open CWS case at time of death**.

A 2-year-old child died from a blunt force injury to the abdomen. The child had been taken to the emergency room by the mother and her boyfriend after vomiting for six hours and lapsing into unconsciousness. The child had bruises to the head, ribs and back. Conflicting accounts were given by the mother and her boyfriend about what had occurred that night. The manner of death was determined by the medical examiner to be homicide, however no charges had been filed by law enforcement by the time the executive child fatality review conducted on this fatality was complete. There was an **open CPS case at the time of the child's death**. The caseworker had 45 open cases and 10 services inactive cases at the time. The only prior referral was 16 days prior to the child's death made by a medical provider, who reported unexplained bruises and

weight loss. The executive fatality review noted the caseworker's high workload and a lack of collateral contacts to the referring medical provider and lack of referrals to other services.

Clear Neglect

A 4-month-old infant died after being placed in a car seat directly in front of a wall heater for the night by the parents. The infant was found dead with radiant heat burns to the body. The medical examiner determined the manner of death to be unknown or undetermined and the cause of death to be hyperthermia (overheating). The parents admitted to using drugs (marijuana and non-prescription valium) the evening prior to the infant's death. The infant had reportedly been ill for several days. The CPS investigation resulted in a founded finding for neglect, but criminal charges were not pursued. Four prior CPS referrals had been received regarding the mother (some from mandated reporters), the most recent one made by a person watching the children a month prior to the infant's death. The referral alleged that the mother left the infant and older 20-month old sibling alone in a motel room resulting in the older child falling out of a ground-floor window, and a severe diaper rash on the infant. It had been accepted for investigation and unfounded for neglect; however, the **CPS case was still open at the time of the infant's death**. The next most-recent referral was made at the time of the infant's birth, alleging the mother tested positive for marijuana, had no prenatal care, the then 17-month-old sibling had received no routine health care and had a bruise and scratch on the cheek. This was accepted for investigation and unfounded for neglect. Prior to that, a referral was received at the time of the older child's birth, alleging that the mother tested positive for marijuana (not investigated). The first referral on the family had been made over three years previously, alleging that the mother left her 16-month old with a neighbor who was unable to handle the child and was passed on to several different caregivers by the following morning. This was investigated and unfounded for neglect.

A 10-month old child, who had been placed by CPS along with a 2-year-old sibling in shelter care status with a relative caregiver, died of acute methadone inhalation. The medical examiner determined manner of death unknown or undetermined. The mother had taken the children from the relative on an unauthorized weekend visit, during which she left the children in the care of a teen relative who had a prior history of abuse of a child. The mother and her boyfriend had gone out to sell drugs and returned to where they had left the children early in the morning. Later that morning, they awoke to find the 10-month-old dead. There had been eight prior referrals regarding the mother neglecting the children, including referrals from mandated reporters. There had been no founded findings following CPS investigations and multiple services had been offered to and accepted by the family. The children had been placed with the relative (and a dependency filed) 3½ months prior to the child's death, after the mother left the children alone in their apartment and the 2-year-old was found wandering the apartment complex crying. **Open CWS case at time of death**.

Child Abuse/Neglect Concerns

A 2-month-old twin died during the night while sleeping between the parents in their bed. The father stated that he might have been accidentally sleeping on the infant. The medical examiner determined the manner of death to be unknown or undetermined and the cause of death to be Sudden Unexpected Death in Infancy (SUDI). It was undetermined whether the bed-sharing and the infant's slight interstitial pneumonitis contributed to the death. Although the CPS investigation of the fatality resulted in an unfounded finding for neglect, OFCO found this fatality to have neglect concerns as a contributory factor. The twins had been born addicted to their mother's prescribed opiate medication (Vicodin) and a CPS referral was made by the

hospital at that time. The babies had been voluntarily placed at a pediatric medical facility to treat their withdrawal symptoms, but had been discharged home to the parents. The **CWS case remained open at the time of the infant's death.** Both parents were taking prescription medications at the time of the infant's death. The mother had a history of five prior CPS referrals regarding her three older children, who were previously dependent due to neglect secondary to the mother's drug use. The children had remained in out-of-home care for over two years and were returned home (prior to the fatality) after the mother completed services and complied with drug court orders.

A 14-year-old youth was found dead in an irrigation ditch two days after being reported missing by the parent. The coroner determined the manner of death to be homicide and the cause of death to be burns and fluid in the lungs, which can be caused by smoking cocaine. Cocaine was found in the youth's system. The youth had been a runaway, truant, acting out at school, using methamphetamines and on probation. The youth's parent had a history of 17 CPS referrals, though there was **no open case at the time of the youth's death**. Referrals had been made by mandated reporters and several had been investigated. The referrals alleged drug activity by the parent, domestic violence, physical abuse by the parent and the parent's partners, neglect and sexual abuse of the deceased youth. Available departmental records showed no founded findings for abuse or neglect as a result of these investigations (one inconclusive finding). The most recent referral, made six months prior to the youth's death, was made by law enforcement after the youth was picked up for shoplifting. Police reported that the youth tested positive for amphetamines, had not attended school for a year, was possibly pregnant and the parent could not be located. The youth was placed in juvenile detention and this CPS referral was not accepted for investigation (a pregnancy test was negative). CA did not conduct a review of this fatality, i.e. it did not count this as a fatality with child welfare involvement within the last year prior to death. OFCO included this fatality in its review and determined the fatality to have abuse and neglect concerns as contributing factors.

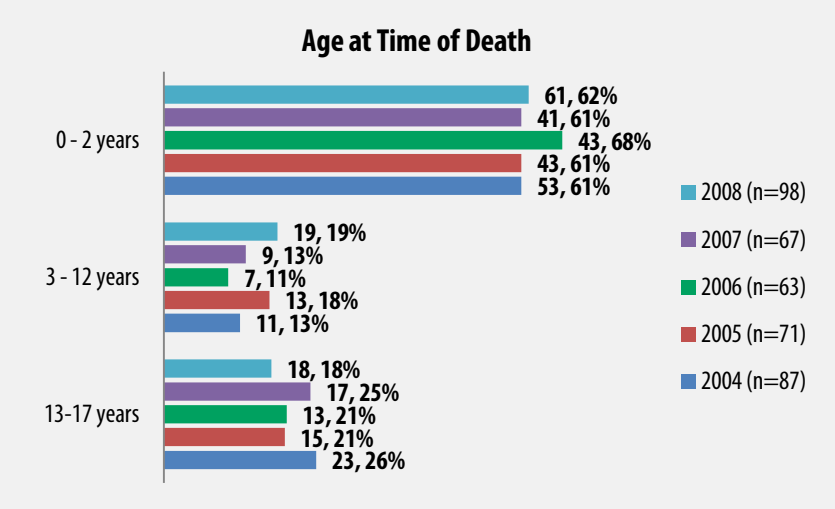
A 21-month-old child was found dead after being put to sleep wrapped in multiple blankets. The mother's boyfriend had rolled the child tightly in blankets, preventing arm and leg movement, with a bottle propped in the mouth. The medical examiner determined the manner of death to be unknown or undetermined and the primary cause of death to be "probable hyperthermia," with the secondary cause being "enwrapment in bedding for the purpose of restraint." There had been five prior CPS referrals alleging domestic violence against the teenaged mother by the child's teenaged father, and consequent vulnerability of this hemophiliac child whom hospital staff had stated "could die if [child] were to be hit just one time," but there was **no open case at the time of the child's death**. OFCO determined this fatality to have neglect concerns as a contributing factor given the use of blankets to restrain the child and the medical examiner's concern about possible child abuse or neglect.

A 2-year-old child died of an accidental drowning in an irrigation pond on the family property. The medical examiner determined the manner of death to be accidental and the cause of death to be drowning. The child was in a guardianship with a relative, with whom the child had been placed following the death of one of the parents and the incarceration of the other. The guardians reported that the child escaped from the house while the caregiver was sleeping. The front door had not been locked. The guardians further reported that they were aware that the child was able to get out of the crib independently and was able to unlock the front door even with the deadbolt locked. In the past, the child was reported to have sometimes woken up, left

the crib and played independently in the home while the caregiver/s were still asleep, but had never before left the home. During CPS investigation of the fatality referral, excessive clutter and numerous safety hazards for children were found in the home and on the property. The guardians had a history of two referrals to CPS six-to-seven years previously, alleging a child being hit on the nose by one of the parents and a dirty home, which were not investigated. OFCO determined this fatality to have neglect concerns due to the guardians' failure to secure the front door to prevent the child from leaving the home while not under direct supervision. **There was no open CA case at the time of the child's death.**

Age of Children

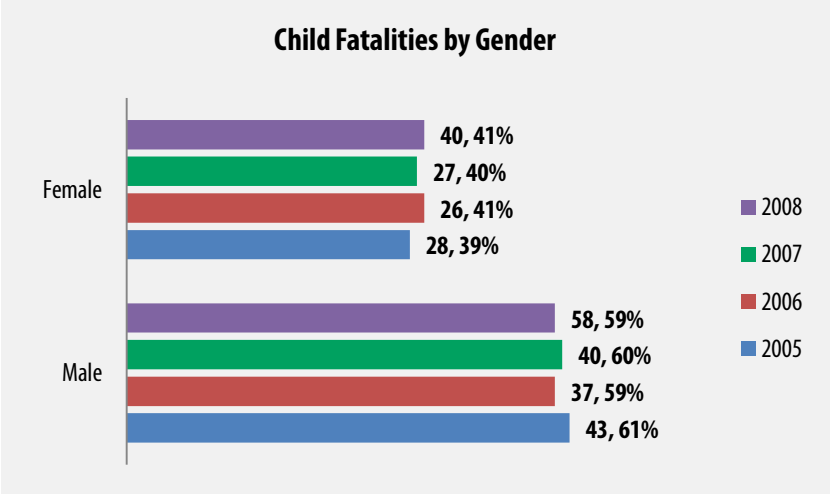
As in 2004, the following graph clearly shows that young children comprise the largest proportion of fatalities that meet OFCO's criteria for review. This data is consistent with data for all child deaths in Washington, i.e. the youngest children are the most vulnerable.[4]



Source: Office of the Family and Children's Ombudsman, October 2009, based on analysis of DSHS CA data

OFCO-Reviewed Fatalities by Gender

In 2004, 37 percent of the fatalities were female children and 62 percent were male, with 1 percent unknown (stillborn). As shown in the graph below, the gender split in the child fatalities remains fairly consistent from year to year.

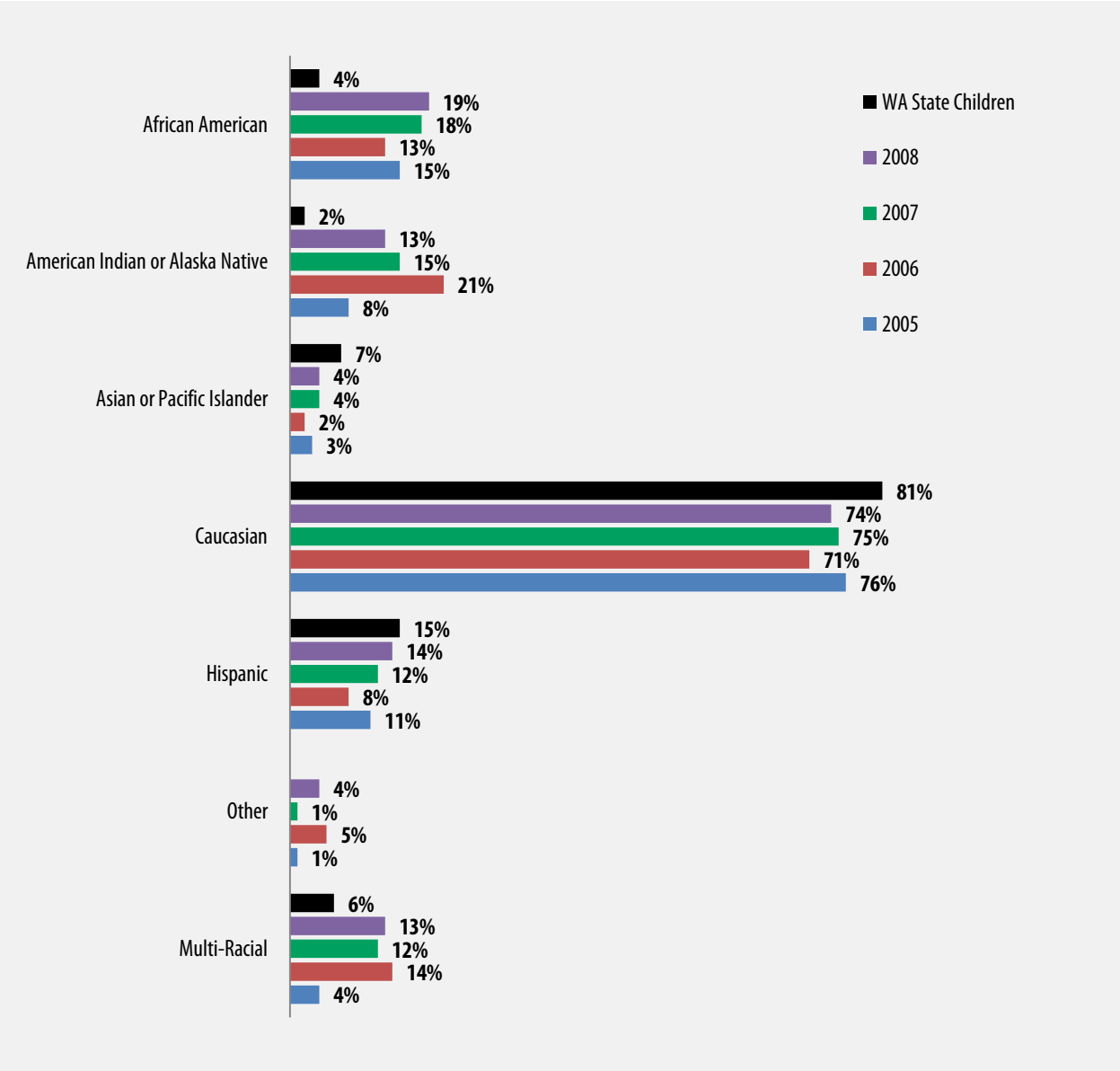


Source: Office of the Family and Children's Ombudsman, October 2009, based on analysis of DSHS CA data

[4] http://www.doh.wa.gov/EHSPHL/CHS/chs-data/infdeath/htmltables/f1.htm Number of deaths for infants less than 1 year of age: 427 in 2007, 406 in 2006, 420 in 2005, 451 in 2004

Race of Child by Year Compared to State Population

Since 2004, fatalities continue to be disproportionally high for Native American and African American children relative to their percentage of the overall state population. Fatalities of African American children appear to be on the rise since 2004, while fatalities among Native American children have declined somewhat.

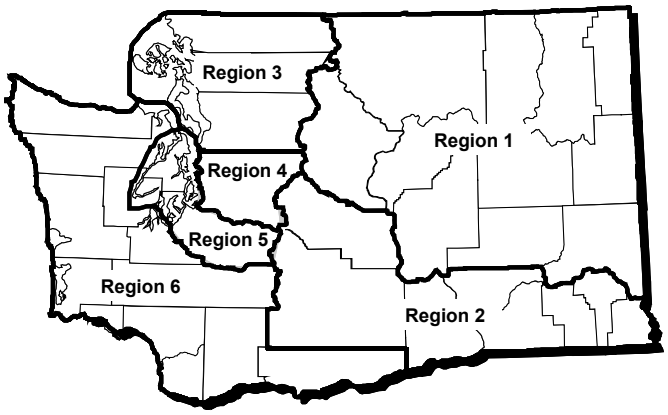


Source: Office of the Family and Children's Ombudsman, October 2009, based on analysis of DSHS CA data

Note: Data adds up to over 100 percent because people may self-identify with multiple races.

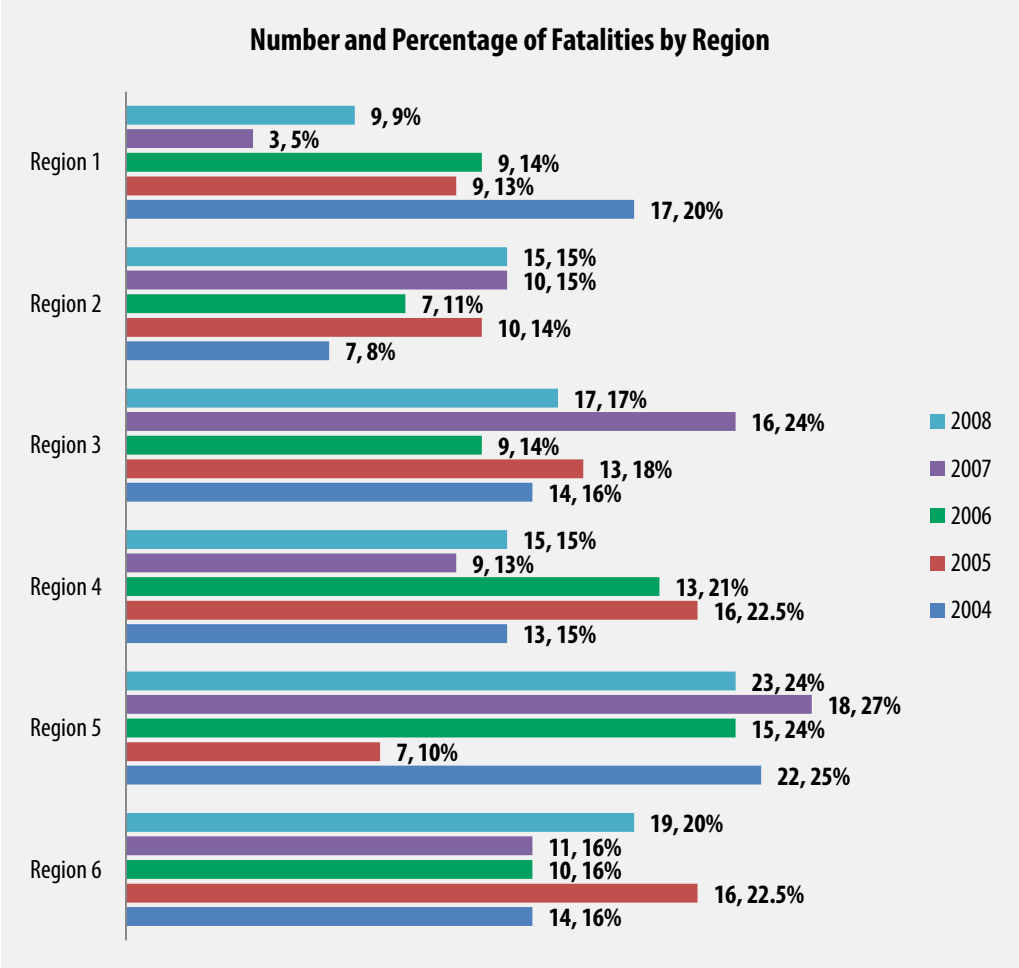
DSHS Regions

Of the total child fatalities that OFCO reviewed, the numbers for each DSHS region are as follows.



Regional Offices:

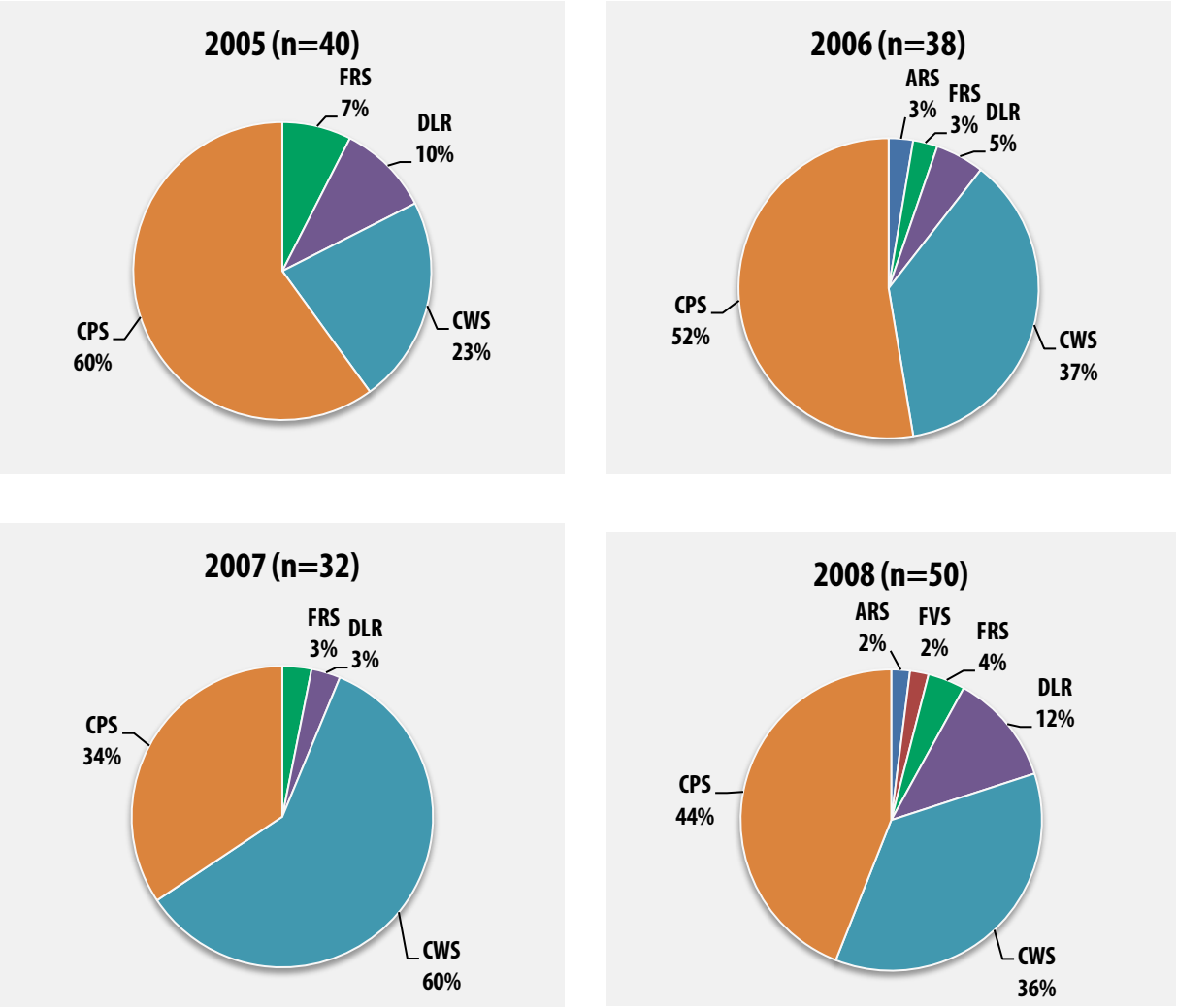
Region 1 – Spokane
Region 2 – Yakima
Region 3 – Everett
Region 4 – Seattle
Region 5 – Tacoma
Region 6 – Vancouver



Source: Office of the Family and Children's Ombudsman, October 2009, based on analysis of DSHS CA data

Type of Open DSHS CA Case at Time of Death

In 2004, of the 44 fatalities with a case open to DSHS CA, 77 percent were open for Child Protective Services (CPS), 16 percent were open for Child Welfare Services (CWS), 5 percent were open for Family Reconciliation Services (FRS) and 2 percent were open for other services. As shown in the charts below, the number and percentage of fatalities that occurred while the case was open to a particular unit within DSHS CA has varied from year to year.[5] With the exception of 2007, the majority of cases were open to CPS. Effective January 2007, there was a CPS/CWS redesign implemented in most CA offices. Its purpose, in part, was to separate service delivery from investigation and assessment.[6] Cases were transferred at an earlier stage in the process from CPS to CWS (now known as Child and Family Welfare Services or CFWS), so this may account for the rise of fatalities occurring while open to CWS rather than CPS in 2007.



Source: Office of the Family and Children's Ombudsman, October 2009, based on analysis of DSHS CA data

[5] The graphs show open cases to CA. CA conducts a CFR on fatalities that happen in facilities licensed by the Department of Early Learning (DEL) if the referral on the death screens in for child abuse or neglect concerns. The number of deaths reviewed that occurred in a DEL licensed facility: 1 in 2005; 1 in 2006; 1 in 2007; 2 in 2008.

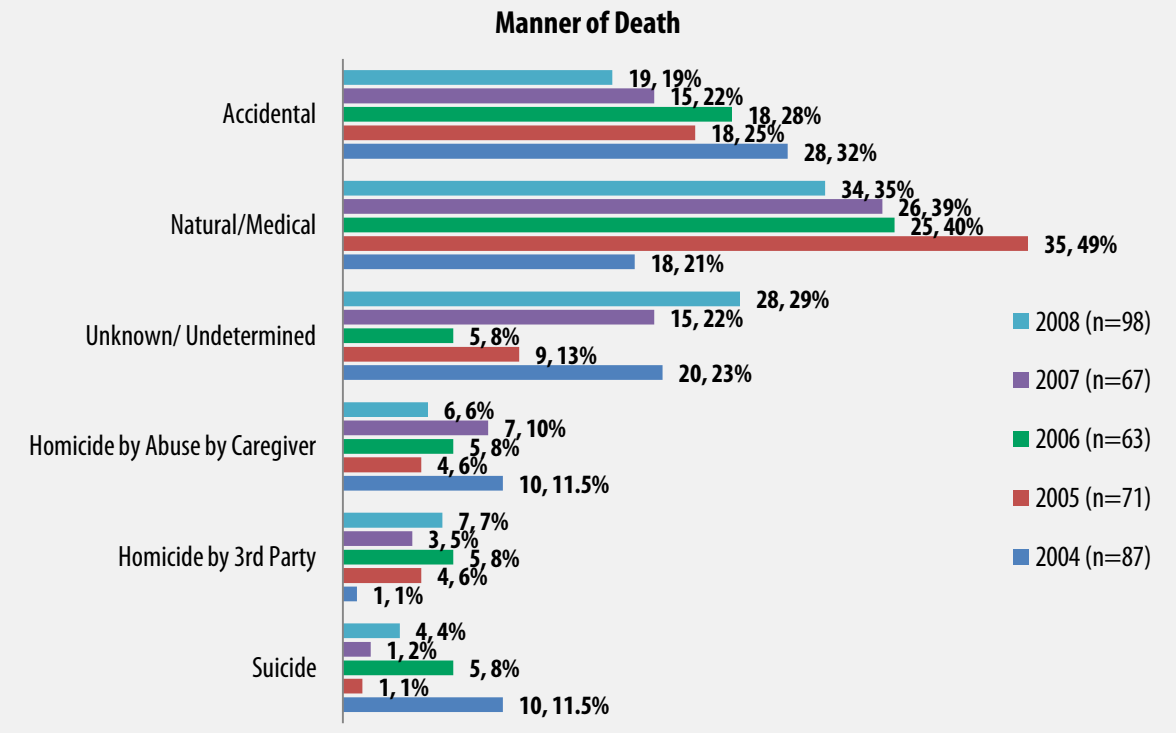
[6] Updates were made to sections 2200, 2300, 2430, 2500, 2600 and 4307 of the DSHS CA Practices and Procedures Guide to implement this change.

Manner of Death[7]

The manner of death is determined by a medical examiner or coroner and describes the context or circumstances of the death. Manner of death is assigned to one of five primary categories. These include: unknown/undetermined, natural/medical, accidental, homicide and suicide. The graph below shows manner of death by category for the fatalities reviewed by OFCO between 2004 and 2008.

Consistent with past reports, more than half of the fatalities OFCO reviewed are children under 2 years of age. Sleep environment of young children may be noted in multiple categories of manner of death. Forty-four percent of the fatalities OFCO reviewed noted unsafe sleep environment. Approximately one-third of the deaths OFCO reviewed noted bed-sharing at the time of death. The percentage of fatalities that documented bed-sharing or unsafe sleep environment increased in 2008. This may be due in part to improved death scene investigations. CA has added infant safe sleep to the CA Academy which provides mandatory training to staff.

There has been much professional discourse and media attention in the last several years to the issue of safe sleeping environments for infants, arising from child fatality data nationally. Washington state is no exception. In the fall of 2009, a group of stakeholders in infant care and safety, facilitated by Representative Mary Helen Roberts, began meeting to talk about Safe Sleep Campaigns to educate the public and other strategies that might be employed statewide to ensure safe sleep environments for young children. The complex issues of Sudden Infant Death Syndrome, Sudden Unexpected Infant Death Syndrome, safe sleeping environments and the work of the Infant Sleep Safety Group will be discussed in greater depth in OFCO's upcoming fatality report.



Source: Office of the Family and Children's Ombudsman, October 2009, based on analysis of DSHS CA data

[7] American Family Physician, February 15, 2005 Volume 71 Issue 4 http://www.aafp.org/afp/2005/0215/p652.html

IMPLEMENTATION STATUS OF CHILD FATALITY RECOMMENDATIONS

INTRODUCTION

In 2008, 98 children died in families who had an open case with DSHS at the time, or within a year, of their death.[1] When a child dies, "we need to learn from the collective pain and the collective experience. . . These are very dark times when a child dies on our watch. It is the worst possible day on a case-carrying social worker's life. We need to understand, did we miss something?"[2] These words were spoken by a DSHS CA administrator and eloquently sum up the importance of conducting child fatality reviews (CFRs). When tragedy strikes, these reviews provide an opportunity to examine what DSHS or others may have overlooked in their oversight of families receiving child welfare services due to child abuse or neglect concerns.

This section of our annual report is comprised of four parts: (1) a discussion of law, policy and practice changes that have been implemented in response to, or in relation to, child fatality recommendations made by OFCO; (2) preliminary summary data describing the implementation status of recommendations issued from CFR teams convened by DSHS CA from 2005 to 2008, based on information reported by each of the six DSHS regions;[3] (3) DSHS CA's categorization of the CFR recommendations into five subject areas with a description of the agency's implementation activities; and (4) a discussion of barriers to implementation of child fatality recommendations as identified by OFCO, based in part on OFCO's interviews of key staff in the six DSHS CA regions, and recommendations for improvement.

I. LEGISLATIVE HISTORY OF 2SSB 6206

In 2008, the Legislature enacted 2SSB 6206,[4] an ambitious bill that created several new reporting requirements for DSHS and OFCO to improve review of child fatalities, near fatalities and families with a chronic history of abuse or neglect. **This new law requires OFCO to submit an annual report to the Legislature on the status of the implementation of child fatality review recommendations.**[5] It was driven by the Legislature's concern about the lack of consistent and coordinated implementation or unknown status of recommendations arising from child fatality reviews convened by DSHS CA.

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[1] Some of these deaths are not related to inflicted abuse or neglect, but may be accidental or expected as in the case of a death from a terminal illness. Detailed fatality data for 2004 to 2008 is presented in this annual report.

[2] October 23, 2009 Interview of Connie Lambert-Eckel, Acting Regional Administrator of Region 1, DSHS CA, by Ombudsman Linda Mason Wilgis.

[3] OFCO analyzed DSHS CA's reported actions to determine where implementation effort was evident, and to what degree: partial or complete.

[4] 2SSB 6206 imposes several other new requirements on DSHS. DSHS must: promptly notify the child's guardian ad litem when a report of alleged abuse or neglect is received involving a child under the court's jurisdiction under chapter 13.34 RCW; promptly notify OFCO when it receives a report of alleged abuse or neglect that constitutes the third or more founded report received on a child or family within a year; issue a report on child fatality review results within 180 days following the fatality; and convene a fatality review team of individuals who have no prior involvement in the case and whose professional expertise is relevant to the case in cases where the fatality is the apparent result of abuse or neglect by a caretaker.

[5] RCW 43.06A.110.

II. Requirement of DSHS to Conduct Child Fatality Reviews

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.[6] Although this provision of the law was enacted in 2004, the department's obligation to review child fatalities in conjunction with other entities such as the Department of Health (DOH) dates back to at least 1995.[7] This collaboration is known as the Child Death Review (CDR) process.[8] DSHS CA collaborated with DOH on these community-based CDR teams until DOH's loss of funding in 2003.[9] Although funds for the CDR program were eliminated in the 2003-05 state budget, the law authorizing CDRs remains in effect. Since 2003, CDRs have sought and had limited success at obtaining other funding sources. Some of the CDRs have remained operational[10] but the data gathered since 2003 is not statewide, nor is it comprehensive.

The CFR process that DSHS initiates is distinct from the CDRs. CFRs increase CA's "understanding of the circumstances around a child's death" and provide an opportunity to "evaluate practice, programs and systems to improve the health and safety of children."[11] CFRs fall into one of two categories: (1) the more common CFR, and (2) the Executive Child Fatality Review (ECFR).[12] A CFR is coordinated by the regional CPS program manager or designee and is comprised of a multi-disciplinary team representative of the child's immediate community. The ECFR is convened by the CA assistant secretary in cases where the child fatality is the result of apparent child abuse and neglect and CA had an open, active case at the time of the child's death. It is an independent review by individuals not directly involved in providing services to the family. The review committee members may include legislators or representatives from OFCO. ECFRs are rare as a percentage of total fatalities reviewed by CA. In 2008, state law was expanded to require a fatality review by individuals who had no previous involvement in the case and whose professional expertise is pertinent to the dynamics of the case on any case where the child death is "the *result of apparent abuse or neglect* by the child's parent or caregiver."[13] This review more closely mirrors an ECFR. Although it is not necessarily convened by the CA Assistant Secretary, it brings together professionals who did not work directly on the case.

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[6] RCW 74.13.640; HB 2984 enacted in 2004.

[7] During the 1995 session, the Washington State Legislature passed SHB SHB 1035 mandating that DOH and DSHS develop a consistent process to review the deaths of children receiving child welfare services. It required DSHS, in conjunction with the 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 CA.

[8] For more information on Child Death Reviews, see http://www.doh.wa.gov/cfh/CDR/CDRDataSheet2008.pdf

[9] 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. CA Performance Report, page 20. http://www1.dshs.wa.gov/CA/pubs/2004perfrm.asp.

[10] For example, some of the counties in which CDRs remain in effect are King, Pierce, and Kitsap counties according to Colin Jones, Program Manager, King County Medical Examiner's office. Telephone conversation with Ombudsman Linda Mason Wilgis on December 8, 2009.

[11] DSHS CA Operations Manual chapter 5200.

[12] DSHS CA Operations Manual chapter 5200 sets forth these types of child fatality review and associated processes.

[13] RCW 74.13.640(4)(*emphasis added)*; 2SSB 6206.

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. DSHS CA submits quarterly child-fatality reports to the Legislature. New law requires that the CFR report be issued within 180 days of the fatality, unless the Governor grants an extension.[14] Since the enactment of 2SSB 6206 in 2008, DSHS posts and is required to maintain all child fatality review reports on a public Web site.[15] This public posting of CFR reports reflects a nationwide trend toward increased accountability and transparency in government. The availability of more information to the public, decision makers and other stakeholders subjects DSHS decision making to greater scrutiny because information is more readily available to evaluate the agency's actions or inactions.

III. OFCO OVERSIGHT OF CHILD FATALITIES REPORTED BY DSHS CA

OFCO, as part of its oversight role over DSHS, receives notice of child fatalities as soon as they are known to DSHS.[16] This notice provides the date of the child fatality 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 database and includes information such as the cause and manner of death; age, gender, race, and legal status of the child; family history; and child abuse and neglect concerns. OFCO reviews all child fatalities that meet the criteria of children who have been in the care of or receiving child welfare services from the department at the time of or within one year of the child's death, including children who died while in licensed care, regardless of whether the death was expected.

Since its establishment in 1996, OFCO has conducted in-depth independent case investigations of certain high profile child fatalities to examine the involvement of DSHS CA with the child and family.[17] The purpose of these investigations is to determine agency compliance with law, department policy and procedure, and to identify changes that could better protect children from abuse and neglect. OFCO's proposed changes are then formulated into recommendations which are included in the reports we issue on our independent case investigations.

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[14] RCW 74.13.640(2).

[15] RCW 74.13.640(2). CFR Reports may be accessed at http://www.dshs.wa.gov/ca/pubs/fatalityreports.asp

[16] OFCO receives e-mail notice from DSHS via an automated critical incident notifier from the CA Administrative Incident Reporting System (AIRS).

[17] These fatality investigations typically result in stand-alone reports published by OFCO and are more detailed than the customary reviews OFCO conducts of all other fatalities. Some examples are OFCO's review of the Robinson and Sotelo fatalities which are discussed in greater detail in this report.

PART 1
STATUS OF IMPLEMENTATION OF OFCO'S CHILD FATALITY REVIEW RECOMMENDATIONS

The following provides fatality-related recommendations OFCO has made in the course of independent fatality reviews and those published in OFCO's annual reports.[18] These are accompanied by a description of law, policy or practice changes that implement the recommendation, or aspects of it. OFCO provides the "status" of whether implementation effort was evident, a subjective judgment by OFCO as to whether the recommendation has been "completely" or "partially" implemented or not at all. The implementation of some recommendations does not necessarily require an amendment to law, policy or procedure. The necessary laws and policies may be in effect, but they were not complied with by the agency. Compliance, in these instances, may be encouraged through greater supervisory oversight, the imposition of tools to make workers more accountable, and training to educate workers and instill social work practice with child safety priorities that may give way with the pressure of heavy caseloads or other demands.

The following table summarizes the implementation status of the child fatality recommendations made by OFCO over the last several years. A detailed description of the implementation status of each recommendation is provided in the pages following this table (pages 112-133).

Rafael Gomez died of blunt force trauma to the head on 9/10/03 at age 2, 6 months after being returned to the care of his parents.	**OFCO Concerns:** • A failure to investigate child abuse and neglect reports about Rafael received by CPS or investigations that made questionable inconclusive or invalid findings; • The failure to assess the parents' risk for physical abuse even though such tools were available and the failure to provide a psycho-social evaluator with adequate background information on the parents; • Lack of critical in-home support services, such as a public health nurse; • Failure to provide complete information to the Child Protection Team as it was deciding whether to support the worker's plan to return the child home; • Mother's non-compliance with substance abuse treatment and worker's failure to reassess plan to return child home despite this; and • Concerns that the Family Preservation Service and Home Support Service providers may not have been adequately trained to identify and assess child safety issues and the parents' potential for physical abuse.	**Status:** Partially implemented. SSHB 1334, the Raphael Gomez Act, became effective July 22, 2007. It requires DSHS to submit specified source documentation to the court when the agency in a dependency or termination of parental rights proceeding is recommending that a child be returned to a parent from whom the child was removed due to abuse or neglect allegations.

[18] OFCO's 2004-05 Annual Report is available at http://www.governor.wa.gov/ofco/reports/ofco_2005_annual.pdf

Justice and Raiden Robinson, ages 16 months and 6 weeks, died 11/14/04 of malnutrition and dehydration; their mother was found intoxicated and passed out in the home.	**OFCO Recommendations:** Improve Supervisory Reviews of CPS Investigations. Case referral to Alternative Response Systems should not preclude investigation by CPS. Implement Caseload Standards. 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. 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.	**Status:** Partially Implemented. Partially implemented. Quality assurance of contractors is not consistent. Partially Implemented. Complete. In 2005, the "neglect law," known as the Justice and Raiden Act, was enacted. The law amended the definition of "negligent treatment or maltreatment" to include "the cumulative effects of a pattern of conduct, behavior, or inaction" and outlined the basis for filing a dependency, in-home dependency, and removal of a child on the basis of neglect or non-compliance with services. No evidence of implementation
Sirita Sotelo, age 4, died 1/22/05 from blows inflicted by her step-mother, two months after her dependency case was closed.	**OFCO Recommendations:** Heightened assessment of non-parent adult caregivers in the home. Increase efforts to provide services once a child is returned to a parent's care. Revise and implement policy requiring regular health and safety checks for children returned to a parent's care.	**Status:** Complete. "Sirita's Law" was enacted and was codified in part at RCW 13.34.138. It requires that prior to a child returning home, DSHS must identify all adults living in the home and conduct background checks on them; identify any person who will act as caregivers of the child and assess whether they need services to ensure the safety of the child (this is regardless of whether such persons are parties to the dependency). Return of the child home may be made contingent upon compliance with services and may be delayed if the prospective caregiver fails to comply. Complete. Complete.

OFCO's 2004-05 Annual Report, compiled, analyzed and reported on data on all unexpected child fatalities in 2004 of children who were in the care of, or receiving child welfare services from, DSHS CA within one year of their death or who died while in state licensed care. This number totaled 87 children	**OFCO Recommendations:** 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.	**Status:** Partially implemented.
	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.	Partially implemented.
	Consistently drug test infants after death to detect presence of illegal substances if the parents have a drug history.	Partially implemented.
	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.	Complete.
	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).	No evidence of implementation.
	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. 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.	Partially implemented. Practice is inconsistent.
	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.	Partially implemented.
	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)or At-Risk-Youth (ARY) petition, to access appropriate services.	Partially implemented. Practice is inconsistent.
	Reinstate a coordinated effort between DOH and DSHS to implement a statewide child fatality review process.	No evidence of implementation.
	Require an Executive Review of both child fatalities and near fatalities upon the recommendation of OFCO.	No evidence of implementation.
	Require DSHS to establish clear criteria, available to the public, on which cases will receive an Executive Child Fatality Review.	Complete.

OFCO's 2004-05 Annual Report (cont.).	**OFCO Recommendations:**	**Status:**
	Establish a professional multidisciplinary technical team that will assist DSHS in prioritizing and evaluating the usefulness of implementing recommendations from child fatalities.	Partially implemented.
	Implement consistent methodology in the investigation of child death and enact a SIDS labeling law so that consistent terminology is used.	Partially implemented.
	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.	No evidence of implementation.
	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.	Partially implemented.
	Require DSHS CA to establish a plan and report to the Ombudsman on the implementation of recommendations the Ombudsman makes in its fatality reviews.	Complete, as of this annual report.
OFCO's 2006 Annual Report	**OFCO Recommendation:**	**Status:**
	Urgently implement recommendations previously made by the Ombudsman, the Joint Task Force on Child Safety and a number of child fatality reviews, to address a workload crisis widely reported by caseworkers and supervisors across the state.	Partially implemented.

A. OFCO Recommendations from Independent Fatality Case Investigations

Within the past several years, the Ombudsman reviewed the fatalities of Rafael Gomez, Justice and Raiden Robinson and Sirita Sotelo at the request of the Legislature. Based on reviews of these child fatalities, the Ombudsman developed several recommendations as follows:

1. Rafael Gomez Fatality[19]

Two-year-old Rafael Gomez died on September 10, 2003, six months after DSHS returned him to the care of his biological parents. An autopsy determined that Rafael died of "blunt force trauma" to his head. A Community Fatality Review (equivalent to the current executive child fatality review process) was conducted in which OFCO participated. At the first review meeting on December 17, 2003, OFCO presented a completed investigation summary and identified several issues and areas of

[19] Unlike the other fatality examples provided in this section, OFCO did not prepare a stand-alone report on the Gomez fatality, but rather, participated in the Community Fatality Review and summarized OFCO's independent findings, concerns and recommendations in OFCO's 2003 Annual Report. These were communicated to the review team. OFCO's 2003 Annual Report is available at http://www.governor.wa.gov/ofco/reports/ofco_2003_annual.pdf

concern. Among these was OFCO's finding that caseworker bias was a key contributing factor in the agency's erroneous decision to advocate for Rafael's return home. OFCO was concerned that the bias of the social worker also caused the worker to downplay or filter to the court and the Child Protection Team abuse concerns that were raised by the child's former foster parent and medical professionals.

Recommendation

OFCO's recommendations were phrased in the form of issues of concerns communicated to the review team. These included:

- A failure to investigate child abuse and neglect reports about Rafael received by CPS or investigations that made questionable inconclusive or invalid findings;
- The failure to assess the parents' risk for physical abuse even though such tools were available and the failure to provide a psycho-social evaluator with adequate background information on the parents;
- Lack of critical in-home support services, such as a public health nurse;
- Failure to provide complete information to the Child Protection Team as it was deciding whether to support the worker's plan to return the child home;
- Mother's non-compliance with substance abuse treatment and worker's failure to reassess plan to return child home despite this; and
- Concerns that the Family Preservation Service and Home Support Service providers may not have been adequately trained to identify and assess child safety issues and the parents' potential for physical abuse.

Status: Partially implemented.

Law: SSHB 1334, the Raphael Gomez Act, became effective July 22, 2007. It requires DSHS to submit specified source documentation[20] to the court when the agency in a dependency or termination of parental rights proceeding is recommending that a child be returned to a parent from whom the child was removed due to abuse or neglect allegations.

Policy/Practice: Have been made and support changes in the law.

2. Justice and Raiden Robinson Fatalities Review[21]

On November 14, 2004, 16 month-old Justice Robinson and 6-week-old Raiden Robinson were found dead in their home. The children died of malnutrition and dehydration, despite food in the refrigerator and pantry. They were in the care of their mother whom police officers found intoxicated and passed out in a nearby bedroom.

[20] The documentation specified relates to substance abuse, mental health, anger management, or domestic violence treatment; visitation; the psychological status of the parent, and a physician's report related to the injuries to the child that occurred while in the care of the parent.

[21] The Justice and Raiden Robinson Fatalities Review Report by OFCO is available at http://www.governor.wa.gov/ofco/reports/ofco_20050412.pdf

On April 12, 2005, OFCO released the results of its case investigation of CPS' involvement with the Robinson family and the circumstances leading to the death of these children. OFCO reviewed all records and reports from CPS, available treatment reports from service providers, Alternative Response (ARS) records, applicable 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. OFCO made the following recommendations as a consequence of this review.

Recommendation

Improve Supervisory Reviews of CPS Investigations.

- CA should take steps to strengthen the supervisory review of CPS investigations. Specifically, CA should institute a standardized process for reviewing and documenting CPS investigations.
- CA should develop and implement an Investigation Master Checklist, designed to aid workers and supervisors to track investigative tasks and time requirements. Use of a checklist would assist supervisors to complete reviews in an efficient, consistent manner, verify tasks completed and identify whether any further investigative action is required. Supervisors and workers should sign off on the checklist attesting that tasks have been completed.
- CA policy should also require that the substance of supervisory reviews, including the completed checklist, be entered in CAMIS.
- CA should develop and implement corrective/disciplinary action if supervisors or workers fail to comply with investigation standards.

Status: Partially implemented. OFCO finds that the substance of supervisory reviews is not consistently entered in CAMIS or FamLink, its successor. The CPS supervisory checklist discussed below, which appears to be an effective tool, is not yet implemented in all regions.

Law: The law has not been changed to directly address supervisory reviews of CPS investigations. However, there have been enactments that improve consistency of CPS investigations, which was part of the impetus for OFCO's recommendation. In July 2007, SHB1333 was enacted to require all counties to update their sex abuse protocols by July 1, 2008. As county protocols have been developed, the need for statewide consistency regarding child placement in out-of-home care was identified.

Policy: Revised placement policy as set forth in section 2331 E (Investigative Standards). Policy has been expanded to assure consistent practice when referrals are received on severe physical abuse and sexual abuse. A procedure has been developed to outline this process. The policy helps guide social workers through the process when considering:

- Out-of-home placement.
- Contact between the victim and perpetrator.
- Critical components of the safety plan.
- A list of categories when out-of-home placement must occur.

Effective April 15, 2008, new policy went into effect to support the belief that children who are seriously injured or sexually abused should ***not*** typically have contact with the alleged perpetrator(s) until the investigation is completed and a service plan is in place.

Revised placement policy as set forth in section 2331 E (Investigative Standards) requires that out of home placement must be pursued if a safety plan cannot be developed for children who fall into one of the following *four* categories:

1. Children who have suffered a serious non-accidental injury
2. Siblings of children who have been fatally or seriously injured due to abuse or neglect
3. Children living with a caregiver who is unwilling or incapable (i.e., due to mental illness or substance abuse) of supervising or protecting the child
4. Children who have been sexually abused

Children who are currently *in foster care* and meet the above criteria must be removed from their placements.[22]

Practice: CA provided information as to some of the more recent steps taken to improve supervisory review:

CPS Supervisory Checklist. Practice consultants within DSHS CA have developed a "CPS Investigation Supervisor Review of Case Closure or Transfer" checklist to remind supervisors of essential steps before a case is closed or transferred. A copy of this checklist is included in the Appendix to OFCO's Annual Report. OFCO thinks this is an excellent document that promotes consistency of practice and helps prevent lapses in supervisory oversight. Some of the aspects of this checklist are incorporated in FamLink. It is our understanding that this document has been made available to only some of the regions and is not yet implemented state-wide. We are hopeful that DSHS CA will encourage the use of this checklist throughout the state.

FamLink is the electronic records system for Washington state and brought a new level of documentation to investigations. FamLink includes areas that are clearly outlined for a supervisory review. All electronic information about the investigation is contained within the investigative assessment module in FamLink. The supervisor must approve that assessment before an investigation can be completed.[23]

FamLink has a CPS checklist to ensure all tasks are completed. FamLink also requires certain pieces of work to be completed before an investigation can be closed. FamLink also offers ticklers to workers on required time specific pieces of work. There is an escalation component built into the tickler system for the alert to move up the chain of command if the task is not completed and documented.[24]

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[22] See DSHS CA Practices and Procedures Guide, section 2331 E, available at http://www.dshs.wa.gov/ca/pubs/mnl_pnpg/chapter2.asp

[23] Information provided by Tammy Cordova, Acting Director, Program & Practice Improvement Division, DSHS CA to Ombudsman Linda Mason Wilgis on December 14, 2009.

[24] Tammy Cordova, December 14, 2009.

Recent requirements have been added to policy requiring field supervisors to conduct monthly case reviews utilizing the computer and checking on the documentation of the worker contained in FamLink. [25]

January 1, 2009, through March 25, 2009, Supervisor Academy Training was also implemented. The training was provided for one week of each month. The curriculum covers: core functions of supervision; supervision and legal issues; hiring, screening, interviewing and performance development plans; just cause and corrective action; working with a multi-generational workforce; critical thinking; clinical supervision; leadership development and supervisory style; and workload management. The curriculum has continued to be modified and adapted with the many new policies including the practice model.[26]

Recommendation

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.
- CA Policy should require CPS to review ARS exit summaries and determine whether ARS intervention adequately addressed issues described in the CPS referral.
- CA should improve oversight and quality assurance of contractors providing ARS services.
- A parent's participation with ARS alone, should not be used as a sufficient basis to reduce the risk tag or change a CPS intake screening decision on a subsequent referral

Status: Partially implemented. Quality assurance of contractors is not consistent.

Law: This recommendation does not require a change in law.

Policy: Practice and Procedure Manual – Section 2332 – Alternate Intervention provides: An alternate intervention will be used when an intake meets the criteria for Alternate Intervention outlined in FamLink. DLR/CPS may not use alternate intervention to respond to referrals. All DLR/CPS referrals must be investigated by a DLR/CPS investigator. Parameters for an alternate intervention include:

- CA response within **10 calendar days** from the date of intake.
- The CA social worker may send a letter to the family, make a phone call to the caretaker(s) or make a brief home visit to provide the following:
  - Notification that CPS has accepted an intake for alternate intervention.
  - Information included in the intake regarding allegations of CA/N.
  - Information on the local DCFS telephone number/contact.
  - Information on community resources which may be available to address the needs of the family; i.e., information and referral.

[25] *Id.*

[26] Information provided by Nicole Muller, Practice Consultant, Division of Field Operations, DSHS CA to Ombudsman, Linda Mason Wilgis on December 4, 2009. Additional information regarding training is available on the CA's internal Web site at: http://ca.dshs.wa.gov/intranet/uploadedFiles/2009%20Supervisor%20Acad%20Sess%2018.doc

    - Notification that no further action will take place in response to this intake.
- Intakes sent to an Early Family Support Service (EFSS) or other community agencies which are willing to accept the intake for services and/or monitoring.
- Intakes sent to an EFSS shall have a case folder created and a case open in DCFS. All other Alternative Intervention intakes shall be opened and closed in FamLink. Collateral information in the form of additional documentation or correspondence shall be filed and maintained by each office.
- If additional Alternative Intervention intakes are made on a family, the intake(s) shall be printed and included in the case file.

Practice:[27] According to CA: *Only referrals assessed at intake as low risk are referred for alternative services. Included in the contract with providers is the expectation that if safety/risk appears to be greater than initially indicated, they will re-refer for investigation. Other changes listed below increase the accountability for alternative services.*

Early Family Support Services

CA has improved its EFSS contracts with public health and private agencies. The outcome-based contracts include a new assessment and classification system to track family and individual outcomes in several domains. The service now has two pathways: short-term service and a longer-term, family engagement services:

- Short Term Service – services up to 30 days. Provider refers to services and/or provides a short-term service or a concrete service. The provider completes at least one follow-up contact and closes the case.
- Family Engagement Service – services up to 9 months. Provider completes a family assessment and service planning. Provider may offer a combination of referrals to services and provide services based on a service plan that includes input from the family and appropriate familial supports. Provider completes a closing assessment and tracks outcomes in the areas identified on the service plan. The provider may utilize screening tools as part of the family assessment such as NCAST, Ages and Stages, Depression Screenings, etc.

Recommendation

Implement Caseload Standards.

- CPS workers' caseloads should allow them to meet department policy and "best practices" standards.
- CPS supervisors should not carry cases and conduct CPS investigations in addition to their responsibilities as a supervisor. The quality of supervisory reviews suffers when supervisors are also handling case investigations because it does not allow adequate time for meaningful case reviews and worker support.
- AAs and RAs should be required to monitor caseloads of line workers and develop a response plan when caseloads exceed an acceptable level.

Status: Partially implemented.

[27] Nicole Muller, December 4, 2009.

Law: Although there is no state law that explicitly sets forth caseload standards, RCW 74.13.017 set 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 2006. Part of the accreditation process involves adhering to certain best practice caseload standards. DSHS CA announced in May 2008 that it was halting its accreditation process with the Council on Accreditation of Services for Families and Children (COA).

Policy/Practice: Caseloads for social workers have decreased. CA reports that caseloads "are currently averaging 15 across programs."[28] OFCO has been unable to verify this number. Although caseloads have improved overall, OFCO still finds excessive caseloads in certain offices around the state.

> **OFCO Commentary:** Since OFCO made this recommendation in the Sirita Sotelo fatality review report and restated a recommendation in its 2005 annual report that "DSHS . . . 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) or COA," the Ombudsman has conducted periodic, random reviews of caseloads in each region to monitor the agency's progress toward establishing manageable caseloads. In addition to these random reviews, in the course of investigating any given complaint, the Ombudsman frequently checks on the current caseload of the workers involved. OFCO also checks the caseload of the assigned social worker in cases in which a child fatality occurs. Using the case-counting guidelines issued by the COA, the Ombudsman still finds high caseloads in some areas of the state.

Recommendation

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.

- 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.

Status: Complete.

Law: In 2005, the "neglect law," known as the Justice and Raiden Act, was enacted. The law amended the definition of "negligent treatment or maltreatment" to include "the cumulative effects of a pattern of conduct, behavior or inaction;" outlined the basis for filing a dependency, in-home dependency and removal of a child on the basis of neglect or non-compliance with services; and

[28] Documentation attached to December 16, 2009, letter to OFCO Director Ombudsman, Mary Meinig from DSHS Secretary Susan Dreyfus. This letter and documentation are included in part 3 of this section of the annual report on page 148.

authorized DSHS CA to offer voluntary services to parents to reduce the risk of further abuse or neglect. RCW 13.34.138(3); RCW 26.44.020(13); RCW 26.44.195.

Policy/Practice: CA policies have been amended to reflect the changes to the law.
For further discussion of the neglect law and its effects, see pages **?** of this report.

Recommendation

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. 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. Similar statutory requirements should exist to identify and treat mental health issues contributing to the neglect or abuse of a child.

Status: No evidence of implementation.

Policy/Practice: Although this recommendation was not implemented, the CA Practice Model requires CPS to assess a caregiver's mental health as it relates to overall family functioning and the family's service needs, as part of the required comprehensive Family Assessment.[29]

3. Recommendations from OFCO's Sirita Sotelo Fatality Review

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 4-year-old Sirita Sotelo. Sirita died as a result of blows from her stepmother to her head and body causing a fractured skull and severed liver.

In August 2005, OFCO released the results of its case investigation of the Division of Children and Family Services' (DCFS) involvement with Sirita Sotelo and her parents.[30] The Ombudsman reviewed all records and reports from DCFS, treatment reports, professional evaluations, applicable CA Policy and Procedure and state law. The law was changed following a call to action by many concerned citizens, stakeholders, policy makers, legislators and the Ombudsman.

Recommendation

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. 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.

[29] See DSHS CA Practices and Procedures Guide Section 2430, available at http://www.dshs.wa.gov/ca/pubs/mnl_pnpg/chapter2.asp

[30] This report is available at http://www.governor.wa.gov/ofco/reports/ofco_20050825.pdf

Status: Complete.

Law: "Sirita's Law" was enacted and codified in part at RCW 13.34.138. It made comprehensive changes to current law relating to child safety and welfare and incorporated several recommendations from the Child Safety Task Force and independent recommendations of OFCO. OFCO also served on the Child Safety Task Force. Sirita's Law requires that prior to a child returning home, DSHS must identify all adults living in the home and conduct background checks on them, and identify any person who will act as caregivers of the child and assess whether they need services to ensure the safety of the child (this is regardless of whether such persons are parties to the dependency). Return of the child home may be made contingent upon compliance with services and may be delayed if the prospective caregiver fails to comply. The department must notify the court if there is a lack of compliance. This law also imposes a duty on parents to keep the agency informed both before placement and after placement as to who is living in the home and who may act as a caregiver for the child. The law also requires annual training of law enforcement on child abuse and neglect and encourages new collaboration with DSHS.

> **OFCO Commentary:** DSHS CA has expressed concerns to OFCO that some regional workers are erroneously interpreting Sirita's Law to only authorize assessment of the parent from whom the child was removed due to abuse or neglect and then returned (and assessment of the non-parent caregivers in that home), rather than assessment of the non-custodial parent (i.e. the parent who did not have custody of the child when the abuse or neglect occurred), or non-parent caregivers in the home of the non-custodial parent. This is not a correct interpretation of Sirita's law which authorizes assessment of all parents and all non-parent caregivers in the home where the dependent child will be residing. In fact, it would undermine the legislative intent of the law which seeks to prevent a repeat tragedy in which a child is killed by a non-parent caregiver in the home of the parent who was not the custodial parent from whom the child was originally removed. It is imperative that training on this topic be bolstered and that the agency consider policy changes to its manuals to clarify this assessment process.

Policy: New agency policy has been adopted to implement Sirita's Law. Updates to the DSHS CA Practices and Procedures Policy (Section 43051A – Trial Return Home Policy) and to the Individual Services and Safety Plans (ISSP) Guide for Social Workers has been made. Under revised policy,[31] prior to a dependent child returning home the social worker must now:

- Conduct criminal background checks on all adults residing in the home. *Background checks for all adults living in the home, age 18 and above, must include:*
  - A CAMIS records check
  - A background check conducted by the DSHS Background Check Central Unit (BCCU)
  - An out-of-state child-abuse and neglect registry check for persons who lived outside of Washington state within the preceding five years. The out of state child abuse and neglect (CA/N) registry check must include all other states the individual lived in during that time.

[31] See DSHS CA Practices and Procedures Guide, section 43051A, available at http://www.dshs.wa.gov/ca/pubs/mnl_pnpg/chapter4_4300.asp

- Identify and assess all caregivers of the child for services related to the safety of the child and recommend the caregiver participate in the identified services; notify the court of any service recommendations made to the caregiver during a regular review hearing.

Recommendation

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. The department should continuously assess the need for and implement appropriate services as long as a case remains open for supervision.

Status: Complete.

Law: "Sirita's Law" requires the department to coordinate with other administrations and contracted service providers to ensure that parents in a dependency proceeding are a priority for remedial services. Remedial Services are time limited family reunification services, such as: Individual groups and family counseling; substance abuse treatment; mental health; domestic violence; temporary child care; therapeutic services for families; and transportation to and from services and activities.

OFCO Commentary: Additionally, in 2007 the Legislature (in 2SHB 1128) directed the Washington State Institute for Public Policy (WSIPP) to study evidence-based, cost-effective programs and policies to reduce the likelihood of children entering and remaining in the child welfare system, including prevention and intervention programs.[32] In its analysis, WSIPP focused on three key questions:

- Is there credible evidence that specific programs "work" to improve these outcomes?
- If so, do benefits outweigh program costs?
- What would be the total net gain to Washington if these evidence-based programs were implemented more widely across the state?

[32] WSIPP's report "**Evidence-Based Programs to Prevent Children from Entering and Remaining in the Child Welfare System: Benefits and Costs for Washington"** is available at http://www.wsipp.wa.gov/rptfiles/08-07-3901.pdf WSIPP reviewed 74 comparison-group evaluations of programs and policies to identify what works to improve child welfare outcomes. WSIPP then estimated the monetary value of the benefits to Washington state if these programs were implemented. In estimating monetary value, WSIPP examined factors such as reduced child welfare system expenditures, reduced costs to the victims of child maltreatment and other long-term outcomes to participants and taxpayers, such as improved educational and labor market performance and lower criminal activity. WSIPP estimated the statewide benefits of implementing an expanded portfolio of evidence-based programs and found that after 5 years of implementing such a strategy, Washington would receive long-term net benefits between $317 and $493 million (of which $6 million to $62 million would be net taxpayer benefits). Several of the cost-effective, evidence-based programs listed in the expanded portfolio are offered and available to a limited degree in the state, including: homebuilders program for intensive family preservation; parent-child interaction therapy; nurse family partnership home visitation program; and parents as teachers.

Policy: DSHS updated the DSHS Practices and Procedures Policy (Section 43051A–Trial Return Home Policy) to implement Sirita's Law.[33] The agency also conducted training of the requirements in September 2007 to support implementation of the bill. The policy states the purpose of a "trial return home" period as to: see that the safety and well-being needs of the child are met when the child transitions home; and support the parents and child in their efforts to achieve a successful reunion. Policy requires that a Reunification Assessment and a Transition and Safety Assessment must be completed if the child has been out of the home for 60 days or more.

Practice: CA states that FamLink provides a better mechanism for keeping track of what services are being provided to the family and what services would be beneficial to stabilize placement when CA returns the child home. FamLink is set up to remind workers that a case may not be closed before certain steps are taken and safeguards are in place. "Family Assessments" and an "Assessment of Progress" must be done.

Recommendation

Revise and implement policy requiring regular health and safety checks for children returned to a parent's care. CA reports that it is currently addressing policy issues regarding health and safety checks of dependent children in a parent's care, and is in the process of revising department manuals. The department should expedite these efforts and assure that caseworkers and supervisors are aware of existing requirements regarding health and safety visits. Moreover, requirements for in-home health and safety checks of dependent children returned to a parent's care incorporated in the revised manual should at least be as stringent as the current standards set forth in CA Policy 01-02.

Status: Complete. Current policy requires 100 percent case review to ensure monthly visits are completed.

Law: No change in the law required.

Policy: In December 2005, CA implemented the 30-day social worker visit policy for children in in-home dependencies.

Effective April 2007, monthly visits were required for children in in-home and out-of-home care, not to exceed 40 days between visits (rather than 30 days) and the policy was expanded to require visits with children 5 and under who were in relative care. The department began to phase in monthly checks from the former policy of 90-day health and safety checks.

Effective September 1, 2008, the final phase in of the monthly visit policy was implemented. It requires the assigned social worker to conduct private and individual face-to-face visits every calendar month not to exceed 40 days between visits for **all** children in care.

The policy now includes children in Long Term Foster Care (LTFC) agreements (Braam requirement) and Voluntary Service Agreement (VSA) cases (Child and Family Services Review

[33] See DSHS CA Practices and Procedures Guide, section 4420, available at http://www.dshs.wa.gov/ca/pubs/mnl_pnpg/chapter4_4310.asp#4420

requirement).[34] These policy changes and clarifications were communicated to AA in September 2008.[35]

Effective July 26, 2009, CA is required to implement a "quality assurance" plan for monthly visits as a result of a Braam panel directive.[36] Supervisors must now review the child/caregiver monthly visits with each social worker on a case. There must be 100 percent case review, which includes monthly supervisor case reviews with the assigned worker, and documentation of each case reviewed in the client electronic case file.

B. OFCO Recommendations from Annual Reports

1. Recommendations from OFCO's 2004-05 Annual Report

In OFCO's 2004-05 Annual Report, we compiled, analyzed and reported on data on all unexpected child fatalities in 2004 of children who were in the care of, or receiving child welfare services from, DSHS CA within one year of their death or who died while in state licensed care.[37]

Recommendation

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.

Status: Partially implemented.

Law: In 2005, the "neglect law" known as the Justice and Raiden Act, was enacted. Although it does not specifically implement this recommendation, it includes provisions that include "the cumulative effects of a pattern of conduct, behavior or inaction" in the definition of "negligent treatment or maltreatment" and provides that *parental substance abuse* as a contributing factor to negligent treatment or maltreatment shall be given great weight. RCW 26.44.020(13); RCW 26.44.195(2), (4).

Policy: With regard to referrals while pregnant:[38] Effective October 22, 2007, new DSHS policy went into effect providing that if CPS receives a referral on alleged substance abuse during pregnancy, the intake worker will document the alleged substance abuse and information on risk and protective factors in an "Information Only" referral. CA staff will then send this "Information Only" referral to a centralized ESA contact and an ESA Program Manager will screen and forward appropriate referrals for First Steps intervention. (First Steps is a program for high-risk, low-income pregnant women.)

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[34] See DSHS CA Practices and Procedures Guide, section 46100, available at http://www.dshs.wa.gov/ca/pubs/mnl_pnpg/chapter4_4600.asp#4610

[35] Memo available on CA's internal website: http://ca.dshs.wa.gov/intranet/pdf/policy/2008_09/Sept%202008%20Memo.pdf

[36] Policy Summary accessed on CA's internal website: http://ca.dshs.wa.gov/intranet/pdf/policy/2009_07/PolicySummary_Monthlyvisits.pdf

[37] This number totaled 87 children.

[38] See DSHS CA Practices and Procedures Guide, Chapter 2552. Intakes on Newborns Identified by a Medical Practitioner as Substance Exposed and/or Substance Affected Newborns by Substances (Not Medically Prescribed) or Has Withdrawal Symptoms Resulting from Prenatal Substance Exposure. See http://www.dshs.wa.gov/ca/pubs/mnl_pnpg/chapter2_2500.asp

With regard to referrals on newborns:[39] DSHS policy provides that if a newborn is substance exposed *but not substance affected*, the referral will be documented as "Information Only."[40] If the newborn is substance exposed *and substance affected,* the referral will be assigned to CPS investigation if the known risk factors indicate a moderate to high risk or the infant is at risk of imminent harm. If the known risk factors indicate a low or moderately low risk to the newborn, it will be referred to alternative intervention and the social worker makes contact with the family to develop a "plan of safe care," which will address issues such as medical care, safe housing, emergency contacts and referrals to necessary services. Since January 1, 2008, these referrals have been referred to an Alternative Response System (ARS) provider.

Practice: DSHS CA has incorporated into statewide training on CPS Best Practices Investigations and "Lessons Learned," data and research showing that young children are the most vulnerable to death and injury. This training urges social workers who have young children on their caseload to monitor them closely and if an alleged injury occurs, social workers should have the child taken to see a medical professional to determine the cause of the injury rather than trying to assess this independently.

Recommendation

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.

Status: Partially implemented. Inconsistent.

Law: New law enacted in 2008, as a result of the passage of 2SSB 6206, provides for increased attention to DSHS CA's response to families with a CPS history of founded referrals. RCW 26.44.030(13) requires DSHS to promptly notify OFCO when a report[41] of child abuse or neglect constitutes the third founded report on the same child or family within a 12 month period, and requires that DSHS notify OFCO of the disposition of the report. This provision does not require OFCO to report specifically on these recurrent maltreatment cases. However, because these cases provide OFCO an opportunity to examine case history and analyze what factors may have made the previous intervention unsuccessful (as based on a recurrence of the abuse or neglect), OFCO provides information on these cases in this report, see pages 174.

[39] DSHS CA Practices and Procedures Guide, Chapter 2552.

[40] "Information Only" means the agency documents the referral/intake in its database but has concluded that it does not meet the legal sufficiency criteria to warrant investigation.

[41] The term "report" in this context means a "referral," which the agency now calls an "intake."

OFCO Commentary: It should be noted that despite this new law which facilitates OFCO's examination of recurrent abuse or neglect, there has been other recent law that may make it more challenging to review a child or family's history in connection with a child fatality. *Effective October 1, 2008*, RCW 26.44.031(2) provides that DSHS shall destroy all records concerning:

- A screened-out report within three years from receipt of the report; and
- An unfounded or inconclusive report within six years of completion of the investigation, unless a prior or subsequent founded report has been received regarding the child who is the subject of the report, a sibling or half-sibling of the child, or a parent, guardian or legal custodian of the child, before the records are destroyed.

Moreover, RCW 26.44.031(4) provides that "[a]n unfounded, screened-out, or inconclusive report may not be disclosed to a child-placing agency, private adoption agency, or any other provider licensed under chapter 74.15 RCW." Concern has been expressed by policy staff within DSHS CA and by OFCO that a child's history may be expunged in the middle of a fatality review process. This may require a statutory or policy change to preclude such records from being redacted pending a review. Furthermore, although DSHS CA's prior computerized database had automated expungement of records, FamLink does not. All expungement at this time is done manually and is expected to occur two times a year.

Policy: New policy contained in section 2540 of the DSHS CA Practices and Procedures guide provides that "When a third founded finding is made involving the same child or family within the previous 12 months, CA must promptly notify the Office of the Ombudsman of the contents of the report and disposition of the investigation." No action is required by social workers; the CA Headquarters CPS Program Manager tracks these cases. Automatic notification to OFCO via FamLink (Release 2) just started.

Practice: DSHS CA has incorporated into statewide training on CPS Best Practices Investigations and "Lessons Learned," data and research showing that young children are the most vulnerable to death and injury. This training urges social workers who have young children on their caseload to monitor closely. If an alleged injury occurs, social workers should have the child taken to see a medical professional rather than trying to determine on their own the cause of the injury.

Recommendation

Consistently drug test infants after death to detect presence of illegal substances if the parents have a drug history.

Status: Partially implemented. This is done regularly in counties with greater resources and more sophisticated technology.[42]

Law: OFCO is unaware of changes to the law specifically addressing this recommendation.

Policy: OFCO is unaware of changes in policy specifically addressing this recommendation.

[42] For example, King County.

Practice: In King County, it has been a long-standing practice to run a toxicology screening test on infants who have died unexpectedly. In discussing OFCO's recommendation that such testing occur consistently, especially with infants whose parents have a history of drug use, Colin Jones, a program manager with the King County Medical Examiner's office, agreed that this makes sense. OFCO is unaware if this is common practice throughout the state and will follow through on surveying other counties.

Recommendation

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.

Status: Complete.

Law: OFCO is unaware of changes to the law specifically addressing this recommendation.

Policy: OFCO is unaware of changes in policy specifically addressing this recommendation.

Practice: According to DSHS CA, practice has been modified over the past few years in a variety of ways to increasingly take into account family history. More detailed information on the CA Practice Model and Structured Decision Making, which are discussed below, are available on the CA Web site.[43]

Practice Model.[44] In 2005, CA staff and management designed and implemented a new practice model. The implementation included training to support the model and incorporated advanced investigation and assessment training for CPS workers. The objectives of this improvement initiative, "The Practice Model" was to provide an overarching framework for child welfare practice in Washington state and give social workers the tools, skills and support they need. Practice Model achievements include Solution Based Casework and Solution Focused Management.

Family Assessment and Assessment of Progress.[45] These tools were created in FamLink which reflect the principles of Solution Based Casework. In the family assessment, social workers document both strengths and needs for the family and individuals in the family. Specific questions are asked about the family view and the sequence of events that led up to CA involvement with the family. The assessment also captures what the family would like to achieve by working with CA. The case plan documented in FamLink reflects information from the Family Assessment. The service plan document has been updated and aligns services and tasks with desired goals and outcomes.

[43] For information regarding Structured Decision Making, see DSHS CA Practices and Procedures Guide, sections 2430 and 2540, available at http://www.dshs.wa.gov/ca/pubs/mnl_pnpg/chapter2.asp and http://www.dshs.wa.gov/ca/pubs/mnl_pnpg/chapter2_2500.asp. Information about CA's Practice Model is available on CA's internal Web site at http://ca.dshs.wa.gov/intranet/practicemodel/index.asp.

[44] Nicole Muller, DSHS CA Practice Consultant. Information provided on December 4, 2009.

[45] *Id.*

Chronicity Flag in FamLink.[46] CA instituted the chronicity flag in FamLink and a policy for staff to follow when a case is identified as chronically referring. The chronicity flag is based on the history of the individuals identified in the intake.

> **OFCO Commentary:** Although DSHS CA discussed these and other new tools in FamLink intended to improve practice, the agency acknowledged that FamLink, in its current state of operation, makes it extremely difficult for intake workers to review a family's history. It is multi-layered and what workers could previously access from CAMIS/GUI in the course of a few key strokes, now takes several. There is no easy or expeditious way to get a cumulative snapshot of a family history and risk factors.

Structured Decision Making.[47] In October 2007, CA adopted an actuarial risk-assessment model, SDM, to replace the former risk assessment tool. The SDM is a research-based, relatively simple and structured assessment. Its purpose is to identify families who are most likely to experience a future event of child abuse or neglect. The principle behind SDM is that decisions can be improved by clearly defined and consistently applied decision-making criteria, readily measurable practice standards, with expectations of staff clearly identified.

Four of 18 questions in the assessment specifically focus on the caregivers characteristics including mental health history, drug and alcohol history and past history of abuse and neglect (of caregiver).

Recommendation

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 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.

Status: No evidence of implementation.

Law: This specific recommendation would require a change in law. However, the Justice and Raiden Robinson Act captures the spirit of this recommendation, which is that parenting history is the greatest predictor of future parenting and there should be greater scrutiny of referrals alleging abuse or neglect by a parent who has had parental rights terminated as to other children. RCW 26.44.020(13) expands the definition of "negligent treatment or maltreatment" to include "the cumulative effects of a pattern of conduct, behavior or inaction."

Policy: Policy has not been implemented to address this recommendation. However, CA states that intake staff are directed to look at all potential risk and safety threats to a child, as well as the strengths and protective factors within a family when an intake is received. Having had parental rights terminated in the past is a risk but generally not the sole reason an intake is screened in.[48]

[46] Tammy Cordova, December 14, 2009.
[47] Nicole Muller, December 4, 2009.
[48] Tammy Cordova, December 14, 2009.

Recommendation

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. 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.

Status: Partially implemented. Practice is inconsistent. Some VSAs are well monitored; others are poorly monitored.

Law: OFCO is unaware of changes to the law specifically addressing this recommendation.

Policy: Effective January 1, 2007, there was a CPS/CWS redesign implemented in most CA offices accompanied by updates to the DSHS CA Practices and Procedures Guide.[49] Its purpose was to:

- Separate service delivery from investigation and assessment;
- Increase the focus on voluntary services to provide early support to families;
- Focus CPS investigations on seeing children quickly, assessing safety and risk and determining families need for services;
- Engage families early to increase child safety and reduce the risk of harm;
- Create a new Voluntary Service function; and
- Create a model that accommodates future practice enhancements.

Recommendation

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.

Status: Partially implemented. Caseloads have declined and supervisors take caseload demands into consideration on an informal basis when making assignments.

Law: There is no statutory requirement that caseload assignments be weighted to take into account higher workload demands of cases that present recurrent abuse and neglect.

Policy: OFCO is not aware of policy that implements a weighted-caseload distribution among workers.

Practice: Although there is no formal or systematic weighted-caseload distribution, DSHS CA reports that pro-active supervisors take this into account on an ad-hoc basis when assigning cases. There is also no electronic means of doing this. It would require a change to the risk assessment intake process.

[49] Updates were made to sections 2200, 2300, 2430, 2500, 2600 and 4307 of the DSHS CA Practices and Procedures Guide.

Recommendation

Ensure that parents and teens requesting services to assist families in crisis, such as Family Reconciliation Services, are provided with sufficient assistance and direction from DCFS on pursuing legal remedies, such as a Child in Need of Services or At-Risk-Youth petition, to access appropriate services. The state should be as responsive and informative as possible to put requested services in place and follow through with ensuring that the family received services. DCFS should re-examine and modify existing protocols to determine if they are sufficient to accomplish these goals.

Status: Partially implemented. Inconsistent depending greatly on a particular caseworker's inclination to assist a family and their familiarity with the process.

Law: This does not require a statutory change.

Policy &Practice: Policy provides guidance on DSHS CA providing families with assistance. However, according to CA, the Office of the Attorney General has advised that giving "direction" to parents on At-Risk-Youth or Child in Need of Services petitions could be construed as social workers practicing law so workers have been cautioned about this. CA also notes that there are notification requirements in most of our preventative services contract that address providing services within our capacity.[50]

Recommendation:

Reinstate a coordinated effort between DOH and DSHS to implement a statewide child fatality review process.

Status: No evidence of implementation.

Law: Effective July 26, 2009, SHB 1303 became law. This legislation takes steps to coordinate data collection and dissemination of information from child mortality reviews. It requires DOH to assist local health departments in their efforts to collect reports of any child mortality reviews. DOH must help the local health departments enter the reviews into a database, and respond to requests for information from the central database. The DOH is further required to provide technical assistance to local health departments and child death review coordinators and encourage communication among child death review teams. Although this law does not specifically address coordination between DOH and DSHS, improved data collection and sharing of information may facilitate future efforts to reinstate statewide coordination.

Recommendation

Require an executive review of both child fatalities and near fatalities upon the recommendation of OFCO.

Status: No evidence of implementation.

[50]Tammy Cordova, December 14, 2009.

Law: Existing law does not grant OFCO the authority to require an Executive Child Fatality Review. However, new law, RCW 74.13.640, requires DSHS to promptly notify OFCO of near fatalities in cases where the child had been in the care of or receiving services from DSHS at the time of the near-fatality or within one year preceding the near-fatality. Additionally, DSHS may propose legislation in this session which would amend RCW 74.13.640 to authorize DSHS to review near-fatalities so as to improve identification of risk factors to prevent future fatalities. RCW 74.13.640 also includes a new provision that specifies that in cases where the fatality *is the result of apparent abuse or neglect*, the fatality review team will be comprised of individuals who had no previous involvement in the case and whose professional expertise is pertinent to the dynamics of the case. Although this is not called an executive review per se, it does speak to the basis of OFCO's recommendation which is that reviews by objective professionals who were not directly involved with the child or family are appropriate in cases of abuse and neglect. These are precisely the category of cases in which OFCO wanted to ensure executive reviews were being done.

Policy/Practice: There is no policy change requiring executive review of both child fatalities and near fatalities upon the recommendation of OFCO. However, OFCO has the authority to convene a fatality review on its own so this is an option if DSHS declines to review a case at the executive review level.

Recommendation

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

Status: Complete. The DSHS CA public Web site is clear about the different types of fatality reviews: http://www.dshs.wa.gov/ca/pubs/fatalityreports.asp

Law: RCW 74.13.640 clearly sets forth the requirements for child fatality review, including executive reviews.

Policy/Practice: DSHS sets forth its practice on child fatalities on the public Web site. http://www.dshs.wa.gov/ca/pubs/fatalityreports.asp

Recommendation

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 Ombudsman on the status of implementation of child fatality review recommendations.

Status: Partially Implemented

Law: There have been no statutory changes requiring this.

Policy: OFCO is unaware of changes in policy specifically addressing this recommendation.

Practice: DSHS CA has convened a Child Fatality Review Project work group[51] to evaluate the child fatality review process, review existing requirements and practice, and consider ideas for improvement. Some topics that have been considered are the scope of review, the definition of "expected" versus "unexpected" death and the definition of what constitutes "prior history" or "service." Changes will be forthcoming.

Recommendation

Implement consistent methodology in the investigation of child death and enact a SIDS labeling law 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, or their equivalent, in each county employ the same autopsy protocol on sudden unexplained deaths.[52] 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.

Status: Partially implemented.

Law: Sirita's Law, enacted in 2007 and codified in part at RCW 26.44.185, contains two key provisions that address OFCO's recommendation to improve investigation of child deaths and provide for consistent protocols in such investigations: (1) it required each county to revise and expand its existing child sexual abuse protocol to include investigations of child fatality, child physical abuse and criminal child neglect cases, and to incorporate statewide guidelines for first responders to child fatalities developed by the Criminal Justice Training Commission (CJTC). It also required that the protocols provide for coordination between essential entities such as the prosecutor's offices, law enforcement, CPS and emergency medical services; and (2) it required CJTC to develop and provide multidisciplinary team training sessions to improve the coordination of, and communication between, agencies involved in the investigation of child fatality, child sexual abuse, child physical abuse and criminal child neglect cases. Each county was encouraged to send a multidisciplinary team[53] to participate in a team training session at least on an annual basis.

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[51] Project Team Members include Paul Smith, Critical Incident Program Manager; Sharon Gilbert, HQ Deputy Director of Field Operations, Mary Meinig, Director of OFCO and other OFCO staff; Nicole LaBelle, Region 1, Regional Program Administrator; Melissa Sayer, HQ Licensed Resources/CPS Program Manager; Marilee Roberts, HQ Practice consultant with Division of Field Operations; Bob Palmer, Region 5 Child Fatality Program Manager; Nicole Muller, HQ Practice Consultant for Division of Field Operations and Colette McCully, CPS Program Manager with HQ Office of Program and Policy.

[52] "The county coroner or medical examiner is responsible for conducting death investigations, including inquests. In counties over 250,000 in population, the county legislative authority may, upon confirmation by county voters, replace the elected office of coroner with an appointed medical examiner under the medical examiner system. In counties with a medical examiner system, the medical examiner performs the functions of the coroner and may perform other duties such as autopsies and lab studies. In counties under 40,000 in population (17 of 30 counties, based on 1997 population), the County Prosecuting Attorney serves as the coroner. While not common, the county coroner is also authorized by law to serve as the County Sheriff under certain conditions." http://www.mrsc.org/subjects/governance/locgov17.aspx#coroner

[53] Teams were to be composed of members from the prosecutor's office, law enforcement, child advocacy groups, DSHS and emergency medical services.

Policy/Practice: CJTC has developed two types of training: one-day training on "C-POD Guidelines for First Responders to Child Deaths and Serious Physical Injury Cases"[54] and, in response to Sirita's Law, three-day strategic planning sessions with multi-disciplinary teams from around the state to address child abuse protocol investigations. OFCO participated in this training. According to CJTC, approximately 30 out of 39 counties have participated in this training,[55] which has been offered eight times in 2009 at various locations throughout the state. Patti Toth, a Program Manager at the CJTC, helped to develop and facilitate these trainings. She noted what a positive experience this has been and how the trainings have helped us "to work together more effectively. It strengthens relationships, improves understanding and makes it easier to go home and work together."[56] Participating counties left the training with a concrete plan on revising their protocols and/or improving multi-disciplinary coordination over the next year.

Additionally, CJTC used the training as an opportunity to promote newly developed infant death investigation guidelines[57] designed for the scene investigator. Despite the development of these excellent guidelines, there is still no consistent methodology used in child death investigations across the state or country. There are variations dependent upon available resources, local procedures, established protocols, and the training and experience of the investigator. King County has a high degree of technical expertise and has assisted other counties with autopsies upon request. Despite the continuing lack of consistency, significant strides have been made over the past few years with the development of the CJTC training, C-POD Guidelines and death scene investigation guidelines.[58]

> **OFCO Commentary:** The economic crisis has affected the number of counties able to participate in this training. Furthermore, like almost all state agencies, CJTC has experienced budget cuts that have reduced its ability to pay expenses for participating multi-disciplinary team members. This will likely affect for the foreseeable future the number of participants who are able to participate in this valuable training.

Recommendation

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.

Status: No evidence of implementation.

Law: State law does not require such audits to ensure that unexplained, sudden deaths of young children are adequately investigated.

Policy/Practice: OFCO is unaware of policy or practice changes in this area.

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[54] The C-POD training was produced in 2006, pre-Sirita's Law and then updated in 2008. The training was funded by a DSHS Children's Justice Act Grant.

[55] Patti Toth, Program Manager at CJTC.

[56] December 30, 2009, telephone conversation between Ombudsman Linda Mason Wilgis and Patti Toth, Program Manager at CJTC. For additional information, go to the CJTC Web site at www.cjtc.state.wa.us or contact CJTC Program Manager Patti Toth at ptoth@cjtc.state.wa.us

[57] See http://www.nisa-sids.org/SUIDI-Guidelines.html

[58] For more information on the guidelines developed by the national interagency panel on SIDS, see http://www.cdc.gov/mmwr/preview/mmwrhtml/00042657.htm

Recommendation

Require DSHS to document caseworker caseloads at the time of the fatality or near fatality[59] in AIRS and incorporate in child death review reports for future analysis.

Status: Partially implemented.

Law: There have been no statutory changes requiring this.

Policy: OFCO is unaware of changes in policy specifically addressing this recommendation.

Practice: DSHS CA does not consistently document caseloads in AIRS reports.

Recommendation

Require DSHS CA to establish a plan and report to the Ombudsman on the implementation of recommendations the Ombudsman makes in its fatality reviews.

Status: Complete as of this annual report.

Law: There have been no statutory changes requiring this.

Policy: OFCO is unaware of changes in policy specifically addressing this recommendation.

Practice: On September 16, 2009, OFCO requested that DSHS CA provide OFCO with the status of implementation of child fatality review recommendations. In early December, DSHS CA provided OFCO with this information based on extensive work prepared by each region. This exercise was the first of its kind and CA reported to OFCO that although it entailed a great deal of work, it was useful and has helped establish a process for future reporting.

2. Recommendation from 2006 Annual Report

Recommendation

Urgently implement recommendations previously made by the Ombudsman, the Joint Task Force on Child Safety and a number of child fatality reviews, to address a workload crisis widely reported by caseworkers and supervisors across the state.

Status: Partially implemented (see discussion of OFCO's recommendation to implement caseload standards on page 117).

Law/Policy: The need for changes in law or policy depends upon the specific recommendation.

[59] "Near fatality" means an act that, as certified by a physician, places the child in serious or critical condition. RCW 74.13.500(1)(4).

PART 2
IMPLEMENTATION STATUS OF CA CHILD FATALITY RECOMMENDATIONS

I. BACKGROUND

On September 15, 2009, OFCO requested DSHS CA to provide our agency with the status of implementation of recommendations developed in response to more than 500 practice, policy and system issues[60] identified in child fatality reviews conducted by CA from 2005 to 2008.[61] OFCO made this request to fulfill our reporting obligations under 2SSB 6206. CA HQ submitted OFCO's request to each of the six DSHS Regions. OFCO received the regional responses on December 3, 2009. OFCO acknowledges the time and effort spent by each region and appreciates the thoughtful responses that each provided.

Upon preliminary review, OFCO found that each region took a different approach to the request,[62] but all provided information about actions taken to address individual issues and recommendations in their jurisdictions. OFCO compiled the regional responses,[63] organized the contents into a uniform format and analyzed[64] the information. OFCO found that CA took action in response to the majority (approximately three-quarters) of issues identified in child fatality reviews.[65] These actions do not necessarily translate into full implementation of recommendations.

Summary data provided below describes whether implementation effort was evident in response to recommendations regarding CA,[66] and to what extent – partial or complete. OFCO provides this information as a starting point and acknowledges that CA's efforts to refine the child fatality review process and tracking of issues and recommendations are ongoing. OFCO will continue to coordinate efforts with CA to facilitate timely reporting to policy makers regarding the implementation status of CA CFR recommendations.

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[60] "Practice," "policy" and "system" are CA assigned categories.

[61] Please note that the issues identified during the course of a child fatality review can vary. Also, some review panels develop more than one recommendation in response to a single issue. For data describing child fatalities from 2004-08, see page 96.

[62] Some regions provided detailed information about the action taken, and whether the actions had been completed. Others provided brief statements about the nature and status of the actions taken. Given the different approaches taken by each region in response to OFCO's request, this analysis should be taken as preliminary. OFCO and CA's ongoing efforts to make the child fatality review process consistent across the state should lead to stronger data and reporting on the status of recommendation implementation.

[63] Taken together, the regional responses amassed approximately 170 legal-sized pages of text.

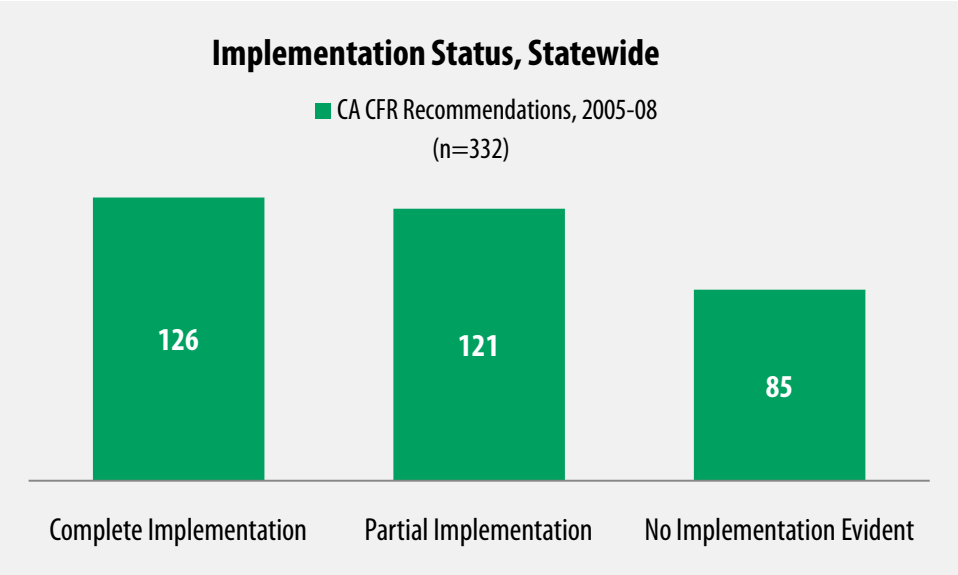
[64] See page 137 for a breakdown of OFCO's process for analyzing the regional responses.

[65] Out of the "recommendations" listed by CA, 65 percent were suggestions to improve CA practice, policy or other system issues. Approximately 31 percent of the recommendations did not contain suggestions for improvement, but rather were statements about an action taken in response to issue identified by CFR teams. A small portion of recommendations (4 percent) were directed at agencies other than CA.

[66] Some recommendations clearly suggest concrete action to be taken by CA, while others recommend changes to CA without indicating who is responsible for making the suggested change.

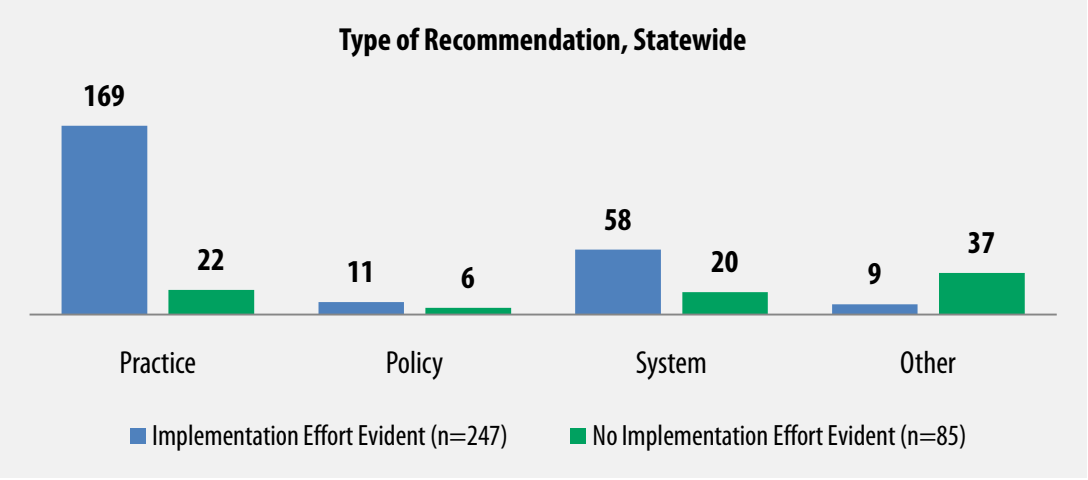
II. Preliminary Summary Data

Statewide Implementation of CA Recommendations. Implementation effort was evident in 74 percent of recommendations developed regarding CA practice, policy or system issues. Of this 74 percent, about half appear to be completely implemented; the remaining half appear to be partially implemented. Implementation effort was not evident in response to over 25 percent of recommendations. See page 159 for a discussion of the barriers to recommendation implementation.



Source: Office of the Family and Children's Ombudsman, December 2009, based on analysis of DSHS CA data

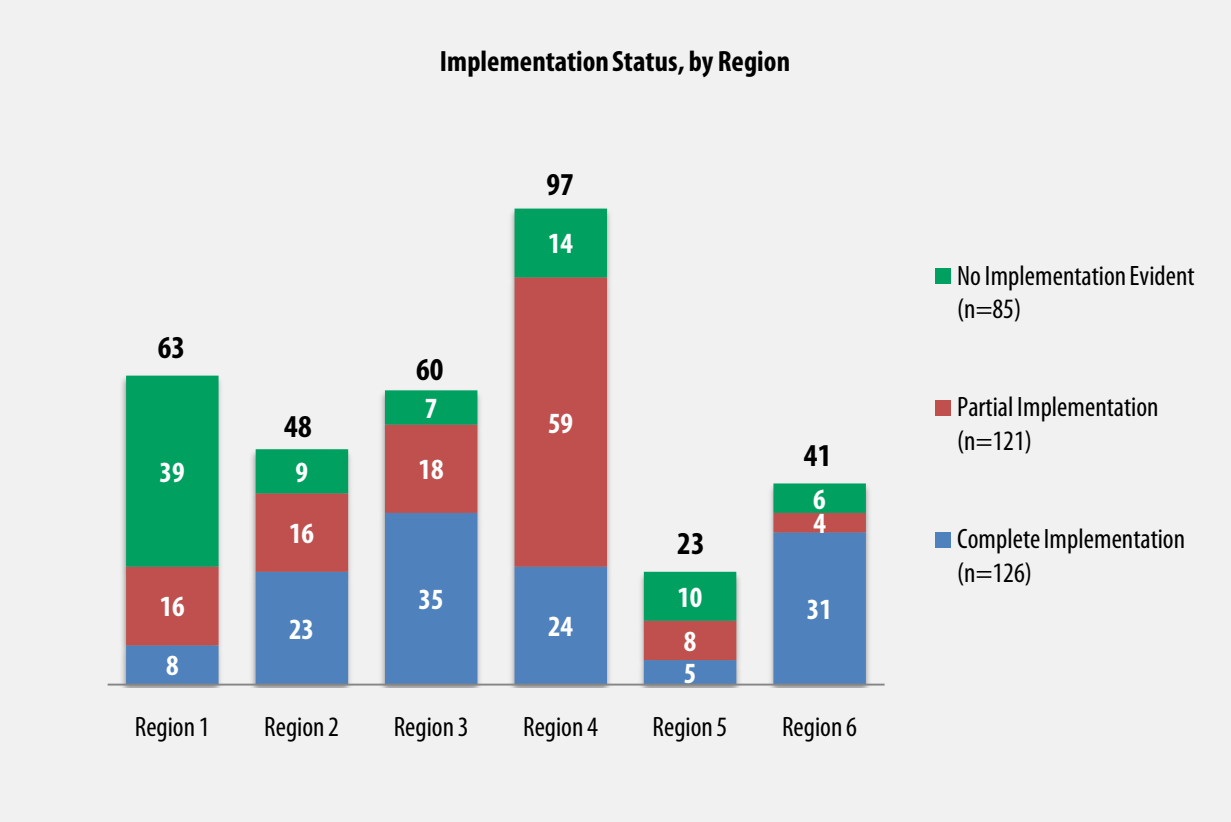
Type of Recommendations Implemented vs. Not Implemented. Type of issue or recommendation (practice, policy, system) is designated by DSHS CA. OFCO assigned the category "other" to recommendations other than practice, policy, or system. "Others" include recommendations CA labeled "quality" or "[child's last name] executive review".



Source: Office of the Family and Children's Ombudsman, December 2009, based on analysis of DSHS CA data

Regional Implementation of CA CFR Recommendations.[67] With the exception of Region 1, each region reported taking action that either partially or completely implemented the majority of recommendations within its jurisdiction. Regions 3 and 6 reported activities that completely implement over half of the child fatality recommendations issued in their respective jurisdictions. Over half of the recommendations in Region 4 appear to be partially implemented.

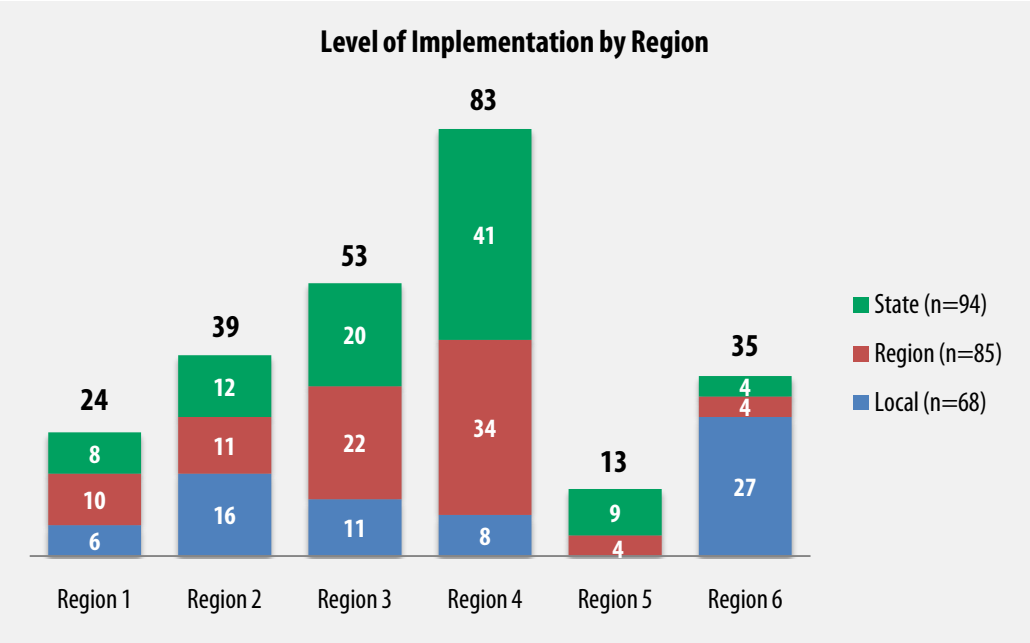
While Region 1 appears to have completely implemented only eight recommendations, the majority of the recommendations where no implementation effort was evident emerged from three executive child fatality reviews. CA HQ is charged with implementing ECFR recommendations. Since CA HQ did not respond regarding individual recommendations, action taken to implement these individual recommendations remains unknown. See page 134 for DSHS' response to OFCO's request for a status update regarding the implementation of child fatality recommendations.



Source: Office of the Family and Children's Ombudsman, December 2009, based on analysis of DSHS CA data

[67] OFCO assigned implementation status codes ("partial" or "complete") based on CA's report. OFCO used a two-reader process to reduce subjective interpretation. Note: The regional responses provided to OFCO varied in the level of detail provided. In some cases, OFCO could not determine, based on the information provided, that recommendations were completely implemented. Consistent and detailed documentation would likely change OFCO's categorization of the extent of recommendation implementation.

Level of Recommendation Implementation, by Region. The graph below describes the level of actions documented in CA's response to CFR recommendations. Anecdotally, many of the state-level actions were changes to law or policy. Additionally, Region 5 CFRs produce few recommendations, but frequently identify taking action locally (See graph on page 139).



Source: Office of the Family and Children's Ombudsman, December 2009, based on analysis of DSHS CA data

III. OFCO Process for Analyzing DSHS CA Response

OFCO first identified and excluded instances where issues and recommendations were not identified. For example**,** excellent social-work practice was frequently identified in some regions.[68] OFCO found 36 instances where excellent practice was discussed. Recommendations are generally not developed in response to excellent practice, since problematic issues have not been identified. While OFCO excluded these from its analysis of recommendation implementation, further examination of excellent practice is warranted and would likely yield meaningful lessons that could result in improved social-work practice throughout the state.

[68] Review teams in Regions 3 and 5 often document excellent social work during child fatality reviews.

Here is an example of excellent practice that was excluded from OFCO's analysis:

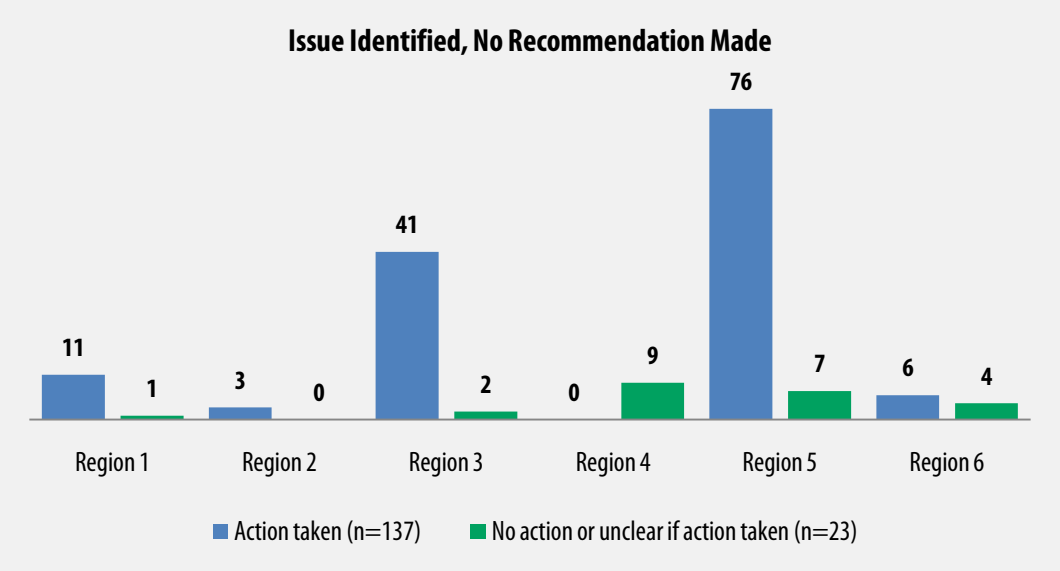
Issue	Recommendation	CA Response/Work Plan
The social worker appears to have met or exceeded most practice expectations in place at the time of a pre-fatality investigation [...]. Specific details of noted quality practice can be found in the fatality review report. A noted minor practice issue was the apparent under-assessment of risk of one risk factor (mental health), but overall the social work practice was excellent.	**None.** CA changed to a different risk assessment model at the end of 2007. The current Structured Decision Making assessment is an actuarial tool that reduces the likelihood of over or under assessment of risk as it is a more structured instrument.	**No Work Plan Recommended**. Individual Action Taken: The assigned worker was not available to participate in the review. The worker was notified in advance of the review and was offered an opportunity to provide comments in writing which would be presented in her absence. Post review, the worker was provided with feedback regarding the overall excellent practice and the minor issues discussed above.

OFCO then identified and eliminated "recommendations" that were not phrased as requests for action or suggested improvements, and thus were not actually recommendations. For example, "recommendations" which are more accurately described as observations, such as "*should have filed dependency"* were excluded from further analysis. OFCO determined that approximately 160 (31 percent) of responses to issues identified by CFRs were not actual recommendations.

- **OFCO identified instances where recommendations were not made, but some action was taken** to address the issue identified by the CFR team. This occurred in response to 137 issues (27 percent of all issues).

No Recommendation, but "Action Taken," by Region. The graph below describes where action was taken absent a recommendation.[69]

- Notably, Region 5 CFRs generate few recommendations, but document taking action in response to the majority of issues identified.
- Region 3 also frequently documents an "action taken" when a recommendation is not issued.
- Some issues identified by CFRs (23 total) appear to remain unaddressed within the regions, with the exception of Region 2.
- Region 4 did not document taking action when an issue was identified, but a recommendation was not made by the CFR.



Source: Office of the Family and Children's Ombudsman, December 2009, based on analysis of DSHS CA data

[69] Anecdotally, many of these actions seem to occur on the local or regional level.

Below are examples of actions taken, absent a recommendation.

Issue	Recommendation	CA Response/Work Plan
The review panel was unable to reach full consensus regarding the screening decisions made on the reported death of a medically fragile child in facility placement. The intake was initially screened out and referred to licensing as a Licensing Complaint (Non-CPS). The intake decision was then revised for DLR/CPS assignment, then re-amended and re-referred back to licensing following consultation between the regional DLR area manager, the CA DLR deputy administrator and CA Critical Incident/Risk Management. The basis for the final amended screening decision was not very clear, with the simple statement that "the allegations do not rise to the level of CA/N." When the facility licensor later obtained more details regarding the circumstances surrounding the child fatality, additional consultation with the DLR/CPS supervisor and regional DLR area manager should have been considered. In review of the additional post-fatality information by the licensor, panel members did not recommended that DLR open an investigation.	**None.**	**No Work Plan Was Recommended.** Individual Action Taken: The regional DLR area manager and the [regional] DLR/CPS supervisor participated in the child fatality review and received feedback regarding the lack of written clarity as to the basis for screening out the intake as a licensing complaint. Additionally, following the panel review, the CA DLR deputy administrator was briefed on the panel review discussion surrounding the intake decision process. While such deficiency appears to be an anomaly, the importance of clear documentation was acknowledged by all involved. Individual Action Taken: The DLR facility licensor participated in the review and acknowledged that she might have reviewed with DLR/CPS the additional information obtained during her licensing investigation for possible reconsideration for a DLR/CPS investigation. The licensor, in reflection of the child fatality review, indicated that in the future she would seek consultation with either the child abuse protection medical consultant or the regional medical consultant when medical issues surface during a licensing investigation, and work more collaboratively with DDD staff.

Issue	Recommendation	CA Response/Work Plan
The social worker appears to have met most practice expectations in place at the time of a pre-fatality investigation in February 2007. Specific details of noted good practice can be found in the fatality review report. Some practice deficiencies and missed opportunities for best practice were identified. Contact with the children's medical provider was less timely than expected. No collateral contact was made with the CSO although the family was receiving services. Ethnic Identity was asked and both parents indicated Native American ancestry, yet there was documentation in the file to show that a tribal search was initiated. Although information in the referral clearly shows mother had another child residing with a maternal relative, the worker appears to have not made any inquiry as to circumstances of that child no longer being in the mother's care. The parents continued to test positive for drugs or no-showed for requested drug tests, but no documentation was found regarding referral for substance abuse assessment or resources provided to the parents for chemical dependency services in the community. Out-stationed CDPs were available to the worker at the time but were not utilized.	None. Policies and practice expectations relating to identified issues during the review were in place at the time of the CPS involvement, but were not followed. Consideration was made for "Lessons Learned from Child Fatalities" training for the Tacoma CPS units late 2008 or in 2009, scheduling permitting. Such presentation would include discussions on making collateral contacts such as with the CSO when there are shared clients, obtaining information regarding the general medical/health of children on a case load, and inquiring with parents about the circumstances for which their other children are no longer under their care and custody.	**No Work Plan Recommended.** Individual Action Taken: The CPS investigator and her AA participated in the review and received feedback regarding the investigation and documentation.

OFCO also identified 15 instances where **recommendations were not developed in response to an issue, and no "action taken" was reported.** This constitutes 3 percent of all responses to CFR identified issues. Below is an example:

Issue	Recommendation	CA Response/Work Plan
While the fatality investigation case was still active with CPS, additional information was provided to […] CPS intake by an anonymous referent in January 2006. The report appeared to have neither an allegation nor any suggestion of imminent harm. The assessed risk at intake was tagged "high" and it is possible that the intake worker artificially assessed high risk in order to provide a basis for screening the anonymous referral in for investigation. The referral should have been taken as information only on an open case, with an alert provided to already assigned social worker.	**None.** There was/ is no indication of a pervasive problem within intake units across the state[70]. The criteria for accepting referrals from anonymous reporters already existed in statute (RCW 26.44.030) and in CA policy and practice (CA Case Services Policy Manual – Section 2131; CA Practices and Procedures Guide – Section 2210).	**No work plan recommended.**

OFCO then identified and eliminated recommendations directed at agencies or entities other than CA, or where CA clearly does not have jurisdiction to implement the recommendation.[71] OFCO identified 18 recommendations (4 percent of all responses to issues identified by CFRs) that were clearly outside of CA's jurisdiction.[72] In some cases, CA documented actions taken or plans to address the issue with the relevant external agency. In other cases, CA did not provide documentation that indicated steps taken to ensure external organizations were made aware of the relevant issue or recommendation.

Examples include:

Recommendation	CA Response/Work Plan
Hospitals should report such incidents	[Region will] work with PHN's, NISA, safe sleep kits, safe cribs; plan for "infant safety summit."

Recommendation	CA Response/Work Plan
There should be resources for autopsies in all counties	

[70] It is unclear how CA reached this conclusion. This issue might have been identified as pervasive if a statewide analysis was done.

[71] 18 recommendations were developed regarding agencies other than CA.

[72] Please note, some recommendations are written very broadly and are not directive about which agency or individual should take action, or even what action should be taken (E.g. *Pregnant and parenting women should be highest priority for services).* OFCO did not evaluate whether broadly written recommendations applied to CA or another entity. Some of the broadly written recommendations could apply, at least in part, to entities other than CA. OFCO pulled out recommendations that were clearly not related to CA.

Recommendation	CA Response/Work Plan
DEL should consider conducting an independent child fatality review when there is a death of child in a licensed day care, home or center. This could be facilitated by DEL risk management staff.	

Once the actual recommendations regarding CA were isolated, OFCO determined whether implementation effort was evident or not, based on CA's self-report. Where implementation effort was evident, OFCO categorized the extent of implementation as "partial" or "complete".[73]

- **Example of responses coded "No implementation effort is evident."** (See page 159, in the section titled "Barriers to implementation" for a discussion about factors that inhibit implementation.) Some contributing factors might include:

  The recommendation is evaluated as non-feasible. For example:

Recommendation	CA Response/Work Plan
Children's Administration [should] consider a childcare assistance program for families needing support following CPS intervention.	Unless services are being provided for a CPS intervention, the case would not remain open and CA does not provide service on closed cases.

  The recommendation is vague:

Recommendation	CA Response/Work Plan
Pregnant and parenting women should be highest priority for services.	

  There is a **lack of information or internal communication**. For example:

Recommendation	CA Response/Work Plan
Each office or region should have a process for automatically consolidating case files when more than one exists for a family.	Unknown if there's been direction provided to master files.

[73] OFCO used a two-reader process to reduce subjective interpretation, but acknowledges that this is a preliminary analysis.

- **Examples of responses categorized as "Yes, implementation effort is evident:"**

  The following was coded as **"implementation complete:"**

Recommendation	CA Response/Work Plan
Recommendation is that DCFS add to the local office protocol agreement with community partners that they provide requested records to DCFS in a timely manner.	The **local protocol was reviewed and updated**.

  Here is an example of a response coded as **"partial implementation:"**

Recommendation	CA Response/Work Plan
ECFR Recommendations: **The agency should establish and maintain control of its personnel system. Staffing levels must match the expectations of law and policy. CA should establish an over-hire pool of previously trained workers who would be available to fill temporary vacancies to assist offices exceeding workload standards. Review of and adherence to the Council on Accreditation Standards for caseload size was recommended.** Council of Accreditation Standards set the standard for CPS investigation caseloads at no more than 15 families and for child welfare services (CFWS) caseloads at no more than 18 children. A December 2004 Executive Child Fatality Review further recommended no more than eight new investigations be assigned to a CPS investigating social worker per month. CA should develop a mechanism to adequately effect a reduction of caseload size. When workload dictates the need to assign a referral for investigation to a supervisor, the supervisor should staff the situation with the AA within 24 hours of assignment. The staffing needs to result in the development and documentation of a plan of action with timeframes for limited assignment identified…	Office Action Taken: […] **initiated a plan that any supervisor assuming a case assignment would be required to notify the AA and to have supervisory case reviews conducted by the AA**. Regional Action Taken: The […] **RA has conveyed to all AAs the expectation that the AAs track the number of cases assigned to supervisors** (as primary assignment) and that such situations should be limited.

OFCO then assigned a "level" of implementation to CA's response: local, regional or state.[74] Some regions further specified local implementation effort by documenting actions taken at the individual, unit and office levels; OFCO coded all of these as "local."

Examples of **local implementation** effort:

Recommendation	CA Response/Work Plan
The issue of case transfers within units and from one unit to another should be addressed at a meeting of supervisors. That discussion should include a review of the protocol for transfers and suggestions from the group on the best strategies for ensuring that the supervisor and newly assigned worker both transmit and understand the most critical pieces of information related to the case that concern the children's safety.	Completed. Management met with the employee(s) involved and took appropriate action. The issues involved were shared with supervisors.

Recommendation	CA Response/Work Plan
An AA in Region 1 will contact the Assistant Attorney General (AAG) supervisor to initiate a workgroup to discuss communication and roles of the attorney general and social worker when developing case plans that may need legal interventions.	The recommendation was followed by the AA following the review.

Example of **regional implementation** effort:

Recommendation	CA Response/Work Plan
The review team recommends that the Regional transfer policy for CPS and Family Voluntary Service cases be updated as necessary to include written expectations for time frames and that this policy be discussed at the upcoming Regional meeting of CPS and Family Voluntary Services (FVS) supervisors.	Completed. A Regional protocol has been developed for this and discussed with CPS and FVS unit supervisors.

[74] When implementation activities occurred on multiple levels, OFCO coded the response to the highest level.

Example of **state-level implementation** effort:

Recommendation	CA Response/Work Plan
Social workers and supervisors should utilize some form of shared decision-making process when a high-risk, emergent referral is received with extremely vulnerable victims. Examples are Family Team Decision making meetings, Child Protection Team meetings and supervisory review staffings.	CA HQ is reviewing the feasibility of this recommendation

OFCO tabulated the categories it assigned to each recommendation. These results are summarized in total and by region on page 137 of this report.

PART 3
CA IMPLEMENTATION ACTIVITIES BY TOPIC, PROVIDED BY CA

Part 3 is attached as a separate document.

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
1115 Washington Street SE P.O. Box 45010
Olympia, Washington 98504-5010

December 16, 2009

Mary Meinig, Director
Office of the Family and Children's Ombudsman
6720 Fort Dent Way, Suite 240
Tukwila, WA 98188

Dear Ms. Meinig:

We have reviewed the child fatality review recommendations from 2005 to 2008 and have categorized the recommendations into five subject areas in the enclosed document. It seems prudent to respond to the recommendations holistically rather than to respond individually to each of the 470 recommendations over this time period.

Under each of the five subject areas we identify the department's implementation activities that are responsive to recommendations made in several of our reviews. We are tracking review recommendations to evaluate patterns or trends in practice that inform us on where improvements are needed.

Over the years there have been many policy changes, modifications to our training curriculum, localized and statewide training on lessons learned and corrective or disciplinary action with individual staff. Many recommendations also address broader systemic issues such as educational and prevention work such as risks associated with co-sleeping.

Under Denise Revels Robinson's leadership, the existing child fatality review process is being revised and will be shared with you shortly. The Office of the Family and Children's Ombudsman has been a strong partner with ensuring the quality of our child fatality review process and products and we look forward continuing this partnership in the future.

I hope this document responds to your questions regarding implementation of fatality review recommendations. Thank you for your partnership in our continuing commitment to improve the health and safety of children and families. If you have any questions, please call Denise Revels Robinson at 360.902.7821.

Sincerely,

/s/

Susan N. Dreyfus
Secretary

Enclosure

cc: Denise Revels Robinson, Assistant Secretary
Michael Tyers, Acting Director, Field Operations
Sharon Gilbert, Deputy Director, Field Operations

Children's Administration Response to Child Fatality Review Recommendations 2005-2008

1. Risk Assessment and Intake Screening Decisions

A. Response Time/Intake Screening Decisions

- In 2005, policy was changed requiring the response time for social worker face to face contact with an alleged child victim. Non-emergent cases changed from 10 days to 72 hours. Emergent cases require a response with in 24 hours.
- In February 2009, policy was changed to support the new risk only intake tool and the modified the CPS sufficiency screen intake tool in FamLink.
- Meetings are held every other month with regional intake leads for consensus building regarding screening decisions. This practice is focused on achieving greater consistency and quality in intake screening decisions statewide.
- Effective August 2009, regions began assessing and making efforts to centralize intake functions within each region rather than located in each office. This change is focused on achieving greater consistency and quality in screening decision statewide.
- Children's Administration requires supervisors to review with staff the expectation of 24/72 hour response for face to face contact with alleged victims. The policy which requires supervisors to conduct monthly 100% case reviews was updated in 2009 to make it clear that the supervisory review include a review of the electronic case file to discuss and verify the completion f specific tasks including timelines of response.
- In April 2009, the Division of Program and Practice Improvement conducted statewide training on intake screening within the new information system, FamLink.
- In October and November 2009, Children's Administration Technology Services (CATS) provided training to supervisors and intake specialists statewide to increase knowledge and confidence of where to locate the most critical information in FamLink.

B. CPS Response to Serious Physical Abuse and Sexual Abuse

- In July 2007, a legislative mandate Substitute House Bill 1333, also names "Sirita's Law" after Sirita Sotelo, required all counties to update their sex abuse protocols between the Office of the Attorney General (lead), DSHS, county prosecutor's offices, law enforcement and other community partners by July 1, 2008, and:
    - Include investigations of child fatality, child physical abuse and criminal neglect cases, and
    - Incorporate the statewide guidelines for first responders to child fatalities developed by the Criminal Justice Training Commission.

- As county protocols were updated the need for statewide consistency regarding child placement in out-of-home care was identified. Effective April 15, 2008 policy was developed to provide written guidance to staff when working with families where allegations of serious physical abuse or sex abuse exist and to support local protocols with law enforcement other community partners associated with Substitute House Bill 1333. The policy guides social workers through the process when considering:
    - Out-of-home placement.
    - Contact between the victim and perpetrator.
    - Critical components of the safety plan.

C. Quality CPS Investigations

- The supervisor academy curriculum was developed and implemented January 31, 2005 through March 25, 2005. This three week training (one week each month) provides tools for social workers on assessment safety.
- Practice consultants provide training with individual units and offices on developing when to develop safety plans and the distinction between safety and service plans.
- The curriculum covers other areas that have been identified in fatality reviews such as the importance of consultation with the Statewide Medical Consultation Network, interviewing children away from caregivers, collateral contacts, not relying on child disclosures or findings from previous investigations, bias and pattern recognition.
- Practice consultants are providing training in local offices on elements of a comprehensive, quality CPS investigation.

D. Reunification and Trial Return Home

- Effective September 30, 2006, revisions to the Reasonable Efforts to Return a Child Home policy expanded the pool of children for whom the assessment and safety plan is required, made the documented record more rigorous and clarified role, responsibilities and timeline with the following changes:
    - Eliminating the age qualifier (12 and under) on the Reunification Assessment and Transition and Safety Plan to include all dependent children in care longer than 60 days due to child abuse and neglect.
    - Requiring additional narrative or report on the Reunification Assessment in the following general areas:
        - Parental empathy and emotional capacity
        - Attachment
        - Developmental and safety concerns of child
        - Family support system and cultural needs

- A six month trial period begins at the time when the child transitions home. During this time CA continues to have responsibility for case planning and supervision until dismissal of the dependency.
    - If the transition period toward reunification is not successful, the transition period ends with placement in out-of-home care, and is not considered a re-entry. This does help to significantly improve our foster care re-entry performance measure.
    - If the period was successful, reunification is considered achieved when the dependency is dismissed at the end of the six month trial return home period.

E. Child Protective Services/Child Welfare Services Redesign

- In January 2007, CA implemented the CPS/CWS re-design.
- The redesign changed how CA was organized to help focus the roles and responsibilities of the CA social worker, primarily to improve the quality of CPS investigations and services to families receiving voluntary services.
- The change in CPS helped CA social workers focus on seeing children quickly; assessing safety and risk and determining families need for services.

F. Health and Safety Visits with Children in Care

- In December 2005, Ca implemented the 30-day social worker policy for children in in-home dependencies.
- In April 2007, policy was changed to require visits every calendar month not to exceed 40 days between visits (rather than every 30-days) and the policy was expanded to require social workers to visits with children ages birth to 5 years in out of home relative care.
- In September 2008, CA expanded the monthly visit policy to include all children in care; including children in Long Term Foster Care agreements (Braam Requirement) and Voluntary Service Agreement cases (Child & Family Services Review requirement).
- In July 2009, CA implemented a policy supporting a “quality assurance” plan for monthly visits. This QA process requires supervisors to review the child/caregiver monthly visits with each social worker on each case. The new policy requires 100% case review, which includes:
    - Monthly supervisor case reviews with the assigned social worker and documentation of each case reviewed in the client electronic case file.
    - The supervisor case review discussion must include:
        - A focus on child safety, including the supervisor’s review that all monthly visits for the child are caregiver were completed and documented as required in the Social Worker Monthly Health and Safety Visit Policy.
        - Steps the family and/or children need to achieve permanency including, concurrent planning, relative search, and community supports.

        - Assessment of the existing services provided to the family, including the family cultural and linguistic needs.
    - In October 2009, a multi-step process of planning, tracking and accountability was implemented to improve child safety, well-being and permanency outcomes and accuracy of FamLink data with monthly social worker visits. The supervisor must verify that the social worker visit is accurately documented in FamLink.

G. Structured Decision Making (SDM)

- In October 2007, CA adopted an actuarial risk assessment model, SDM, to replace the former risk assessment tool.
- SDM is a research-based, structured approach to identifying families who are most likely to experience a future event of child abuse or neglect.
- Decisions can be improved by clearly defined and consistently applied decision-making criteria, readily measurable practice standards, with expectations of staff clearly identified.

2. Collaboration and Information sharing with Community Partners and Across CA Programs and DSHS Administrations

A. Practice Model

- In 2005, CA staff and management implemented a new practice model that focuses on family strengths, respectful partnerships and collaboration with the family and service providers.
- The implementation included training to support the model and incorporated advanced investigation and assessment training for CPS workers.
- The Practice Model provides an overarching framework for child welfare practice in Washington State and gives social workers the tools, skills and support they need in assessing a family's strengths and protective factors in caring for their children.
- Staff and management statewide were trained in Solution Based Casework and Solution Focused Management.

B. Family to Family

- In 2004, CA partnered with the Annie E. Casey foundation in initiating the four Family to Family strategies designed to improve child outcomes. These strategies are:
    - Building Community Partnerships.
    - Family Team Decision Making (FTDM).
    - Resource Family Recruitment, Development, and Support.
    - Self-Evaluation.

C. Family Team Decision Making Meetings (FTDM)

- Increased use of Family Team Decision-Making meetings within 72 hours of placement, at reunification, during placement moves, and for disruption prevention. CA collaborates with contracted community partners to maximize service alignment with the new practice model to protect children and prevent removal.
- All offices in the state are implementing Family Team Decision-Making meetings. Research is showing that FTDM supports child welfare practice resulting in:
    - More children placed with relatives.
    - Shortened length of stay for children placed with relatives.
    - Increased placement stability.
    - More reunifications with biological parents.

D. Records to Courts (Rafael Gomez Act-SHB 1334)

- Effective July 2007, social workers will provide relevant supporting documents to the court. Supporting documents may include:
    - Substance Abuse and/or Mental Health treatment reports
    - Anger management and/or domestic violence class report
    - Visitation reports
    - Psychological reports
    - Physicians report documenting injuries
    - Home study, licensing actions or background check information
- When social workers submit an Individual Safety and Service Plan (ISSP) to the court and recommend a new placement or change in placement (i.e. placement with a parent, relative or other suitable person), they must:
    - Submit documents related to persons in the home where placement is recommended.
    - Submit only relevant sections and not the entire history of the subject of the report.

3. Substance Abuse

A. Substance Abuse Assessment - Global Appraisal of Individual Needs - Short Screener (GAIN-SS)

- Effective April 30, 2007 revisions were made to the drug and alcohol assessment policy and tool. The GAIN-SS policy revisions include:
    - Using the tool on adolescents age 13 and over, rather than 12 and over.

- Clarifying who must complete the screen and when.
- Clarifying how to make a referral.
- Emphasizing the word "significant" when asking the suicide question.

- The GAIN-SS form (DSHS 14-486) was updated, to include:
  - The new names for the CPS/CWS redesign program services.
  - Two additional check boxes (client unable to answer questions and client not referred).
  - The numbering of key pieces of information for data collection purposes.
- Each office must establish a central collection point for all GAIN-SS screens and forward them to their regional office. The regions forward the documents to CA headquarters on a monthly basis for data collection.

4. Chronicity

A. Neglect Legislation

- In January 2007, CA implemented the chronic neglect legislation which expanded the definition of negligent treatment or maltreatment of a child allowing the department to engage families earlier and place a stronger emphasis on the issue of neglect. There were associated changes to the WAC and CA wrote new guidelines for social work staff.

B. Chronicity Indicator

- In the fall of 2008, a Chronicity Policy and Chronicity Indicator in FamLink were developed. It was designed to help the social worker identify families re-referred to CPS. In the FamLink intake module, the Chronicity Indicator is automatically checked when a participant has the role of victim or subject in a case and meets the following criteria:
  - 3 accepted CPS or DLR/CPS intakes in the prior year;
  - 4 accepted CPS or DLR/CPS intakes in the prior 2 years;
  - 5 accepted CPS or DLR/CPS intakes in the prior 3 years; or
  - 2 or more founded allegations in the past 2–6 CPS referrals.

- When the Chronicity Indicator is flagged on a person, social workers must review the history and assess for patterns of acts or omissions by the parent/caregiver and follow policy for services and case staffings.
- This is a major topic in Lessons Learned curriculum. The Lessons Learned curriculum also instructs social workers to consider information-only or unfounded intakes and investigations in their assessment of child safety.

5. Background Checks/Licensing Home Studies

A. Child Abuse and Neglect (CA/N) History Checks

- In October 2007, CA implemented policies related to Substitute House Bill 1333. The policy requires a social worker to do the following prior to a dependent child returning home:
  - Complete a background check on all adults living in the home.
  - Identify and assess all caregivers for service need.
  - Inform parent of their responsibility to notify the department if there is a child in caregivers.
  - Notify the court if caregiver is not engaged in services.
- In August 2008, CA criminal background policies related to the Adam Walsh Child Protection and Safety Act legislation were updated to reflect the new federal requirements.
- CA conducts FBI fingerprint-based checks for all prospective foster/adoptive parents, relative caregivers and all other adults in the home. Social workers can receive immediate criminal history data prior to placing a child with unlicensed individuals.
- CPS investigators can also request criminal history information on the subject of the investigation to increase child and worker safety.
- A background check tip sheet was created for social workers when considering placement of children with relatives or other suitable persons. This includes a requirement that the background check includes a review of CA history.

6. Other

A. Caseload Size

- Caseloads for social workers have steadily decreased and are currently averaging 15 across programs.

B. Safe Sleep

- Training academy curriculum for new social workers covers safe sleeping information.
- The Division of Licensed Resources provides training and expectations regarding safe sleeping for licensed providers.
- The department is committed to working with other community agencies in supporting public education efforts regarding safe sleeping.

PART 4
BARRIERS TO IMPLEMENTATION – CHILD FATALITY REVIEW RECOMMENDATIONS

OFCO CONCERNS ABOUT LACK OF IMPLEMENTATION COMMUNICATED TO LEGISLATURE

In the early days of the 2005 Legislative Session, OFCO met with legislators to address concerns about lack of follow through by DSHS CA with recommendations issued by child fatality review (CFR) teams convened by the agency. In taking a collective look at the fatality reviews of 3-year-old ZyNyia Nobles, 2-year-old Rafael Gomez, 16-month-old Justice Robinson, 6-week-old Raiden Robinson and 4-year-old Sirita Sotelo, OFCO found the same or similar practice deficiencies were identified in each of these CFR reports and proposed remedies were strikingly similar.[75] It was unclear to OFCO and the Legislature what the status of implementation was on the various recommendations CFR teams had issued over the years.

Themes of repeat deficiencies identified in these and other fatalities included:

- Flaws in the child fatality review/investigation process
- Inadequate screening and investigation of CPS referrals
- Poor risk assessment (at intake, during CPS investigations, etc.)
- Inadequate inter- and intra-agency communication
- Inadequate supervision of line social workers
- Inadequate training (to various professionals – including home visit workers)
- Ineffective response to families with substance abuse and mental health issues, i.e. services
- Insufficient health and safety checks
- Inadequate court oversight
- Inadequate monitoring and enforcement of voluntary service agreements
- Social worker bias
- Excessive caseloads
- Inadequate documentation of case record (i.e. Service Episode Records – SERs[76])
- Poor or non-existent reporting by mandated reporters
- Inadequate response to families with a history of chronicity: chronic maltreatment/repeat referrals
- Criticisms over the definition and application of child "abuse" or "neglect"
- The need to improve technical/data system; and
- The need to implement various public education campaigns (safe sleep, fire arms, etc.)

[75] See grid OFCO provided to Legislature comparing recommendations and issues in these fatalities. It is included in the Appendix to this annual report.

[76] SERs are the text entered in the agency's computerized database (formerly CAMIS, now FamLink) by DSHS CA social workers and supervisors documenting casework. They include documentation of agency contacts with the family and children, service providers and other professionals, and descriptions of health and safety visits with the children and persons with whom they are placed.

We were concerned that *DSHS was not consistently tracking and reporting on the implementation of child fatality review recommendations either within the agency or to outside entities. OFCO also expressed its concern that the agency did not conduct Executive Child Fatality Reviews[77] (ECFRs) in enough cases.* The use of community experts who have relevant expertise but were not directly involved in the case, as required by an ECFR, is essential to independence in the review process, critical thinking and objective critiquing of casework.

The Legislature was galvanized by OFCO's concerns regarding the tracking and reporting of child fatality review recommendations and in 2005, SHB 2156 was enacted into law. SHB 2156 created the Joint Task Force on Child Safety, in which OFCO participated. The task force made recommendations to the Legislature and Governor on current and ongoing department work groups or work plans regarding child safety, placement, removal of children from the home, termination of parental rights, reunification with parents and other issues deemed relevant to improving child safety outcomes. In OFCO's first presentation before the Joint Task Force on Child Safety in August 2005, Director Mary Meinig testified that, "Each death teaches us something and is an opportunity to improve the system but only if there is follow through on recommendations that come out of a review."[78] Otherwise, we have inertia. In concert with OFCO's first presentation to the task force, DSHS also gave a presentation to the Legislature and acknowledged that there were redundancies in many of the recommendations compiled by child fatality review teams, and that even years following a CFR, many recommendations had not been implemented.[79]

This was followed in 2008 by the enactment of 2SSB 6206, which requires OFCO to report on the status of child fatality review recommendations and is the basis for this report. This legislation has been discussed extensively in prior sections of this report regarding the status of fatality recommendations.

SUMMARY OF OFCO FINDINGS AND OBSERVATIONS RELATED TO IMPLEMENTATION OF CHILD FATALITY RECOMMENDATIONS

In preparation for this report, OFCO initiated conversations with key DSHS CA staff responsible for the CFR process at the regional level and CA HQ: regional CPS managers; deputy regional administrators, the HQ critical incident manager, the director of Field Operations and others.[80] Our purpose was to learn from HQ and regional staff what they believe is working well with the current CFR process and implementation of CFR recommendations, and what needs to be improved. We also reviewed existing law and policy as a context for our discussions.

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[77] The Executive Child Fatality Review Process is described in more detail at page 107 of this report.

[78] OFCO Presentation to Joint Task Force on Child Safety, August 2005.

[79] Presentation to Joint Task Force on Child Safety, by Toni Sebastian, DSHS CA, August 2005.

[80] Ombudsman Linda Mason Wilgis interviewed from **Region 1**: CPS Program Manager Nicole LaBelle, Acting Regional Administrator (RA) Connie Lambert-Eckel; **Region 2:** CPS Program Manager Robert Rodriguez; **Region 3:** Social and Health Program Consultant Sue Welch, Regional Implementation Program Manager Patty Turner; **Region 4**: CPS Program Manager Jeff Norman**; Region 5**: CPS Program Manager Bob Palmer; **Region 6:** Critical Incident Manager Sonja Heard; and at the CA Headquarters Level: Deputy Director of Field Operations Sharon Gilbert; Critical Incident Manager Paul Smith; Interim Director of Program & Practice Improvement Tammy Cordova; and Nicole Muller, Practice consultant within the Division of Field Operations.

Here is what we learned:

- Law does not *require* CA to systematically review, evaluate or implement recommendations from child fatality reviews. Although policy provides for review and evaluation,[81] it appears that this is process varies from region to region and involves a great deal of discretion.
- CPS Program Managers and/or administrators from region to region do not use consistent methodology to keep track of fatality review recommendations and the status of their implementation.
- DSHS does not have a multidisciplinary technical team to assist the agency in evaluating and implementing recommendations from CFRs. This was a prior recommendation of OFCO.
- There is no established mechanism for statewide coordinated review of recommendations.
- AIRS was created by DSHS to provide a centralized database for documenting fatalities and near fatalities. While its purpose is sound, data entry is cumbersome, repetitive, antiquated and excessively time-consuming.
- Although CA has the structure to track recommendation implementation (via policy, procedure and AIRS work plans), most regions do not use these tools to track implementation. Implementation is largely reduced to the self initiative of specific CPS program managers and RAs and is typically set in motion via Email or informal staffing/conversations between CPS program managers and staff designated as responsible for the recommendation.
- CPS Program managers report they seldom, if ever, use the Fatality Review Work Plan function in AIRS, which is designed to track progress in addressing practice or system issues.
- CFR recommendations sometimes apply to agencies and systems outside of DSHS. Regions complain of not having a designated pathway for cross-system recommendations. They want clarity on where such recommendations should go and certainty that the recommendations have been reviewed by appropriate entities in a position to evaluate the merits of the recommendations and to implement them if appropriate.
- There is no established protocol between CA HQ and regions to provide feedback from HQ to the region on whether and when a recommendation will be implemented. This is the case even when the recommendation originated from that region.
- Regions critique the quality of recommendations and several regions express the view that the system could be improved by using a standard format for CFR report writing and recommendations, e.g. a template. At the same time, there is concern that standardization may remove the "heart and brains" from the process and rely excessively on check boxes and number values. The current disparate quality in fatality review recommendations may affect ease of implementation.
- CFRs are under resourced and the burden falls on CPS program managers who typically fulfill other roles in addition to their work reviewing child fatalities and providing summaries to RAs. They juggle many competing work priorities.
- Several regions report they do not see raw fatality data from other regions and believe this would be helpful in avoiding mistakes other regions have made. According to the CA HQ Critical Incident Program Manager,[82] this information is available in AIRS. This disconnect between what is actually available versus what regions think they can access seems to highlight the difficulties in using AIRS.

[81] See Section 5160 DSHS CA Operations Manual which is set forth in this section and discussed in more detail.
[82] According to Paul Smith in telephone conversation with OFCO staff, Rachel Pigott, on December 30, 2009.

OFCO Reviews a Broader Category of Child Deaths than DSHS

As discussed earlier in this report, DSHS must conduct a child fatality review when a child dies unexpectedly and the child was in the care of or receiving services from DSHS or a supervising agency at the time of or within one year of the child's death. [83] OFCO reviews all child fatalities that meet the criteria of children who have been in the care of or receiving child welfare services from the department at the time of or within one year of the child's death, including children who died while in licensed care, *regardless of whether the death was expected.* OFCO reviews a broader scope of fatalities than DSHS because even though a death may be "expected," abuse and neglect may have contributed to the death. We believe there is something to be learned from reviewing these deaths. For example, a child may die of a terminal illness but if the parent severely neglected the child and the negligent treatment impacted the child's quality of life so it hastened the child's death, then OFCO believes that a review of the circumstances of the case is warranted.

Current Developments

DSHS is proposing legislation[84] in the upcoming legislative session to amend RCW 74.13.640 to limit the agency's obligation to review child fatalities to those cases in which the child *death was suspected to be caused by child abuse or neglect*. The agency's rationale is that it is time consuming to review deaths that are clearly accidental, such as from a car accident, or deaths from a long-term medical condition and that these are unrelated to abuse or neglect.[85] This proposal would authorize DSHS to review near fatalities to improve identification of risk factors to prevent future fatalities. For DSHS CA, this is a question of prioritizing resources: "We spend an enormous amount of time looking at cases where we had no or very little involvement. I think we should not have to review these cases. We should look at near fatalities and that's where we're going to learn something. . .If a child is in a hospital from a traumatic injury, this is when we should assign it [to a team] to review and dig into the case file. This is something we can intervene on. [The agency] may say we are offering services, but this is different than taking a team approach to evaluate what we did on the case [and asking] how did we get here and what could we have done differently."[86]

OFCO will continue to apply its current criteria for review, regardless of the success of such legislation, to identify cases where abuse or neglect by a caretaker contributed to the death of the child.[87]

Roles and Responsibilities Related to CFR recommendation implementation

The key DSHS CA staff responsible for child fatality reviews are the regional CPS program manager or designee, deputy RAs and RAs. The regional CPS program manager or designee must review the case record within 14 calendar days of receiving notification of a child fatality and provide the RA with a summary of the case within 45 days.[88] The following chart provides a summary of key timeframes for required activities related to reviews of child fatalities and near fatalities as set forth in the DSHS CA Operations Manual.

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[83] RCW 74.13.640(1).

[84] Z-0780.2, Comprehensive Case Review in Child Welfare Cases provided to OFCO by David Del Villar Fox, DSHS CA legislative liaison.

[85] October 28, 2009 letter from David Del Villar Fox, legislative liaison, DSHS CA to community partners.

[86] December 1, 2009, Interview of Sonja Heard, Region 6 Critical Incident Manger, by Ombudsman Linda Mason Wilgis.

[87] A common example would be the death of a child from injuries caused by a car accident. It may be "accidental" but we may also discover that the parent driving had a history of substance abuse and was under the influence of drugs or alcohol at the time of the accident.

[88] Section 5160 DSHS CA Operations Manual. http://www.dshs.wa.gov/CA/pubs/mnl_ops/chapter5.asp

5160. Administrative Incident Reporting Timelines

Activity	Due
Child fatalities or near fatalities resulting from alleged CA/N on open cases or on families receiving services within 12 months of fatality	Report to Office of Risk Management by telephone within **1 hour** of receiving information.
All Administrative Incident Reports	Report in AIRS within **24 hours** of receiving information. When automated transmission in AIRS is not possible, report by phone to ORM or DLR as appropriate.
RA or designee reviews administrative incident report	Review within **48 hours** of receipt of AIRS email notification.
Completed Initial Administrative Incident Report including follow up in AIRS	Completed in AIRS within **10 working days**.
Child Fatality	The regional CPS program manager or designee reviews the case record within **14 calendar days** of receiving notification of the child fatality.
Child Fatality	The regional CPS program manager or designee provides the RA with a summary of the case within **45 days**.
Child Fatality Review	Final report is completed and documented in AIRS within **180 days** of report of fatality.
Executive Child Fatality Review	Completion of the final report and documentation in AIRS within **180 days** of the report of fatality.
CFR Work Plans	Work plans are completed and documented in AIRS within **30 days** of the Child Fatality Review or Executive Child Fatality Review.
Quarterly reviews of all administrative incidents documented in AIRS	Reviews occur quarterly*: • Statewide program managers with responsibility for management of administrative incidents conduct an internal review to evaluate occurrences, potential trends and summarize findings, with recommendations. • Regions and each local office review administrative incidents occurring in their jurisdictions *January-March, April-June, July-September, October-December
Summary report of administrative incidents statewide to CA management	Report provided **twice yearly** to CA Management by Office of Risk Management in partnership with program managers.
Alleged employee misconduct or criminal conduct that may potentially receive media or other high profile attention	Notification through chain of command by telephone **as soon as possible**. Employee misconduct is **not** documented in AIRS. Follow: • DSHS Personnel Policy 545 • DSHS Administrative Policy No. 6.01. • Executive Order 96-01 (WSP/DSHS Interagency Agreement

5150. REVIEWS OF ADMINISTRATIVE INCIDENT AGGREGATE DATA[89]

A. At least quarterly, statewide program managers designated responsible for management and oversight of administrative incidents conduct an internal review to evaluate occurrences, summarize findings, identify areas for further study and make recommendations to strengthen practice, programs and systems. Results of the quarterly statewide review are provided to the appropriate directors.
B. At least quarterly, an internal review of all administrative incidents is conducted by each region and local office. The Office of Risk Management and Division of Program and Practice Improvement provides support and consultation as needed. Summary reports from AIRS are used to evaluate practice and identify trends and strategies to improve outcomes. Results of the local office review are provided to the local office Continuous Quality Improvement (CQI) Standing Team. Results of the regional review are provided to the Regional Management Team.
C. Twice yearly, the Division of Program and Practice Improvement, in partnership with statewide program managers designated with responsibility for management and oversight of administrative incidents, publishes a summary report for CA management review that identifies statewide and regional trends.

SUCCESSES AND SHORTCOMINGS IN THE CURRENT CHILD FATALITY REVIEW PROCESS

Based on our conversations with DSHS CA staff and a review of existing law, policy and practice, OFCO made a number of interesting discoveries that illuminate the lack of consistent follow through on implementation of CFR recommendations and identify barriers to implementation. The following provides a discussion of what appears to be working and what areas invite improvement to the system:

What is Working

- **Regional leaders are united in a common purpose, which is to engage in a meaningful fatality review process that is conducive to learning and digesting information so that practice can improve.** As Connie Lambert-Eckel, acting RA of Region 1, observed, "The review process has moved from a process that was horrifically terrifying for staff—a portal of accusation—to a process that is [conducive] to learning, doing better and focusing on where we might have been weak. [This is done] through facilitation and engagement. If people are afraid, they don't learn. They don't assimilate, they are closed off . . . We invite risk managers and partners in the community, including tribal representatives, to participate in fatality reviews."[90]
- DSHS CA management recognizes the trauma experienced by field staff when they lose a child on their case load to a fatality. **The agency established a peer support program several years ago** to help workers through this process. Peer support is provided by trained personnel from outside of the worker's region.
- **More CA staff and people within the community are recognizing how vitally important child fatality reviews are** and the agency reports getting better cooperation in conducting these reviews.
- **The fatality review process is now more transparent with the implementation of the public Web site which allows public access to quarterly fatality review reports**

[89] http://www.dshs.wa.gov/CA/pubs/mnl_ops/chapter5.asp
[90] October 23, 2009 Interview of Connie Lambert-Eckel, Acting Regional Administrator of Region 1, DSHS CA, by Ombudsman Linda Mason Wilgis.

summarizing fatality reviews from a given year. In the past, DSHS CA has done a comprehensive assessment of all fatalities in a year, but aggregate data was not provided since 2005 until recently with the release of some aggregate data.

- **Fatality reports must now be issued within a designated timeframe – within 180 days of the fatality – unless the Governor grants an extension.**[91] This is a requirement of new law brought about by the enactment of 2SSB 6206.[92] Regions generally support the mandatory 180-day timeframe: "The 180 days keeps people moving and on track. Child fatality reports can feel cumbersome and overwhelming. We have to put all these pieces of the case together, but the deadline pushes us [to get it done]."[93] However, they note the timeframe can be difficult to meet in jurisdictions where there is not good cooperation between DSHS and the medical examiner/ coroner's office in obtaining cause and manner of death information or where the case is subject to delays from investigation by law enforcement and potential criminal prosecution. Although DSHS is authorized to request an extension from the Governor, regions are reluctant to do so.
- **Lessons learned training** is a very well done statewide training program offered to DSHS CA and other stakeholders. This training, developed by Toni Sebastian,[94] discusses factors[95] that caseworkers and other child welfare system participants should consider in gathering information and making informed decisions about children and families based on "lessons learned" from fatalities and critical incidents.
- **CPS program managers participate in quarterly consensus meetings on a regional basis to identify practice concerns**. These may include a discussion of issues that arose from a CFR. There are also CPS coordinator meetings which occur once a month. These are between regions and also include HQ.
- **Many issues related to practice concerns are addressed by DSHS CA long before a child fatality review is convened**. Program managers report that within 1-to-2 days of a child's death, CA begins a comprehensive review of the circumstances of the death and takes action to address factors that may have contributed to the death. A formal CFR may not occur until 4-to-5 months after the death of child. A CFR is not convened until the official cause and manner of death is determined.
- Program managers also point to a **growing energy and collaboration around cross-systems issues.** An example cited is heightened attention to infants dying from co-sleeping situations.
- **DSHS CA convened a Child Fatality Review Work Group to evaluate the current child fatality review system and make improvements.** OFCO participates in this workgroup, which began meeting in late 2009.
- **There are a number of promising efforts by private and non-profit entities outside of DSHS CA that can assist with efforts to improve implementation of CFR recommendations.** The Center for Children and Youth Justice, spearheaded by founder and Director Justice Bobbe Bridge, has developed a tool to track recommendations related to child welfare. These are not limited to recommendations from CFRs.

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[91] RCW 74.13.640(2).

[92] *Id.*

[93] December 1, 2009, Interview of Sonja Heard, Region 6 Critical Incident Manger, by Ombudsman Linda Mason Wilgis.

[94] Toni Sebastian is a practice consultant with DSHS CA HQ and is head of Central Intake.

[95] Factors such as the pattern of abuse; the family, case and service history; and whether there is evidence of bias influencing decision making should be taken into account.

OPPORTUNITIES FOR IMPROVEMENT

Regional Priorities

OFCO asked each region what they would prioritize if they could make a single change in the child fatality review process. Priorities are as follows:

Region 1: To have raw data on fatalities shared with each region across the state on a quarterly basis; to share the recommendations that arose from a review of these fatalities; and to designate one person to review recommendations and coordinate implementation.

Region 2: To update or replace the AIRS program, which is archaic.

Region 3: To have more HQ oversight and a consistent dialogue on what concerns should become a recommendation and more information about what other regions are doing in their practice.

Region 4: To have a coordinated statement of commitment from the Governor, DSHS CA executive team, DOH and local health authorities recognizing there is too much infant mortality related to unsafe sleeping conditions, and to implement a specific plan to address this. The successful "Back to Sleep" campaign developed in the mid-1990s which addressed the importance of positioning babies on their backs when they sleep as a targeted strategy to reduce sudden, unexplained death of infants provides some guidance on approaches that may be useful to raise public awareness.

Region 5: To have HQ take over the executive reviews (homicides by abuse). It would be better for a team from outside the region to conduct these reviews because there may be bias when team members are reviewing practice in their own region.

Region 6: To have data from FamLink automatically imported into AIRS[96] so the data screens in AIRs would be prefilled. This would eliminate the time-consuming exercise of cutting and pasting text and having to retype referrals. This would reduce data entry errors, save time, promote consistency and make the data easier to read.

HQ: Regions should not review their own fatalities. Sometimes it is uncomfortable for people to review the work of their peers. Perhaps we should have a standing team that reviews all fatalities within a few regions. There are different ways of structuring this that bear further consideration.

[96] AIRS was created by DSHS to provide a centralized data base for documenting fatalities and near-fatalities.

OFCO RECOMMENDATIONS

1. Make AIRS more user friendly and provide enhanced training for staff to ensure consistent data entry of child fatality reviews.

The purpose of AIRS is to consolidate the reporting of child fatalities and critical incident into one uniform electronic system.[97] AIRS became operational in 2004 and replaced what had up until then been a more ad-hoc, paper-driven system of reporting on fatalities and critical incidents. Reports up until AIRS were not consistent or accessible by computer statewide.

While acknowledging the worthwhile purpose behind AIRS, Jeff Norman, Region 4 Program Manager, stated, "AIRS was born out of desperation to have one common environment where reports would be written and could not be taken from there." He tells of the pre-AIRs days in which reports could get "lost." He recalls a staff person in HQ who kept the child fatality reviews in a file cabinet in his office. One day an aide to then DSHS Secretary Jean Soliz came and removed all of the child fatality reviews from his file cabinet (for purposes of a staffing). "He never got them back!" exclaimed Norman, so there was great impetus to develop a better system.

AIRS was developed in the early stages of Web development, so text entry is cumbersome. According to Robert Rodriguez, program manager in Region 2, there is a lot of repetition in text entry and it requires the insertion of special typed codes to do the most basic of functions, such as creating a paragraph. He added, "If you forget to input something, it is hard to correct. You have to re-open the review in AIRS, which then sends an alert to [a wide variety of people] which is a problem." Jeff Norman reinforced this view, as did others. He stated, "It's a terrible environment to write reports. There is very primitive text editing. You can take a document in '[MS] Word that is nicely formatted, paste it into AIRS and the formatting goes away completely. Also, there are a finite number of characters you can put into a text box so if you have a complex review, you have to input the data all over the place."

Sharon Gilbert, HQ Deputy Director of Field Operations for DSHS CA, agrees that AIRS is an antiquated system. There were plans to incorporate AIRS into the agency's new online computerized database FamLink, so there would not be two separate systems required for data entry. But this has not been possible due to many problems in FamLink that the agency is working to resolve.

Regions acknowledge it could be helpful to design a standardized format for child fatality review reports. Gilbert reports that the agency is in the process of doing this already. "We are redesigning the actual child fatality review report, trying to simplify it." There was consideration given to designing a single format to be used by other administrations within DSHS that write similar reports, but according to Gilbert, the priorities of each agency were too different to adopt a uniform format. This issue may be revisited.

Although CA has the structure to track implementation of recommendations through its AIRS "work plans," almost none of the regions use this tool. The DSHS CA Operations Manual provides that, "Upon completion of the CFR, if there are practice or system issues identified during the review process, a formal Fatality Review Work Plan is developed and entered into the AIRS system

[97] See AIRS Companion Guide, October 16, 2004.

within 30 days of completion of the review."[98] RAs are tasked with developing, implementing and following up on work plans and submitting them to the assistant secretary, director of Field Operations, and the chief of Risk Management.[99] According to the AIRS companion guide, "the Child Fatality Review Team will recommend to the RA if the team believes a formal work plan should be developed, however ultimately the decision is up to the RA and HQ management."[100]

Regions uniformly report to OFCO that they seldom use the work plan function in AIRS, despite practice and system issues being identified.[101] They cite a few key reasons: by the time the CFR occurs, many issues related to the case have already been addressed; or the work plans are more appropriate for complex recommendations involving multiple steps and/or community stakeholders, which do not describe most of the recommendations arising from CFRs. Bob Palmer, CPS program manager of Region 5 stated candidly, "I have not done a work plan in AIRS since about 2005. . . We got smart and started to do things without waiting for a work plan. It makes sense to me [that if there are] . . . issues to work on and areas to improve practice, we start working on it right away."[102]

There is recognition by some managers that AIRS is evolving and improvements, while slow, have been forthcoming. Additionally, although few formal work plans are created, CA managers indicate that action is being taken on a local level to address issues identified in child fatalities and these are recorded in other data fields in AIRS.[103] Despite this, OFCO found that the limitation of AIRS affects the quality of fatality reports and staff's willingness to embrace it as a helpful tool. It is a significant barrier to implementation of recommendations.

2. Establish and implement written guidelines on how to draft effective recommendations.

Regions acknowledge that the quality of recommendations written by CFR teams varies from region to region and the lack of clear direction in recommendations can be a barrier to implementation. Recommendations should identify the problem meant to be addressed, demonstrate knowledge of best practice for addressing the problem and show an understanding of the capacity of the system to address the problem. The recommendation should also state who will take action, who will benefit from the action (e.g. a person, community group or agency), and detail a plan of action with a timeframe to ensure follow up. The agency should review progress on implementation on a consistent basis. It may also be helpful to add simple discrete database fields that categorize CFR recommendations in a variety of ways, such as by topic[104] or by the agency that will be responsible for implementation.

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[98] DSHS CA Operations Manual chapter 5200 D.1.d.

[99] *Id.*

[100] The AIRS Companion Guide is available at http://www.dshs.wa.gov/pdf/ca/AIRSGuide.pdf

[101] This is consistent with OFCO's finding based on our preliminary review of aggregate data. We found that from January 2006 to August 2008, CA completed 144 CFR reports. Ninety-seven (67 percent) of those reports included issues and recommendations, but only three included work plans to formally address issues and implement recommendations in a methodical way. Notably, each work plan was generated by the same person during a one week period. This finding confirms what regions report, which is that they are seldom initiating work plans.

[102] November 2, 2009 Interview of Bob Palmer, CPS Program Manager of Region 5, DSHS CA, by Ombudsman Linda Mason Wilgis.

[103] An example of an "action taken" is a "lessons learned" training presentation.

[104] OFCO does this in identifying complaint issues we investigate and it eases review and analysis of data and helps the Ombudsman to spot trends in practice deficiencies. CCJY has also organized its meta analysis of system recommendations by topic.

Because of a lack of clear guidelines for writing CFR recommendations in our state, some recommendations generate confusion. There has even been debate within regions whether something identified as a "recommendation" should be implemented or whether it is an "issue" being identified for further study or consideration. Program managers support the development of written guidelines on how to draft effective recommendations so there is greater clarity and consistency: "It would be wonderful to have written guidelines and to know what timeframes are appropriate and what resources are available."[105] Helpful guidelines already exist and could be adapted to meet the needs of our state child welfare system.[106]

3. **Create a designated pathway for CFR recommendations so that recommendations are reviewed and evaluated, based on established criteria, by appropriate entities and steps toward implementation are clearly defined. Specifically designate who or what is responsible for implementation.**

   - **Centralized review is important.**

     Every region supports the development of a statewide coordinated review of child fatality recommendations. The regions see merit in having some form of centralized review of recommendations. The advantage of having this at the state level is that it provides a more global view of competing priorities and available resources, which must be factored into developing criteria for implementation. In 2005, Dee Wilson, former DSHS CA administrator, wrote an account of CA's difficulty tracking the agency's response to recommendations. He noted that it's a "laborious chore" and stated:

     > *One reason given to me by top CA managers during this period of time for not instituting a yearly systematic review of all abuse/neglect-related fatalities on open or recently open cases was that a system of this type would inevitably generate large numbers of additional recommendations for practice changes, recommendations to which CA would be held accountable. Too many agency initiatives had already (by the late 1990s) made CA managers wary of further structural innovations that might result in an unmanageable reform agenda. These attitudes were widespread within CA before accreditation, Kids Come First II (the agency's reform initiative) and the Braam Settlement Agreement.*[107]

   - **Criteria by which to evaluate the recommendation are essential.**

     Nicole LaBelle, Region 1 program manager, expressed the view of most regions that criteria must be adopted: "We need to prioritize recommendations. There are no criteria for implementation and the only question is whether the recommendation is within the region's capacity. . .There needs to be more scrutiny over what's realistic. We also need to consider whether we have the authority to implement the recommendation, rather than making an inherent promise to the CFR team that we will implement something that's not realistic." Others agreed: "There needs to be a thoughtful way of looking at every request and recommendation [and asking] do we have the resources to do this, does it make sense? It is not practical to respond to or implement every recommendation. . . If we take everything on, the whole agency is going to implode. . . At some point you need to make the decision to say

[105] December 1, 2009, Interview of Sonja Heard, Region 6 critical incident manger, by Ombudsman Linda Mason Wilgis.
[106] See guidelines for writing effective recommendations at: http://www.childdeathreview.org/Tools/EffectiveRecl.pdf **"**A program Manual for Child Death Review" provided to OFCO by DSHS CA**.**
[107] See Dee Wilson article at http://depts.washington.edu/nwicf/director/pubs/wilson2.pdf

"no," but how do you do that when you are talking about the business we are in?"[108] Sharon Gilbert, Deputy Director of Field Operations, DSHS CA, described an effort initiated a few years ago by the agency to adopt a business model of "portfolio management" in helping to rate and triage recommendations. But she added, "Everything was a priority. That was the problem! It made sense to do many of these, but [the agency] did not have the capacity to do them all." This approach has been set aside. LaBelle agreed that "most policy and system recommendations are beyond the capacity of the region. They are then sent to HQ for review." A few regions, notably Region 3, expressed the view that if a recommendation is issued in a CFR, that alone provides sufficient basis to warrant implementation. But most regions took a more critical view of needing to weigh the merits of implementation of a CFR recommendation against other priorities.

Finally, some administrators while generally in support of establishing criteria for recommendations, warned against a cookie-cutter approach: "We are cautious about applying significant structure to cases that are so different from each other . . . It's like trying to apply structure around unique little snowflakes that may not fit . . . we may lose something in the process if we reduce things too much to a form with check boxes and numbers. There is great value to the professional judgment of a well trained clinical social worker."[109]

- **A designated pathway is important to ensure the recommendation gets the attention of those who can make a difference.**

  Several regions highlight the fact that **some CFR recommendations involve agencies beyond DSHS CA. In order to implement the recommendation, it requires cross-system cooperation and the ability of DSHS CA to partner with agencies outside of DSHS CA.** Typically, there is no protocol for doing so.

  In still other cases, a CFR recommendation transcends the jurisdiction of DSHS CA.[110] Connie Lambert-Eckel, acting RA of Region 1, expressed concerns that it can be difficult to track implementation of large system issues that extend beyond DSHS CA:

  > *Quite honestly, we don't know who to contact for some of the recommendations that extend beyond CA. We need pathways for specific recommendations and then have these reflect back to the chain of command. . . It would be nice to send these large system issues to be evaluated . . . rather than trying to have us glue [them] together with baling wire and tape . . . If we had a designated pathway, I would feel more confident that I did what I was supposed to do–I would know that I got the recommendation in front of the people that are responsible, that the right people know about this [and] my responsibility and obligation is complete.*[111]

  For example, Lambert-Eckel cited the case of a recommendation that DSHS and the county health district share information between their two data bases. However, implementation of

[108] November 24, 2009 Interview of Sharon Gilbert, Deputy Director of Field Operations, DSHS CA, by Ombudsman Linda Mason Wilgis.

[109] October 23, 2009 interview of Connie Lambert-Eckel by Ombudsman Linda Mason Wilgis.

[110] In OFCO's review of CFR recommendations between 2005-08, discussed at page 134 of this report, OFCO identified 18 recommendations (only 4 percent of all responses to issues identified by CFRs) that were clearly outside of CA's jurisdiction.

[111] October 23, 2009 interview of Connie Lambert-Eckel by Ombudsman Linda Mason Wilgis.

this concept became so overwhelming due to considerations of needing appropriate releases of confidentiality, an interagency agreement and implications of the Health Insurance Portability Accountability Act (HIPAA) that it never occurred. It may be helpful for DSHS CA to consider using analysts with technical expertise to provide a broader perspective regarding the prevalence of issues identified in fatality reviews and how they relate to various public systems.[112]

Region 4 echoed concerns of Region 1 and others that **a potential pitfall is that the recommendation is never brought to the attention of the actual entity that might be in a position to implement it.** For example, Jeff Norman, Region 4 program manager, recalled the tragic drowning death of a teenager who was in a dependency guardianship at the time. The youth, who had epilepsy for which he took medication, had died while on a church outing in Okanogan County. The youth was swimming at a state park abutting a lake. It gave the illusion of safety – a groomed beach, a defined swim area with buoys, a floating raft. But one critical component was missing: a lifeguard. The park had lost its funding so that lifeguards were no longer there during all designated swim hours. On the youth's return from swimming out to the raft, he drowned. After participating in the fatality review, Norman and others were inspired to recommend that the state fund lifeguards at all state parks. He acknowledged that he had no idea what became of the recommendation or even if "the appropriate powers that be" had considered it.

In our conversation with Norman, he also drew attention to the failure of the county where the youth died to conduct an autopsy. "If this kid had died in King County, this would have been an automatic autopsy."[113] Like many rural counties in our state, the local county prosecutor in Okanagan County doubled as the coroner. Norman bemoaned the lack of consistent standards for autopsies and urged the state to fully review the autopsy process used around the state and to consider increased funding so that consistent standards are implemented regardless of the population density of the county. In OFCO's 2004-05 Annual Report, we reported that less populated counties must use coroners, and in the smallest counties (40,000 people or less), the local prosecuting attorney serves as the coroner. We stated in that report, "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 . . ."

[112] i.e. other systems that serve children outside of DSHS CA such as DEL, who has many responsibilities including the licensing of child care providers. For more information, see http://www.del.wa.gov/default.aspx

[113] The King County Medical Examiner's Office investigates sudden, violent, unexpected, and suspicious deaths that occur in King County. http://www.kingcounty.gov/healthservices/health/examiner.aspx

- **Regions report fewer barriers to implementation with recommendations that are local in scope**.

  Regions acknowledge they need to be responsible for region-specific recommendations they can track and manage, and generally report an easier time in implementing practice-related recommendations. Child fatality review recommendations typically fall into one of four categories: policy, practice, contracts or systems. Region 5 was able to articulate to OFCO a more systematic process for review of their CFR recommendations. According to Bob Palmer, Region 5 CPS program manager, the region convenes a monthly safety team meeting composed of the regional administrator and deputy regional administrator, the CPS program area managers and the regional intake area manger.[114] They review a copy of the actual CFR reports, review the recommendations within these and discuss among themselves what steps need to be taken to implement these. They have been doing this since at least 2008. Palmer praises RA Nancy Sutton's efforts in this area and reports that he is "very pleased with what we have done in Region 5 in terms of being proactive." The region has also requested HQ to participate in a summer training program developed by Region 5 called the "Summer Institute" whose aim is to teach staff about new policies and practices that have been implemented. This was developed a few years ago.

4. **Substantially modify existing AIRS data base or develop a new statewide database available to all regions to improve tracking and implementation of child fatality recommendations and the status of implementation.**

   Top administrators report that there is not a statewide database available to all regions to keep track of child fatality recommendations and the status of their implementation. Yet, DSHS CA critical incident program manager,[115] Paul Smith reports that AIRS has this capability. This reveals how difficult AIRS is to use when even high-level administrators within regions are unclear about its capability. Information needs to be in a database that staff throughout every region can access and use more easily. As Connie Lambert-Eckel, acting RA of Region 1 observed: "If an issue is identified on one region, it would benefit all [to be informed of this]. To fix [a problem] on a county by county basis is not productive, it does not influence the larger system, does not grow to scale. Unfortunately systems recommendations do not get fully addressed."

   Fortunately there have been other DSHS CA developments that are more user friendly. Sharon Gilbert, HQ Deputy Director of Field Operations, pointed to the agency's new practice of posting all child fatality reports on the DSHS CA Web site and noted that all regions have access to these and they can be instructive.

   There are also existing database models that may provide some guidance in reformulating or creating a new data base for DSHS CA. The Center for Children and Youth Justice works on systemic change for the child welfare system and has developed a tool to track recommendations related to child welfare. The Center for Children and Youth Justice has a "comprehensive database of 1,957 recommendations from 256 reports issued over the past 10 years by government panels, nonprofit organizations, task forces, etc. regarding the child welfare system."[116] This meta analysis

[114] There are other monthly meetings that regions convene. Some of these are discussed in the "What is Working" portion of this sections.

[115] This position falls within the HQ Division of Field Operations.

[116] See http://www.ccyj.org/uploads/publications/CCYJ%20fact%20sheet.pdf

seeks to analyze the broad-based work that has been done, endeavors to determine what changes are viable and includes some, but not all, CA CFR recommendations. The Center for Children and Youth Justice engaged in series of summits with stakeholders to further enhance this project. It may be helpful for DSHS CA to further coordinate with them on this.

5. **DSHS needs to develop a protocol for timely and consistent transfer of knowledge learned from fatality reviews so that learning is shared between regions and regions are consistently informed about the implementation status of recommendations.**

   The regions and HQ mutually acknowledge that there is no established protocol for sharing information from fatalities with other regions or between HQ and regions on a timely basis. Regions expressed regret that they seldom know what becomes of a recommendation once it goes to HQ even if it originated from a fatality review in their region. They report this hinders their ability to identify patterns that relate to policy or practice that should be addressed at the state level. Sonja Heard, Region 6 critical incident program manager, suggested that it could be helpful to have HQ summarize on a quarterly basis the top three issues they learned from fatalities and then promote this in statewide training.[117] Sharon Gilbert, HQ Deputy Director of Field Operations, noted that she and other HQ management team members have been in ongoing conversations with new Secretary Susan Dreyfus to address this issue and that, "Secretary Dreyfus has been very clear from day one that this is a big issue to her – the need to close the loop between what we are learning and what we are implementing." The agency is developing new protocols around quality assurance. In November 2009, OFCO and DSHS entered into an unprecedented Interagency Agreement (the Agreement)[118] to improve oversight by OFCO of DSHS and provide better quality assurance by requiring DSHS to provide status reports to OFCO on action plans and implementation plans no less than two times per year at six month intervals. DSHS welcomed these changes and even sought to strengthen quality assurance provisions within the Agreement.

CONCLUSION

OFCO found the department's responses to our information gathering encouraging on several levels. First, all agency staff interviewed were extremely generous with their time and very cooperative. They were also candid which increased the value of this exercise. In terms of their response to substantive questions about what is working in the current system of child fatality review and what needs improvement, there was a surprising degree of consensus. Even more encouraging is that many of the solutions proposed by regional staff, which partly form the basis of some of OFCO's recommendations, appear to be pragmatic, relatively inexpensive and practical to implement. OFCO encourages the Legislature and agency decision makers to consider these as a blueprint for improving future evaluation and implementation of child fatality review recommendations.

[117] December 1, 2009 Interview of Sonja Heard, Region 6 critical incident manger, by Ombudsman Linda Mason Wilgis.
[118] A copy of the OFCO-DSHS Interagency Agreement is available at http://www.governor.wa.gov/ofco/interagency_ofco_dshs.pdf

IMPLEMENTATION OF 2SSB 6206: RECURRENT MALTREATMENT

Addressing and even defining the related and overlapping issues of recurrence,[1] chronicity[2] and chronic child neglect[3] have long been among the most pressing issues in child welfare practice.[4] The challenge facing public policy makers and child welfare agencies is predicting which families are at risk of recurrence and implementing effective interventions to prevent and reduce the recurrence of abuse or neglect. **In 2008, the Legislature enacted law, RCW 26.44.030(13),[5] that provides:**

> *If a report[6] of alleged abuse or neglect is founded[7] and constitutes the third founded report received by the department within the last 12 months involving the same child or family, the department shall promptly notify the office of the family and children's ombudsman of the contents of the report. The department shall also notify the ombudsman of the disposition of the report.*

OFCO's review of families who have experienced three founded reports of abuse or neglect within a one-year timeframe is one way to create a sample of individual cases where we can ask: Has DSHS/CA effectively intervened to prevent repeated abuse and/or neglect in this family? If not, why not and what could be done differently?

In June 2008, OFCO began receiving monthly notifications under this provision. Although DSHS CA was only required to provide notification beginning in June 2008 and forward, the first notification in June 2008 included reports which constituted the third founded report of abuse or neglect for a child or family within the past year dating back to January 2008. Thus, the data summarized below covers January 1, 2008 – August 31, 2009. **For this 20-month period, OFCO reviewed a total of 93 reports.**

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[1] A federal measure of agency performance measures the *absence of maltreatment recurrence*, which is defined as the percentage of children who were the victims of a founded report of abuse who *did not* have a subsequent founded report within six months of the initial report. The Data Measures, Data Composites, and National Standards to be Used in the Child and Family Services Reviews, 71 Fed. Reg. 109, 32973 (June 7, 2007). The current national standard for the absence of maltreatment recurrence is 94.6 percent; in FFY 2007, Washington's rate reached 92.7 percent. See http://www.acf.hhs.gov/programs/cb/pubs/cm07/table3_16.htm ; see also CA Annual Performance Report 2007, http://www.dshs.wa.gov/pdf/ca/07Report3Safety.pdf at 14.

[2] DSHS CA uses a "chronicity indicator" which is used to identify individuals (either an alleged victim or alleged subject) who meet the following criteria: "3 screened in CPS or DLR/CPS intakes in the prior year; 4 screened in CPS or DLR/CPS intakes in the prior 2 years; 5 screened in CPS or DLR/CPS intakes in the prior 3 years; or 2 or more founded allegations in the past 2-6 intakes." Other similar terms include "re-referral," "recidivism," "chronically referring families," and "frequently encountered families."

[3] Chronic child neglect refers to the ongoing and serious deprivation of a child's basic physical needs, including abandonment, inadequate nutrition or a lack of supervision.

[4] Another term that is used is "re-abuse." "Reentry" – where a child has been removed from their parents, later returns to their care, and thereafter reenters foster care – is also considered a related issue.

[5] This became effective June 12, 2008. Second Substitute Senate Bill 6206, Chapter 211, Laws of 2008, http://apps.leg.wa.gov/documents/billdocs/2007-08/Pdf/Bills/Session%20Law%202008/6206-S2.SL.pdf

[6] In this context, "report" means a "referral" to Child Protective Services, which DSHS CA now calls an "intake."

[7] "Founded" means the determination following an investigation by the department that, based on available information, it is more likely than not that child abuse or neglect did occur. RCW 26.44.020(8).

Under the statutory language, DSHS CA's notification requirement is not triggered until the third report of abuse or neglect is investigated, assessed, and determined to be founded.[8] By policy, CPS Investigative Assessments must be completed within 45 days of DSHS CA receiving the report of alleged abuse or neglect.[9] This means that there is typically a 2-to-3 month delay between when the report is first received by DSHS CA and when it is conveyed to OFCO following the disposition of the report as founded.[10]

With DSHS CA's transition to FamLink in late January 2009, OFCO did not receive notification for several months. The first notification after the FamLink conversion was on June 10, 2009, and it covered cases in which the investigation was completed during the months of February, March, April and May 2009.[11] DSHS CA informed OFCO that it would continue to send notification on a monthly basis until an automatic notifier system can be arranged via FamLink. Automatic notification could shorten the delay between receipt by DSHS CA and notification to OFCO.

BACKGROUND

Because neglect is the most recurrent form of child maltreatment[12] and because child welfare agency interventions in neglect cases have historically been less effective compared to interventions in physical or sexual abuse cases,[13] chronic child neglect has garnered particular attention. **Lack of timely intervention in chronic child neglect cases has been a major issue of concern for OFCO since its first annual report in 1997.[14]** Although CA agreed and began taking meaningful steps to improve its response to chronic neglect cases,[15] the Ombudsman found in 1999 that CPS often failed to assist families or protect children until after it had received multiple reports of suspected child maltreatment. By 2000, the Ombudsman recommended modifying the statutory definition of neglect to clarify that neglect may result from a pattern of conduct and to consider cumulative harm in determining dependency. OFCO reiterated the need for statutory change in its

[8] OFCO then receives notification on a monthly basis, around the middle of the month following the month in which the investigation of the report was completed.

[9] See Children's Administration Practices and Procedures Guide, Section 2540.

[10] For example, a report received by DSHS CA in late January usually would be investigated and assessed by early March and then sent to OFCO in approximately mid-April.

[11] It is our understanding that since the FamLink conversion, DSHS CA only has the ability to identify *individuals* who are either the subject or victim in three founded referrals. This means that there may be some *families* missing from the notifications, and once this problem is resolved, OFCO may receive an influx of notifications.

[12] See, e.g., Child Neglect Fact Sheet, CA Office of Children's Administration Research, January 2005, available at http://www.dshs.wa.gov/pdf/ca/NeglectFact.pdf ("Families referred for neglect have higher re-referral and recurrence rates [18 and 12 percent] than do families referred for physical abuse [16 and 3 percent] or sexual abuse [13 and 5 to 6 percent]."); Pamela Diaz, Information Packet: Repeat Maltreatment, National Resource Center for Family-Centered Practice and Permanency Planning, May 2006, http://www.hunter.cuny.edu/socwork/nrcfcpp/downloads/information_packets/Repeat_Maltreatment.pdf at 3 ("In comparison to children who experienced physical abuse, children who were neglected were 23 percent more likely to experience recurrence.").

[13] See, e.g., Dee Wilson, *Can CPS Agencies Be Reformed?,* September 2006, available at: http://depts.washington.edu/nwicf/director/pubs/wilson2.pdf at 11-12 (comparing a national trend in recent decades of substantially decreased rates of sexual abuse to steadily increasing rates of neglect).

[14] OFCO reports are available online at http://www.governor.wa.gov/ofco/reports/default.asp

[15] DSHS CA established a task force to revise the Risk Assessment Matrix, sponsored a statewide conference on chronic neglect, and each region implemented at least one local chronic neglect project.

2005 report on the fatalities of Justice and Raiden Robinson, two young children who died as a result of serious chronic neglect.[16]

Legislation was introduced in 2001 and 2002 intended to address many of the concerns raised by OFCO and other stakeholders. Legislation was passed in 2005 and came into effect January 1, 2007.[17] The bill made clear in its legislative intent that early engagement of parents in services is essential:

> *The Legislature finds that whenever possible, children should remain in the home of their parents. It is only when the safety of the child is in jeopardy that the child should be removed from the home.*
>
> *It is the intent of the Legislature that the Department of Social and Health Services be permitted to intervene in cases of chronic neglect where the health, welfare or safety of the child is at risk. One incident of neglect may not rise to the level requiring state intervention; however, a pattern of neglect has been shown to cause damage to the health and well being of the child subject to the neglect.*
>
> *It is the intent of the Legislature that when chronic neglect has been found to exist in a family, the legal system reinforce the need for the parent's early engagement in services that will decrease the likelihood of future neglect. However, if the parents fail to comply with the offered necessary and available services, the state has the authority to intervene to protect the children who are at risk. If a parent fails to engage in available substance abuse or mental health services necessary to maintain the safety of a child or a parent fails to correct substance abuse deficiencies that jeopardize the safety of a child, the state has the authority to intervene to protect a child.*[18]

This set of legislative changes, titled the Justice and Raiden Act, is known as the "neglect law." The law amended the definition of "negligent treatment or maltreatment" to include "the cumulative effects of a pattern of conduct, behavior or inaction;"[19] outlined the basis for filing a dependency, in-home dependency and removal of a child on the basis of neglect or non-compliance with services;[20] and authorized DSHS CA to offer voluntary services to parents in order to reduce the risk of further abuse or neglect.[21] Because many chronic neglect cases involve parental substance abuse, the neglect law emphasized that parental substance abuse as a contributing factor to negligent treatment or maltreatment shall be given great weight.[22]

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[16] OFCO's Justice and Raiden Robinson Fatalities Review is also available online at http://www.governor.wa.gov/ofco/reports/default.asp

[17] ESSB 5922, Chapter 512, Laws of 2005, http://apps.leg.wa.gov/documents/billdocs/2005-06/Pdf/Bills/Session%20Law%202005/5922-S.SL.pdf

[18] Id. § 2.

[19] RCW 26.44.020(13).

[20] RCW 13.34.138(3); RCW 26.44.195(4).

[21] RCW 26.44.195.

[22] RCW 26.44.020(13); RCW 26.44.195(2), (4).

DSHS CA's notification to OFCO of the third founded report regarding a family or child within a year is not a substitute for a comprehensive assessment by the agency of the effect of the neglect legislation.[23] As indicated above, not all cases reported to OFCO under this section involve chronic child neglect. Some cases OFCO reviewed concern repeated physical or sexual abuse; some involve multiple subjects in complex family constellations;[24] and a few involve sporadic[25] or situational neglect.[26] OFCO's review of cases where a child or family had repeated contact with DSHS CA is an opportunity to consider the issue of recurrence and prevention generally, and for OFCO to consider, in the subset of chronic neglect cases, whether the neglect law is effectively addressing the problem of chronic neglect.

In one case reviewed, the family had a history of more than 90 prior reports of child maltreatment, and the children had previously been dependent and placed in foster care. The CPS social worker wrote in the Investigative Assessment:

"It has been difficult for this worker and others in the past to give a founded finding because [no single incident met the legal definition of maltreatment]. [N]ew legislation will now allow for a finding of neglect with respect to this family."

[23] The final section of the neglect bill would have required DSHS CA to report on implementation of the provisions of the bill to consider the need for possible amendment or additional allocation of resources. Specifically, DSHS CA was to report "any change over previous years in the number or type of child abuse and neglect referrals received and investigations conducted, any change in in-home and out-of-home dependency placements and/or filings, any increased service costs, barriers to implementation, and an assessment of the fiscal and workload impact on the department. ESSB 5922, Chapter 512, Laws of 2005 § 8. This section was vetoed by the Governor because the date the implementation report was due was prior to the date the law came into effect. See Governor Gregiore's Veto Message on SB 5922-S, dated May 17, 2005, available at http://apps.leg.wa.gov/documents/billdocs/2005-06/Pdf/Bills/Vetoes/5922-S.VTO.pdf. As a result, DSHS CA has not publically reported on the impact of the neglect legislation.

[24] For example, a child who is abused by one caregiver and then later neglected or abused by a different caregiver.

[25] Sporadic neglect occurs where a parent or caregiver experiences a recurring but short-term impairment, such as a mental health crisis. Child abuse or neglect does not tend to occur in the interim periods of stability. Because of the time which passes between episodes, sporadic neglect is less likely to be captured by the criteria of three founded reports within one year. Only one case during this reporting period was clearly an example of sporadic neglect: a parent had an acute psychiatric crisis and then another 11 months later. The public agency best responds by ensuring the child's safety during the current episode, assisting the caregiver to receive appropriate treatment and working with the family to create an action plan for anticipated future episodes.

[26] Situational neglect can occur, for example, when a family experiences a crisis, such as the loss of a caregiver. Here, the public agency attempts to respond to the immediate problem presented by the situation and interventions are usually specific and short term.

In 1999, the Ombudsman wrote, "How to prevent and effectively respond to chronic child neglect is an extraordinarily difficult question. The question involves a variety of disciplines, including – social services, public health, health care, mental health, education, law enforcement and the judiciary – and raises challenging public policy and resource issues."[27] Research[28] and experience[29] demonstrate that effectively addressing recurrent maltreatment may require long-term services and support.[30]

By the time the mother had her first child at age 15, CPS had investigated her family of origin for abuse or neglect multiple times over many years.[1] Over the next nine years, the mother was the subject in almost 30 reports to CPS, 11 of these reports had been investigated but none were founded and voluntary services had been offered to the family several times.

Nine years later, the mother was a single parent to two pre-school-aged children and a school-aged child. The first report in which neglect was founded concerned the oldest child's poor attendance at school and concerns that the child was alone both before and after school, resulting in poor hygiene and poor supervision. The investigative assessment noted: "Multiple services have been offered to mother without any success."[1] A later report alleged that the oldest child was caring for the younger siblings and continued to have poor school attendance. At this juncture, the agency obtained agreement from the mother to participate in voluntary services for an entire year; the unit supervisor agreed that a social worker with a relationship with the family would be assigned to the case for the duration. The father of the oldest child sought and obtained custody of the child based on the mother's history of CPS involvement. The two younger children remained in the home.

Several months later, while the family was receiving voluntary services, a third report of neglect was founded based on the fact that the mother's drug use was contributing to her continued failure to meet her children's basic needs. DSHS CA asked the mother to sign a safety plan and continue to participate in voluntary services. The mother was aware that if she failed to participate in services or if the risk of harm to her children were to rise, the agency would seek dependencies for her two younger children. In addition to various in-home services, both children were enrolled in therapeutic child care and the agency conducted after-hours unannounced visits to the home.

OFCO continued to periodically monitor this case for progress in services and to see if the services offered were effective in reducing the risk of further neglect. Although the family experienced some setbacks, by the end of the year the social worker's assessment was that the family had made great progress. To date, no further reports have been received regarding abuse or neglect in this family.

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[27] 1999 Annual Report, http://www.governor.wa.gov/ofco/reports/ofco_1999_annual.pdf at 39.

[28] Research shows that the episodic service model of child welfare service planning – even when evidence-based services which have proven successful overall are provided – are "a mismatch with chronic, unresponsive relapsing conditions," such as chronic neglect. Mark Chaffin, "Evidence-Based Case Management in Child Welfare," presented December 8, 2009. Presentation is available at: http://depts.washington.edu/hcsats/FCAP/resources.html#

[29] See, e.g., Dee Wilson, "Issues in Case Planning" and "Lessons from Neglect" in "Understanding Neglect," presented March 30, 2009. DSHS/CA offers this training around the state. Two OFCO staff attended this training in 2009.

[30] Based on the time required of social workers in recurrent cases, the Ombudsman recommended in OFCO's 2004 Child Fatality Report: "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." http://www.governor.wa.gov/ofco/reports/ofco_2004_fatality.pdf, at 21.

Providing this level of services to all families is unlikely for a public child welfare agency during an economic and budget crisis. In 1999, OFCO wrote about this resource issue, "In addition to raising challenging issues, the question presents new opportunities for innovation with respect to public-private partnerships and organizational collaboration."[31] **2009 legislation Second Substitute House Bill 2106,[32] which directs a "transformation" of child welfare services in Washington towards performance-based contracts with private agencies, may offer a vehicle for such innovation and collaboration.**[33] Specifically, the legislation broadly defines "child welfare services" as "social services including voluntary and in-home services, out-of-home care, case management, and adoption services which strengthen, supplement, or substitute for parental care and supervision for the purpose of: (a) Preventing or remedying, or assisting in the solution of problems which may result in families in conflict, or the neglect, abuse, exploitation or criminal behavior of children; … (d) Protecting and promoting the welfare of children, including the strengthening of their own homes where possible, or, where needed."[34] In two demonstration sites, all child welfare services will be provided by private agencies under performance-based contracts beginning July 1, 2012. **The Ombudsman is a member of "The Child Welfare Transformation Design Committee" created by SSHB 2106.**

DISCUSSION

For the period of January 1, 2008, through August 31, 2009, OFCO received a total of 93 notifications under RCW 26.44.030(13). Nine notifications were the second notification regarding the same child or family (meaning that there was a fourth founded referral for a child or family within a one-year time period).[35] Only one file was created for each of these families, accordingly OFCO opened 84 files for "systemic investigation."[36]

OFCO established a standard process for these recurrent maltreatment cases which consisted of the following five steps: review, data collection and analysis, intervention, monitoring and reporting.

Although this process mirrors OFCO's complaint investigation and response process in several respects, our main goal here is not to provide a critique of agency failures based on a retrospective review of case files. Rather our intention is to provide the reader with a window into the issue of recurrence and to begin a discussion with DSHS CA, policy makers and other stakeholders to improve practice to better serve these vulnerable children and families.

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[31] 1999 Annual Report, http://www.governor.wa.gov/ofco/reports/ofco_1999_annual.pdf at 40.

[32] Second Substitute House Bill 2016, Chapter 520, Laws of 2009, http://apps.leg.wa.gov/documents/billdocs/2009-10/Pdf/Bills/Session%20Law%202009/2106-S2.SL.pdf

[33] See "Florida Shifts Child-Welfare System's Focus to Saving Families," by Erik Eckholm, NYTimes, July 25, 2009. This article cites an independent report which found that "the rate of re-abuse of children within six months after their cases were closed was cut in half from 2006 to 2007," following Florida's shift to focus funding on family preservation and prevention services provided primarily by nonprofit agencies.

[34] RCW 74.13.020(4).

[35] For seven of these nine, OFCO was notified *simultaneously* of the third and fourth founded report; in most of these, the third and fourth founded reports were both assessed on the same investigative assessment. For the remaining two, OFCO was notified *subsequently* of the fourth founded report. One of these two subsequent notification involved a youth who remained at home on in-home dependency after his younger siblings had been placed in foster care. The second was a report of inadequate supervision by relative caretakers who were caring for a large sibling group following their neglect by their parent.

[36] See WAC 112-10-070(c)(i) "A systemic investigation is intended to produce information that will enable OFCO to identify systemic issues and recommend appropriate changes in law, policy, procedure, or practice."

REVIEW

For each of the 84 files, OFCO began by reviewing all the relevant DSHS CA electronic records for the child or family and making follow-up calls to the social worker or supervisor when necessary to determine current case information. Unlike OFCO's standard complaint review process, in these recurrent maltreatment cases OFCO did not have a complainant who offered us a perspective regarding the relevant issues and the agency's actions. As a result, OFCO independently determined which issues were relevant, relying exclusively on information provided by DSHS CA through written records or contacts with staff. All cases were staffed by a review team consisting of ombudsmen with varied backgrounds.

DATA COLLECTION AND ANALYSIS

OFCO documented various aspects of every case reviewed in its database. For example, we captured basic demographic information for the members of the family, including: the legal status of all children; the nature of the allegations which were founded for abuse or neglect; whether the reports included concerns regarding caretaker domestic violence, substance abuse or mental illness; the family's prior history and experience with DSHS CA; and the agency's efforts to intervene with the family to address the child abuse or neglect that had already occurred and to reduce the future risk of recurrence. Since these last two pieces of information can require extensive contextual detail to make sense and can vary widely case by case, OFCO does not have a way to present this information for this large a number of cases at this time.

OFCO also documented whether any family member was previously known to OFCO, either through a complaint[37] or another notification such as notification of a fatality or near-fatality.[38] These other sources of information, particularly a complaint received from a member of the family, offered the OFCO review team an additional perspective.

OFCO received a complaint regarding the removal of an 8-year-old child from a relative custodian. OFCO closed the complaint after determining that DSHS CA had reasonable cause to believe that the child had been physically abused in the home; ***the social worker informed OFCO that a Child Protection Team had recommended filing a dependency on the caregiver's four other children****, based on the family's history and current concerns about abuse in the home and the caregiver's failure to allow social workers into the home to monitor compliance with a safety plan and services.* ***However, DSHS CA did not file a dependency petition at that time based on advice from the OAG.*** *DSHS CA planned to close the case because the caregiver refused to participate in any services, but the Child Protection Team did not approve and requested a meeting with an AA or RA. DSHS CA did not follow the impasse procedures to resolve the agency's disagreement with the Child Protection Team's recommendation.[1] Six months later, an incident occurred which put the four remaining children, plus a newborn baby, at serious risk of physical harm. They were all removed and a dependency was filed. Following these children's removal, several of them began to disclose abuse similar to that experienced by the 8-year-old child who was removed earlier.*

[37] Out of 84 cases, OFCO had 11 complaints or inquiries relating to the child or family.

[38] See RCW 74.13.640 (5) (DSHS CA is required to notify OFCO of near-fatalities of children where DSHS CA had an open case within a year prior to the incident); DSHS CA practice has been to provide notification to OFCO of fatalities or near-fatalities of children where DSHS CA had an open case within a year prior to the incident. Of the 84 three-founded cases, one related to a fatality; and two related to near-fatalities. For each of these, the fatality or near-fatality was one of the three reports founded for child abuse or neglect, so OFCO first received notification of the fatality/near-fatality at the time it occurred, and then later received notification of the three founded reports.

SUMMARY OF DATA

OFCO's data for this group of cases with three founded reports within one year appears to be fairly consistent with state- and nation-wide child welfare data in that:

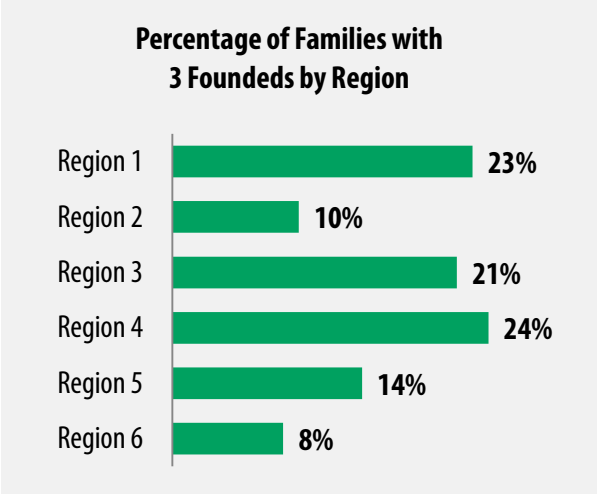
- Reports of neglect constituted 77.5 percent of the founded reports, physical abuse 17.8 percent and sexual abuse 4.4 percent.[39]
- Neglect is more likely to recur than physical or sexual abuse.[40]
- Caregiver substance abuse is the most prevalent risk factor (38 percent) in these recurrent cases.
- Nineteen percent of families have five or more children in the home.
- A significant percentage of families (31 percent) have had a previous dependency for either a parent (6 percent) or a child (25 percent).

[39] In the federal government report, Child Maltreatment 2007, nationwide statistics showed: "During FFY 2007, 59 percent of victims experienced neglect, 10.8 percent were physically abused, 7.6 percent were sexually abused, 4.2 percent were psychologically maltreated, less than 1 percent were medically neglected, and 13.1 percent were victims of multiple maltreatments." http://www.acf.hhs.gov/programs/cb/pubs/cm07/chapter3.htm#types

[40] See, e.g., Child Neglect Fact Sheet, CA Office of Children's Administration Research, January 2005, available at http://www.dshs.wa.gov/pdf/ca/NeglectFact.pdf ("Families referred for neglect have higher re-referral and recurrence rates [18 and 12 percent] than do families referred for physical abuse [16 and 3 percent] or sexual abuse [13 and 5 to 6 percent]."); Pamela Diaz, Information Packet: Repeat Maltreatment, National Resource Center for Family-Centered Practice and Permanency Planning, May 2006, http://www.hunter.cuny.edu/socwork/nrcfcpp/downloads/information_packets/Repeat_Maltreatment.pdf at 3 ("In comparison to children who experienced physical abuse, children who were neglected were 23 percent more likely to experience recurrence.").

Recurrent Maltreatment by Region

Regions 1, 3 and 4 had more recurrent maltreatment cases (ranging from 21 to 24 percent of all cases reviewed) than regions 2, 5, and 6 (ranging from 8 to 14 percent of all cases reviewed).

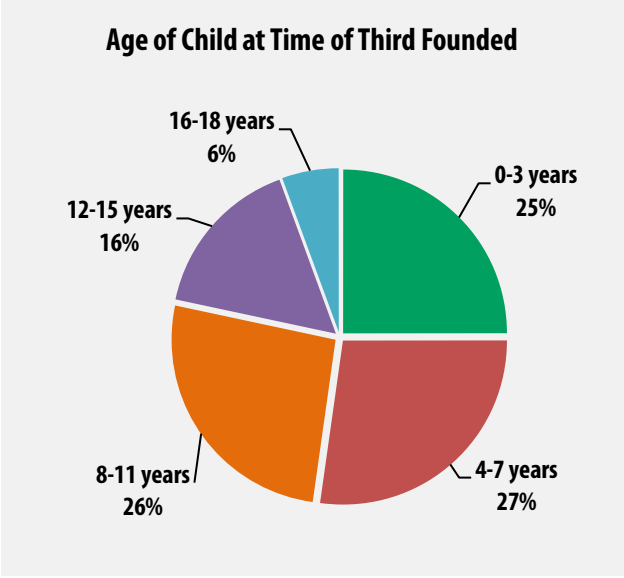


Source: Office of the Family and Children's Ombudsman, October 2009, based on analysis of DSHS CA data

Child Demographics

Age

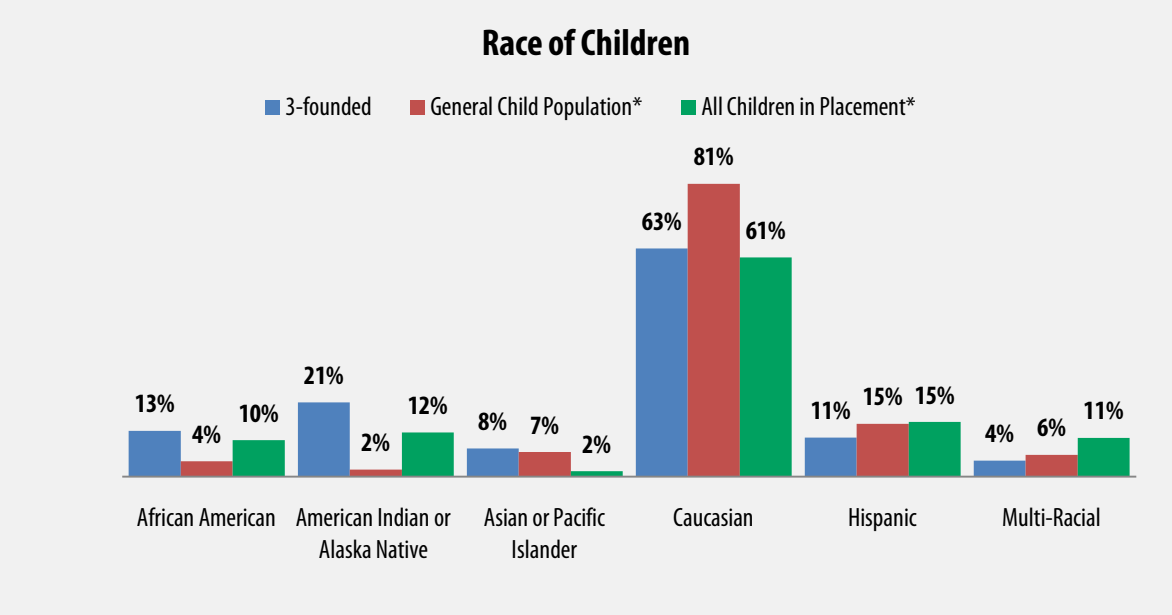
Nearly 79 percent of children identified in these cases were age 11 or younger. Age groups within this majority (0-3, 4-7 and 8-11) were relatively evenly distributed, with 22 percent being 12 years or older.



Source: Office of the Family and Children's Ombudsman, October 2009, based on analysis of DSHS CA data

RACE AND DISPROPORTIONALITY

Nearly 63 percent of children identified were Caucasian. While other groups are represented in smaller proportions, African American, Indian and Asian[41] children were disproportionately represented in the recurrent maltreatment cases reviewed by OFCO.



***** Race of children in placement, taken from CA Performance Report 2007 http://www1.dshs.wa.gov/pdf/ca/07Report2Intro.pdf

Source: Office of the Family and Children's Ombudsman, October 2009, based on analysis of DSHS CA data

This percentage of Indian children (21 percent) is similar to that found in OFCO's 2004-05 Annual Report on child fatalities in Washington, which found that 17 percent of child victims were Indian, compared to 2 percent of the state population.[42] The 2008 DSHS report *Racial Disproportionality in Washington State* concluded that Indian children were three times more likely than Caucasian children to be reported to CPS, and that those reports regarding Indian children were more likely to be accepted for investigation by CPS, and were more likely to be assigned a high-risk tag at intake than those relating to Caucasian children.[43] Disproportionality at each of these decision points may contribute to the disproportionality seen in these recurrent maltreatment cases. A variety of factors may underlie this high rate of recurrent abuse or neglect of Indian children. On one hand, the state is required under the Indian Child Welfare Act[44] to make "active efforts" to prevent the breakup of Indian families, which may result in more extensive attempts being made to resolve child abuse or neglect concerns prior to seeking removal of Indian children from their homes. On the other hand, abuse or neglect may be recurring at a higher rate due to a lack of appropriate services available to address the needs of Indian families and/or due to institutional bias. Why this is occurring and how DSHS CA can best respond demand further attention and study.

[41]Note: the percentage of children identified as Asian may be skewed by the relatively small number of children and families in this sample. Additionally, one of the families with more than seven children identified as Asian or Pacific Islander.

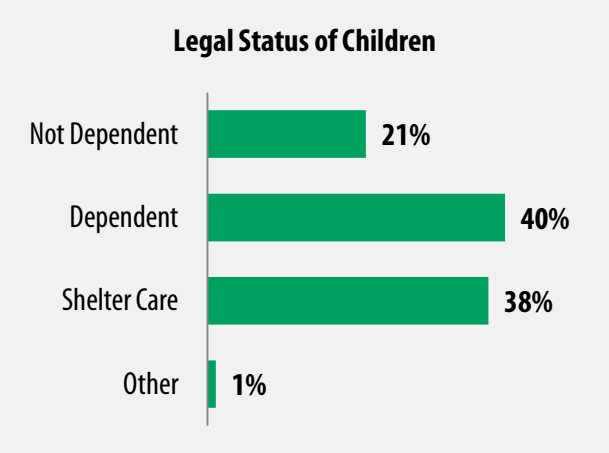
[42] 2004- 05 Annual Report, http://www.governor.wa.gov/ofco/reports/ofco_2005_annual.pdf at 55.

[43] Washington State Racial Disproportionality Advisory Committee and the Department of Social and Health Services (2008), http://www.dshs.wa.gov/ca/pubs/DisproportionalityReport.asp.

[44] 25 U.S.C. §§ 1901 – 1923 (1978).

Legal Status

For 78 percent of the cases reviewed, DSHS CA had already taken affirmative legal action – either through an in-home or out-of-home dependency – to ensure the safety of the children.[45] Only 22 percent of children identified were not dependent or in shelter care at the time OFCO received notification of the child or family's third founded report of child abuse or neglect. In the future, OFCO plans to capture whether dependent children remain in the care of their parent under an in-home dependency or are placed out of their homes. Furthermore, OFCO will document which cases are transferred to the jurisdiction of a tribal court.

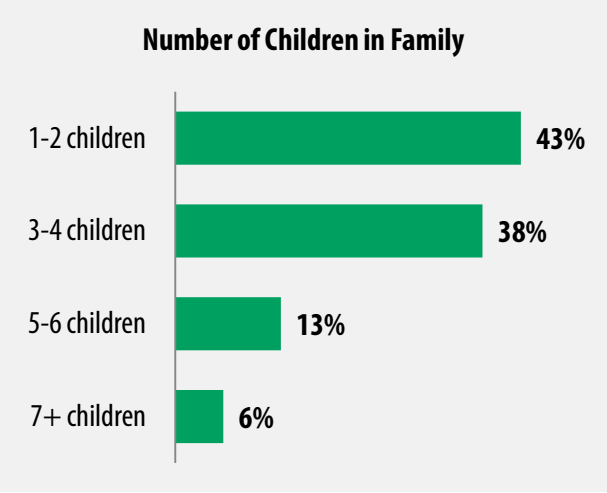


Source: Office of the Family and Children's Ombudsman, October 2009, based on analysis of DSHS CA data

Family Characteristics

Number of Children in Family

While 43 percent of families had one to two children, nearly 20 percent had five or more and 6 percent had seven or more children.

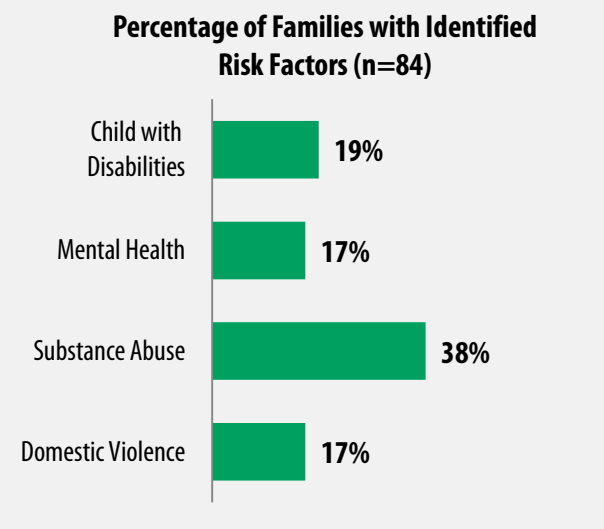


Source: Office of the Family and Children's Ombudsman, October 2009, based on analysis of DSHS CA data

[45] Because of the time lag between when the report was received by DSHS CA and when OFCO is notified of the third founded report, DSHS CA has usually had sufficient time to determine whether or not legal action will be taken.

PRESENTING RISK FACTORS[46]

Substance abuse was identified as a risk factor in more than 38 percent of the families. Nearly 20 percent of families had at least one child with a disability, while 17 percent experienced mental health or domestic violence.[47] These rates of caretaker substance abuse (38 percent), mental illness (17 percent), domestic violence (17 percent) and child disability (19 percent) may be low in the this sample due to the fact that OFCO only counted cases where these risk factors were explicitly identified in the reports of child abuse or neglect. Once DSHS CA interacts with and assesses a family, we think it likely to find these risk factors present in additional families. OFCO has not attempted to determine the rates of more subjective risk factors such as social isolation, poor parenting skills or parent-child attachment, problem solving deficits or family poverty.



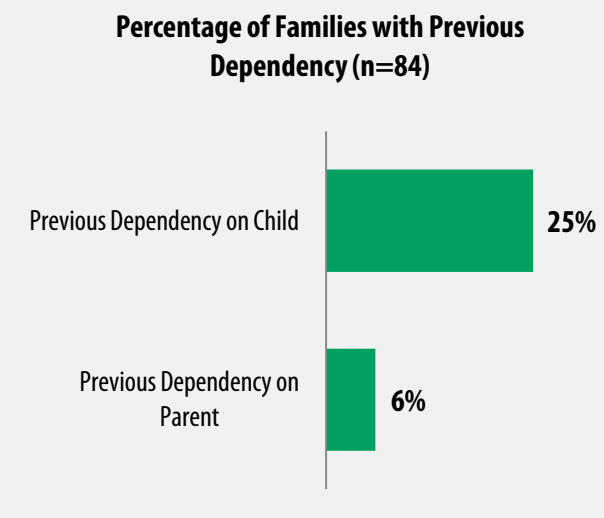
Source: Office of the Family and Children's Ombudsman, October 2009, based on analysis of DSHS CA data

[46] Research has established poverty as a clear risk factor for recurrent maltreatment. OFCO does not currently have access to information about families' financial status, and thus has not collected information regarding families experiencing poverty.

[47] OFCO's 1999 Annual Report found: "These cases involved parents who were struggling with chronic substance abuse, domestic violence, and/or mental health issues." http://www.governor.wa.gov/ofco/reports/ofco_1999_annual.pdf at 37.

PREVIOUS DEPENDENCIES

Many families (25 percent) had at least one child who was previously dependent and 6 percent had at least one parent who was dependent as a child. These cases involve a wide range of circumstances: parents who were in foster care as youths;[48] parents who had rights terminated to older children;[49] children with previous out-of-home placement(s) and subsequent reunification(s); children who are placed with relatives; and adopted children who are now the victims of abuse or neglect in their adoptive homes.



Source: Office of the Family and Children's Ombudsman, October 2009, based on analysis of DSHS CA data

In the future, OFCO plans to look more thoroughly at the subset of these recurrent maltreatment cases where a parent or a child in the family was previously dependent. Given the extensive involvement of the agency in the lives of these families, in a few cases the agency had placed the child with the caregiver who later was the subject of the three founded reports, these situations warrant closer analysis.

In one intergenerational neglect case, the mother was a dependent child from age 11 to 16. Her dependency was dismissed when she was 16 years old, only weeks before she gave birth to her first child. Mother was provided no ongoing support or services at the time, which may have been due to her resistance to services.

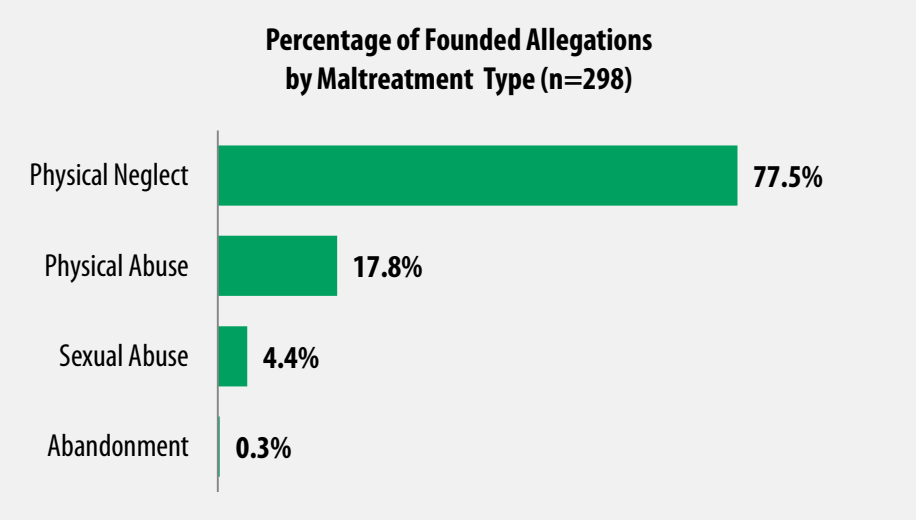
[48] In OFCO's 2004 Child Fatality Report, the Ombudsman recommended giving greater weight to parents' histories of abuse in their families of origin, particularly in cases of teen parents, in assessing risk and developing a case plan. http://www.governor.wa.gov/ofco/reports/ofco_2004_fatality.pdf at 21.

[49] OFCO recommended closer monitoring of parents with infants where there is history, such as dependency or termination of parental rights, regarding older siblings. Id.

CHILD MALTREATMENT

TYPE OF MALTREATMENT

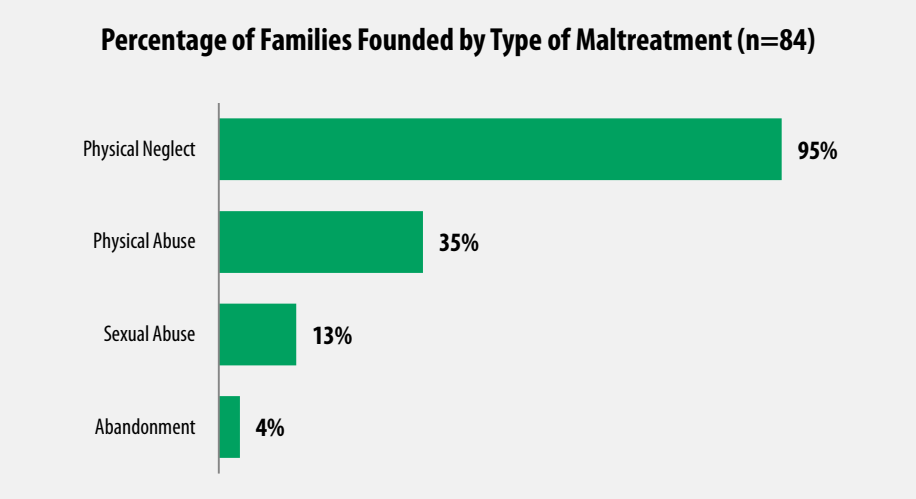
The graph below summarizes the type of maltreatment substantiated in the first, second, and third founded reports.[50] Physical neglect is, by far, the most common type of maltreatment experienced by children in these recurrent cases, comprising nearly 78 percent of all founded reports examined by OFCO.



Source: Office of the Family and Children's Ombudsman, October 2009, based on analysis of DSHS CA data

TYPE OF MALTREATMENT BY FAMILY

Another way to look at findings is to look at what type of maltreatment was experienced by each family. Nearly 95 percent of the families had at least one founded report of physical neglect. Over 35 percent of families had a founded report of physical abuse, 13 percent of sexual abuse and 4 percent of abandonment.

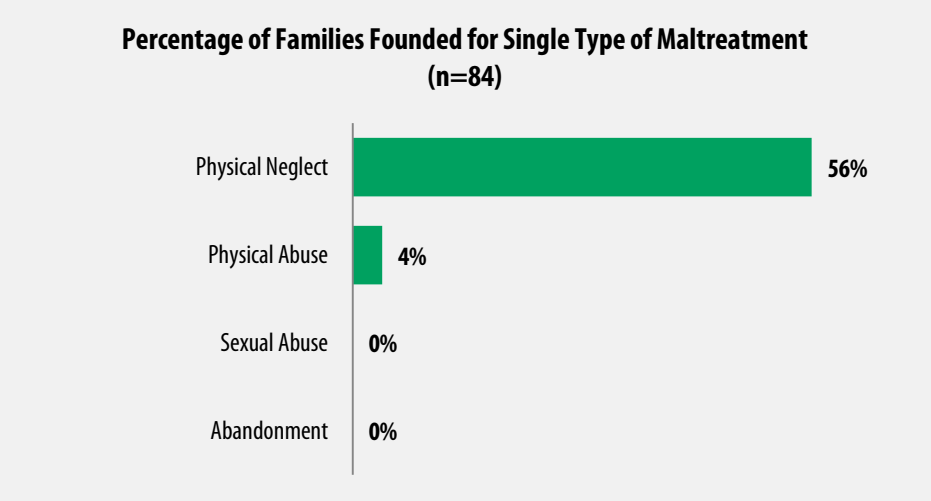


Source: Office of the Family and Children's Ombudsman, October 2009, based on analysis of DSHS CA data

[50] A single report may be substantiated for more than one type of maltreatment, e.g., a report of sexual abuse is often founded for sexual abuse against the offending caregiver and founded for physical neglect (failure to protect) against the non-offending caregiver who knew or should have known the abuse was occurring. In some cases, OFCO received notification of more than three founded allegations of child abuse or neglect. All findings are included in the graph titled "Percentage of Founded Allegations by Maltreatment Type."

FAMILIES EXPERIENCING ONE FORM OF MALTREATMENT

Over half (56 percent) of the families identified in OFCO's review had three founded reports for physical neglect only. Four percent of families had three founded reports for only physical abuse. The remaining 40 percent of families experienced multiple forms of maltreatment during a one-year period.



Source: Office of the Family and Children's Ombudsman, October 2009, based on analysis of DSHS CA data

OFCO CONCERNS ABOUT ACCESSIBILITY OF PAST HISTORY

A theme that repeatedly emerges from OFCO complaints, fatality reviews and these recurrent maltreatment cases is the extent to which history should be taken into consideration by CPS when making screening decisions on new reports alleging child maltreatment. In terms of chronicity and recurrence, the specific concern is that incident-based decision making (i.e. the intake worker considering only the current allegations) may fail to account for situations where a child may be experiencing the cumulative effects of long-term, though perhaps less severe, abuse or neglect.[48] **Two recent changes, DSHS CA's conversion to FamLink and statutory change regarding the destruction of records, may hamper policy and practice efforts[49] to increase consideration of a family's history.**

Using FamLink, OFCO has experienced difficulties in accessing a family's referral history (now called "Prior Involvement"). One issue is that prior involvement (integrating all reports, both screened-in and screened-out, CPS and non-CPS) is not available chronologically. Another issue is that there is no way in FamLink for users to view an individual's prior history or findings (information that was easily accessible in the prior CAMIS-GUI system). **The Ombudsman is concerned these FamLink issues affect workers in the field, particularly intake workers who are making screening decisions and supervisors who are assessing possible cumulative harm in cases where chronicity is indicated, to an even greater extent.**

Also, there was a statutory change in 2007 regarding the retention and destruction of records. RCW 26.44.031 now requires DSHS CA to destroy all records concerning:

(a) A screened-out report within three years from the receipt of the report; and

(b) An unfounded or inconclusive report within six years of completion of the investigation, unless a prior or subsequent founded report has been received regarding the child who is the subject of the report, a sibling or half-sibling of the child, or a parent, guardian, or legal custodian of the child, before the records are destroyed.

This will limit the historical information that is available to intake workers and supervisors, OFCO and other parties attempting to review case histories.

[48] See ESSB 5922, Chapter 512, Laws of 2005 § 2 ("One incident of neglect may not rise to the level requiring state intervention; however, a pattern of neglect has been shown to cause damage to the health and well-being of the child subject to the neglect."

[49] For example, "risk-only" intakes and chronicity policies. See CA Practice Guide to Intake and Investigative Assessment at 25-27; CA Practices and Procedures Guide, Section 2200(K).

A. Intervention

OFCO assessed the current situation of the family to determine whether there were any unaddressed issues regarding child safety which required immediate intervention. The Ombudsman intervened to ensure immediate child safety in two cases.

OFCO INTERVENTIONS IN RECURRENT MALTREATMENT CASES: ENSURING IMMEDIATE CHILD SAFETY

ISSUE OF CONCERN	OMBUDSMAN ACTION	OUTCOME
Three founded reports for a single-parent household with four school-aged children (6, 7, 8 and 9 years old) raised serious concerns of chronic neglect, parent's failure to cooperate with investigations and services, and most urgently, neglect of the 8-year-old child's serious dental needs. The child's dental needs were so severe that during one recent investigation, law enforcement placed the child into protective custody and charged the parent with criminal mistreatment in the second degree. CPS returned the child to the parent's care the following day, and failed to follow up to see that the parent obtained dental care for the child. In closing the most recent investigation as "founded," the social worker wrote: *"This appears to be a case of chronic neglect that has not been ameliorated by the [parent] despite assistance and instruction from the department. The cumulative effects on the children are numerous….This writer feels that it is in the best interest of the children to develop court structure as that may motivate [parent] to carry out … parental duties."* However, the OAG had advised CPS that the facts were insufficient to support filing for dependency.	**Upon receiving notification regarding the three founded referrals regarding this child, OFCO contacted the AA and requested that the AA review the case and consider higher-level review by OAG.**	The AA responded that CPS would follow up regarding dental care for the child and request a pick up order if necessary care had not been provided. CPS learned that the child's dental needs had not been addressed. The parent scheduled a dental appointment and was told that CPS would file a dependency petition if the appointment was not kept. The parent did fail to take the child to the scheduled dental appointment. DSHS CA filed a dependency petition and all four children were removed and placed out of the home. The 8-year-old child received appropriate dental care.

ISSUE OF CONCERN	OMBUDSMAN ACTION	OUTCOME
Three founded reports concerned sexual abuse of a 17-year-old developmentally delayed youth by her father. Investigations were also founded against the youth's mother for neglect based on failure to protect. Based on the initial findings of sexual abuse and failure to protect, DSHS CA filed a dependency and placed the youth in out-of-home care. The third substantiated incident of sexual abuse occurred during an unsupervised weekend visit in the mother's home. Visits were temporarily suspended while the third report was investigated. However, a few months later DSHS CA agreed to an order to increase and liberalize visitation and transition the youth home with her mother in anticipation of her 18th birthday. Unsupervised weekend visits began again the following weekend.	Based on the youth's vulnerability to re-abuse, and the mother's history of failing to acknowledge or protect the youth from sexual abuse by the father, **OFCO requested that DSHS CA conduct unannounced drop-in visits at the mother's home during the youth's weekend visits to ensure that the father was not present and that the youth was not left alone.**	DSHS CA agreed to conduct unannounced visits. DSHS CA reported that a therapist was also working with mother and daughter in the home. However, several weekends went by and DSHS CA did not conduct any unannounced visits. CPS then received new reports alleging that the youth was again sexually abused during a visit. These most recent allegations are under investigation. The court recently ordered the youth to be returned to her mother's care over the objection of DSHS CA. Since this youth is still at risk, OFCO continues to monitor the situation.

In 78 percent of the cases reviewed, DSHS CA had already taken some legal action to ensure the safety of the children. However, there were a number of cases where DSHS CA was relying on voluntary services to correct parental deficiencies.[50] For those, OFCO attempted to determine whether voluntary services were sufficient and whether the parent was complying with the service and safety plans. In two such cases, OFCO intervened to request that the agency consider taking legal action, rather than relying on voluntary services, when there was consensus among the OFCO review team that this was appropriate.[51]

[50] In some cases, by the time OFCO is notified of the third founded report DSHS CA has closed its case, meaning that the case is beyond the point of possible intervention.

[51] OFCO recognizes that deciding whether a case is appropriate for family voluntary services or whether a more assertive response is necessary is complex and that DSHS CA is mandated by law to make reasonable efforts (or active efforts in cases governed by the Indian Child Welfare Act) to prevent removal of children from their parents.

OFCO INTERVENTIONS IN RECURRENT MALTREATMENT CASES:
ENSURING APPROPRIATE CASE PLANNING

ISSUE OF CONCERN	OMBUDSMAN ACTION	OUTCOME
Three founded reports for chronic neglect of children ages 1, 2 and 5. In response to the first two founded reports which concerned inadequate supervision and poor hygiene, DSHS CA provided the family with Family Preservation Services for six months to assist the family with housing resources. Despite this intervention and the family finding shelter, additional reports alleged parents' failure to supervise the children and medical neglect (which had not been addressed during Family Preservation Services.	**OFCO asked the Area Administrator to review the case and recommended filing a dependency petition to provide legal structure and bolster the agency's interventions with the family.** The same day, another report was received by DSHS CA stating, *"…since the CPS social worker stopped contacting the parents, the neglect issues have resurfaced."*	The agency did not file a dependency petition but did schedule a Child Protective Team meeting to seek professional opinions as to how to proceed. The Child Protective Team meeting was scheduled for two months later. In the interim, yet another report was received from law enforcement, reporting that the 5-year-old child was in protective custody after the child was found alone in a public area and the child's parents could not be located. **OFCO contacted the AA again and recommended filing a dependency petition to mandate a minimal level of care for the children by their parents.** DCFS declined to file a petition because the parents were located and agreed to a safety plan. The Child Protective Team recommended that the children remain in the care of their parents with voluntary services to continue for an additional three-to-six months. The family's case is now closed with no additional reports for more than a year.
Three founded reports related to chronic neglect of children ages 4, 5 and 9. The family had a long history of allegation of child maltreatment and had participated in voluntary services in the past.	**OFCO asked the AA to consider taking legal action to establish an in-home dependency.**	The AA responded that the family had agreed to participate in ongoing services for an entire year, but that if the parent failed to make progress in services or the risk of harm to the children were to rise, the agency would file for in-home dependency. Long-term voluntary services were successful in this case. For more details, see page 178.

B. Monitoring

After the initial review of each case, OFCO periodically monitored for new reports of abuse or neglect or additional child safety concerns: (1) cases in which the Ombudsman intervened; (2) cases where circumstances may soon change [i.e. reunification may soon occur, a new baby was expected or a parent was about to complete inpatient treatment or be released from incarceration]; and (3) closed cases or cases where children remained in the home without court structure. During this reporting period, OFCO staff monitored approximately 24 of these recurrent maltreatment cases. Going forward, OFCO plans to further define which cases benefit from ongoing monitoring and at what interval. For consistency with the federal measure of recurrence, which looks at the six-month period following an substantiated occurrence of abuse or neglect,[52] the Ombudsman will consider working with DSHS CA to develop a way for OFCO to receive automatic notification of subsequent reports of abuse or neglect within the initial six-month window as soon as they are received by DSHS CA.

C. Reporting

RCW 26.44.030(13) does not require OFCO to report specifically on these recurrent maltreatment cases. However, since review of these cases presents an important opportunity for public education and systemic analysis, we intend to share this information periodically. The form and content of our reporting may vary from year-to-year.

CONCLUSION

Moving forward, the Ombudsman's goals are to:

- Continue to take immediate action to intervene with the agency to address child safety or other case planning concerns where there have been three founded reports of child abuse or neglect.
- Continue gathering and analyzing quantitative information on these cases.
- Provide more qualitative descriptions of individual cases.
- Examine case history, where it is available, of families which have experienced a previous dependency to analyze what factors made the previous intervention unsuccessful (based on the recurrence of child maltreatment).
- Respond to feedback from the agency, legislators and other stakeholders regarding what information should be included in future OFCO reports on recurrent maltreatment cases.

[52] The Data Measures, Data Composites, and National Standards to be used in the Child and Family Services Reviews, 71 Fed. Reg. 109, 32973 (June 7, 2007).

SUMMARY REPORT: PATTERNS IN MANDATED REPORTER REFERRALS, 2006-2008

2SSB 6206 – CHAPTER 211, SEC 6, LAWS OF 2008

In July 2009, OFCO released its report, "Patterns in Mandated Reporter Referrals 2006-2008."[1] This report complied with the Legislature's directive set forth in 2SSB 6206[2] that OFCO analyze and report on a random sampling of child abuse and neglect referrals made by mandated reporters to DSHS CA during 2006 and 2007. 2SSB 6206 required that OFCO include in its report:

- The number and type of referrals,
- The disposition of each referral by category of mandated reporter,
- Any patterns established by DSHS in how it handled the referrals, and
- Whether the history of deaths in 2006 and 2007 showed referrals by mandated reporters and any other information OFCO deems relevant.

OFCO contracted with the Washington State Institute for Public Policy to perform a study of whether the source of a referral influenced the response by CPS. The Washington State Institute for Public Policy examined 96,000 referrals made between January 2006 and February 2008.[3] Additionally, OFCO examined whether there were mandated reporter referrals present in the history of the caretakers of 241 children who died in 2006, 2007 and 2008.

This section of our annual report provides a summary of OFCO and the Washington State Institute for Public Policy's key findings, data, recommendations and case examples from our full report. Among the key findings: *OFCO found that most child deaths were preceded by a referral from a mandated reporter and almost half of the children who died were infants less than 1 year old. The Washington State Institute for Public Policy found that the biggest variation in referral outcome was determined by DSHS region and the history of the individual intake worker, rather than by type of reporter.*

OFCO FINDINGS

- 83 percent of the 241 child deaths OFCO reviewed had a mandated reporter referral present in the deceased child's caretaker's total history.
- 46 percent of the 241 deaths had one or more mandated reporter referrals screen in for agency response within one year of the child's death.
- 32 percent of the deaths had one or more mandated reporter referrals screened out as "information only"* within one year of the child's death.
- 48 percent of the children who died were infants less than one year old. 33 percent of these infants had a screened out "information only" referral prior to their death, with 74 percent of these made by mandated reporters.
- 24 percent of the "information only" referrals on infants were pre-natal referrals with almost 90 percent made by mandated reporters.

* "Information only" means that DSHS CA determined that the referral did not meet the legal sufficiency criteria for screening in the referral to investigate it. Thus, the agency did not investigate these referrals.

[1] The full text of OFCO's report "Patterns in Mandated Reporter Referrals 2006-2008" may be accessed at OFCO's Web site at http://www.governor.wa.gov/ofco/reports/mandated_reporter_referrals_2006_08.pdf

[2] Original sponsors to 2SSB 6206 were Senators Zarelli, Pflug, Hargrove, and Stevens.

[3] WSIPP's work is included in the text of OFCO's full report "Patterns in Mandated Reporter Referrals 2006-2008," supra n 1, and may also be accessed on the WSIPP Web site at http://www.wsipp.wa.gov/pub.asp?docid=09-06-3901

BACKGROUND

A. FEDERAL AND STATE LAW

Every state, including Washington, has enacted a mandatory child abuse and neglect reporting law.[4] This qualifies states for federal funding under the Child Abuse Prevention and Treatment Act (CAPTA), 42 U.S.C. 5101, et seq.,[5] a law designed to assist states in preventing, investigating, treating and prosecuting child abuse and neglect.

RCW 26.44.030 requires designated professionals to report[6] to law enforcement or DSHS if they have "reasonable cause to believe that a child has suffered abuse or neglect."[7] "Abuse or neglect" means "sexual abuse, sexual exploitation, or injury of a child by any person under circumstances which cause harm to the child's health, welfare, or safety, excluding conduct permitted under RCW 9A.16.100[8]; or the negligent treatment or maltreatment of a child by a person responsible for or providing care to the child."[9] State law defines "negligent treatment or maltreatment" as "an act or a failure to act, or the cumulative effects of a pattern of conduct, behavior, or inaction, that evidences a serious disregard of consequences of such magnitude as to constitute a clear and present danger to a child's health, welfare, or safety, including but not limited to conduct prohibited under RCW 9A.42.100.[10] When considering whether a clear and present danger exists, evidence of a parent's substance abuse as a contributing factor to negligent treatment or maltreatment shall be given great weight. . . ."[11]

B. LEGISLATIVE HISTORY OF 2SSB 6206 IN RELATION TO THE OFFICE OF FAMILY AND CHILDREN'S OMBUDSMAN

In 2007 and 2008, OFCO engaged in a series of informal conversations with legislators and staff about the current mandated reporter law and what we viewed as potential areas that needed further assessment and possible strengthening. These conversations ranged from the need to designate

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[4] RCW 26.44.030.

[5] CAPTA was amended and reauthorized in 2003 by the Keeping Children and Families Safe Act of 2003 (P.L. 108-36). See http://dc.mandatedreporter.org/pages/docs/About-CAPTA.pdf

[6] Throughout this report, OFCO uses the terms "referent" and "reporter" interchangeably to refer to individuals making a referral or report to CPS alleging concerns of child abuse or neglect.

[7] RCW 26.44.030(1)(a). Non-mandated reporters, such as a neighbor or relative, may make a referral if they have reasonable cause to believe a child has suffered abuse or neglect. RCW 26.44.030(3).

[8] RCW 9A.16.100 provides that: "the physical discipline of a child is not unlawful when it is reasonable and moderate and is inflicted by a parent, teacher or guardian for purposes of restraining or correcting the child. Any use of force on a child by any other person is unlawful unless it is reasonable and moderate and is authorized in advance by the child's parent or guardian for purposes of restraining or correcting the child." RCW 9A.16.100 also sets forth use of force presumed unreasonable: "(1) Throwing, kicking, burning or cutting a child; (2) striking a child with a closed fist; (3) shaking a child under age 3; (4) interfering with a child's breathing; (5) threatening a child with a deadly weapon; or (6) doing any other act that is likely to cause and which does cause bodily harm greater than transient pain or minor temporary marks. The age, size and condition of the child, and the location of the injury shall be considered when determining whether the bodily harm is reasonable or moderate. This list is illustrative of unreasonable actions and is not intended to be exclusive."

[9] 26.44.020(12); WAC 388-15-009.

[10] RCW 9A.42.100 provides that "[a] person is guilty of the crime of endangerment with a controlled substance if the person knowingly or intentionally permits a dependent child or dependent adult to be exposed to, ingest, inhale or have contact with methamphetamine or ephedrine, pseudoephedrine, or anhydrous ammonia, including their salts, isomers, and salts of isomers, that are being used in the manufacture of methamphetamine, including its salts, isomers, and salts of isomers. Endangerment with a controlled substance is a class B felony."

[11] RCW 26.44.020(15).

guardians ad litem as mandated reporters,[12] the need for improved training of mandated reporters, possible barriers to persons reporting, to concerns about referrals from mandated reporters being screened out from investigation.

The issues OFCO brought to the attention of legislators arose, in part, from our investigative work on complaints from citizens. In OFCO's 2007 and 2008 Annual Reports, we made 13 adverse findings of failure by DSHS CA to screen in a CPS referral for investigation or other screening errors.[13] These findings included failure to screen in referrals from mandated reporters, but also included referrals from non-mandated reporters. The following example provides OFCO's investigative findings on a complaint alleging failure to investigate a report from a mandated reporter:[14]

> CPS failed to screen in a referral for investigation from a mandated reporter alleging physical abuse of an 11-year-old, non-dependent child by the parent. The Ombudsman found that the referral was poorly documented (the referent reported providing a good deal more information than was documented), but even so could have been screened in for investigation based on the allegations and the chronic history of similar referrals. A new referral from a different mandated reporter was then screened in for investigation after the child reported being hit with a belt causing a welt on his back. OFCO reviewed the investigation on the new referral and found the child had been seen and interviewed four days after the referral had come in. This was a violation of policy and by that time, the "red 5-inch welt" described by the referent was a faint mark. CPS was preparing to close the investigation. OFCO determined that the agency should gather more information to better assess the child's need for protection, given the family's history of CPS involvement. **After OFCO intervention, CPS arranged a Family Team Decision Making meeting and the parent agreed to multiple services, including wraparound services in the home.**

[12] In 2008, OFCO participated in a workgroup convened by Senator Debbie Regala to examine issues related to CASAs and GALS under title 13 (dependency) cases and title 26 (family court) cases. In 2009, the Legislature passed SSB 5285 (whose original primary sponsor was Senator Regala) designating CASAs and GALs as mandated reporters. RCW 26.44.030(1)(e)(Effective 07/26/09).

[13] OFCO 2007 and 2008 Annual Reports at page 20. See http://www.governor.wa.gov/ofco/reports/ofco_07-08_annual.pdf

[14] OFCO 2007 and 2008 Annual Reports at pate 28. See http://www.governor.wa.gov/ofco/reports/ofco_07-08_annual.pdf

More recently, in the context of investigating a complaint on a different issue in a dependency case, OFCO had concerns about CPS screening out the following referral[15] from a mandated reporter as "information only:" [16]

> Mother delivered a baby and her urinalysis tested positive for METH. The referent stated that the mother did not receive any prenatal care and 'she lost three other children to CPS' . . . The referent indicated that the child's behaviors are jittery, irritable with high-pitched screams and fussy. Prior to this referral, the mother had a founded finding . . . for Physical Neglect. The referent stated that the mother and father have substance abuse histories (METH). The mother's last address listed was homeless.
>
> In follow-up calls from referent to the CPS intake unit, referent reported that the urinalysis results for the baby are positive for METH. . . "the doctor was surprised that CPS was not going to get involved." Referent also reported the mother did not know her address, did not have a phone, a car or car seat, but says she does not need a car seat and that she plans to walk to appointments. The referent stated "we are all worried about this baby" and do not understand why CPS is not opening a case**.**
>
> **CPS did not screen in this referral for investigation.**

SCOPE OF REVIEW

ANALYSIS OF CHILD ABUSE AND NEGLECT REFERRALS

2SSB 6206 provides that OFCO may contract to have all or some of these tasks completed by an outside entity. OFCO contracted with WSIPP[17] to analyze child abuse and neglect referrals from mandated reporters and the outcomes of these referrals.[18] Due to WSIPP's analytical capacity, it was able to broaden its analysis beyond the "*random sampling of child abuse and neglect referrals made by mandated reporters to the Children's Administration during 2006 and 2007"* required by 2SSB 6206. WSIPP analyzed 96,000 referrals received by CPS between January 2006 and February 2008. This represents virtually **all** referrals received by the agency over this time period, not merely a random sampling from mandated reporters.

PRESENCE OF MANDATED REPORTER REFERRALS IN CHILD DEATHS

In compliance with 2SSB 6206, OFCO examined whether there were mandated reporter referrals present in the history of the caretakers of 241 children who died in 2006, 2007 and 2008 (2008 is one year beyond the required scope of 2SSB 6206) by collecting and analyzing additional data as

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[15] OFCO requested an explanation from DSHS CA about its screening decision rationale. In a 07/16/09 conversation between OFCO and the CA Kelso AA, CA asserted that that the referral was appropriately screened out pursuant to the policy in effect at the time the referral was received in July 2008. The AA stated that since the implementation of FamLink, CA's new computerized database, in February 2009 **(see fn 35),** CA has a "risk-only" option for screening intakes, and this referral would now screen in as "risk only" based on the family's history including parents' drug use, prior termination of parental rights, and the mother's homeless status. See DSHS CA Practices and Procedures Guide, Chapter 2552. Intakes on Newborns Identified by a Medical Practitioner as Substance Exposed and/or Substance Affected Newborns by Substances (Not Medically Prescribed) or Has Withdrawal Symptoms Resulting from Prenatal Substance Exposure. See http://www.dshs.wa.gov/ca/pubs/mnl_pnpg/chapter2_2500.asp

[16] Significant portions of the allegations text are verbatim. Some text has been edited to delete identifying information or shorten the text without altering the meaning or context of the referral.

[17] The Washington Legislature established WSIPP in 1983 to provide non-partisan research at legislative request. http://www.wsipp.wa.gov/

[18] WSIPP analyzed data from the CA Management Information System.

part of its routine review of child fatalities.[19] These 241 children met OFCO's criteria for review,[20] which means they were either in the care of, or had received child welfare services[21] from, DSHS CA within one year of their death, or died while in state-licensed care. When OFCO receives notice of a child death known to DSHS CA, it reviews the child welfare case and circumstances of the death and then records the death in an internal database if OFCO's criteria for review are met.[22]

OFCO paid particular attention to whether the referral history included referrals from mandated reporters within one year of the child's death; and also to DSHS CA's screening decision made on the last referral the agency received (regardless of reporter type) prior to the child's death.

CHILD PROTECTIVE SERVICES SCREENING OF REFERRALS

This section sets forth the sufficiency criteria under law and policy that determine whether a referral is screened in for agency intervention.

OUTCOMES OF REFERRALS TO CHILD PROTECTIVE SERVICES: COMPARING REPORTERS

This section sets forth WSIPP's analysis of the outcomes of referrals to CPS. WSIPP examined the significance of referral outcomes by referent type, region and individual intake worker. The complete results of WSIPP's analysis, analytical approach and methodology are in the full text of OFCO's mandated reporter report. The section of OFCO's mandated reporter report, which sets forth WSIPP's work is entitled: "Outcomes of Referrals to Child Protective Services: Comparing Reporters (WSIPP)."[23]

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[19] OFCO receives notice of child deaths known to DSHS from an automated critical incident notifier via Email from AIRS and reviews these fatalities. Prior to January 2009, OFCO received notification of fatalities and critical incidents via a CAMIS alert. 2SSB 6206 also requires CA to notify OFCO of near fatalities and of cases with three founded findings within the last 12 months and provide the disposition. According to DSHS CA, "the HQ CPS program manager will track these cases and notify OFCO until FamLink (Release 2) provides automatic notification. OFCO has been receiving required notification of cases with three founded findings. See http://www.dshs.wa.gov/ca/pubs/mnl_pnpg/chapter2_2500.asp

[20] To put the 241 child deaths reviewed by OFCO in the context of total child deaths in Washington state, there were 831 child deaths aged 0-19 in 2006 and 821 deaths in 2007. 2008 figures are not yet available publicly. Also note that the overall deaths reported by DOH include children up to age 19 (one year beyond the age range examined by OFCO). http://www.doh.wa.gov/EHSPHL/CHS/chs-data/death/dea_VD.htm Mortality Table B2. Autopsy by Age and Manner of Death for Residents, 2007.

[21] This refers to the child and/or the child's family receiving services from DSHS CA.

[22] OFCO attempts to reconcile the fatalities it records in its database with CA's records. Sometimes there is a discrepancy between the number of child fatalities due to a variety of factors. For example, OFCO includes in its database expected deaths of children (e.g. a child with a terminal illness), while CA typically does not if they meet our criteria, i.e. they were in the care of, or receiving child welfare services from DSHS CA within one year of their death or died while in state licensed care.

[23] Marna Miller (2009). *Outcomes of referrals to Child Protective Services: Comparing reporters. Olympia: WSIPP*, Document 090-06-3901.

SUMMARY OF WSIPP FINDINGS/CONCLUSIONS:

- Similar to national trends, **Washington state educators and social service professionals make more referrals to CPS than other types of mandated reporters**.
- **Outcomes of CPS referrals vary by reporter type. Referrals from law enforcement were more likely to be accepted for investigation and to result in removal of a child from their home.** The proportion of referrals accepted by DSHS ranged from 47 percent for mental health professionals to 69 percent for law enforcement.
- The **biggest variation in referral outcome was determined by DSHS region and the history of the individual intake worker** (more so than by reporter type).

PRESENCE OF MANDATED REPORTER REFERRALS IN CHILD FATALITIES

OFCO FINDINGS OF MANDATED REPORTER REFERRALS IN CHILD DEATHS

This section of OFCO's mandated reporter report provides data gathered and reviewed by OFCO regarding the presence of mandated reporter referrals in the 241 child deaths of children ages 0-18 that OFCO reviewed from 2006, 2007 and 2008. As stated earlier, this data set includes children who meet OFCO's criteria for review, i.e. those children who were in the care of or whose families received child welfare services from DSHS CA within one year of their death, or who died while in state licensed care.

Important factors to consider in reviewing this data:

- Not all of the child fatalities are caused by child abuse and neglect. Some are accidental or the result of natural or medical causes.
- Mandated reporters make the majority of referrals to CPS, so it follows that most deaths have a mandated reporter referral in their history.[24]
- The mandated reporter referral on the caretaker does not necessarily mean the referral pertained to the child who died. The referral could relate to abuse or neglect of a sibling.
- The referral history pertains to the "caretaker's" history.[25] The caretaker is defined as the caretaker at the time of the child's death. The child may have had various caretakers throughout his or her life.

OFCO's findings are summarized as follows:

- A large majority of the 241 child deaths OFCO reviewed had a mandated reporter referral present in the deceased child's caretaker's total history.
- Almost one-half of the deaths had one or more mandated reporter referrals screen in for agency response within one year of the child's death.
- Close to one-third of the deaths had one or more mandated reporter referrals screened out as "information only" within one year of the child's death.

[24] See discussion of referrals in WSIPP section of this report, available at http://www.governor.wa.gov/ofco/reports/mandated_reporter_referrals_2006_08.pdf.

[25] Total caretaker history includes any referral that names the caretaker at the time of death as the subject of the referral. It includes referrals on the caretaker even if the deceased child is not an identified victim. It does not include referrals that list the caretaker as a victim, i.e. when the caretaker was a minor.

- Nearly half of the children who died were infants less than 1 year old. About one-third of these infants had a screened out "information only" referral prior to their death, with close to three-fourths of these made by mandated reporters. Close to one-quarter of the "information only" referrals on infants were prenatal referrals with almost 90 percent made by mandated reporters.

More detailed information that provides specific percentages related to number of child deaths is provided at the start of this summary in the text box **OFCO Findings.**

LAST SCREENING DECISION PRIOR TO EACH CHILD'S DEATH

This section of the report provides charts that show the screening decisions made by DSHS, by reporter type, on the last referral prior to each child's death in 2006-08.

CHILD FATALITY REVIEWS

This section of OFCO's full report sets forth the state law and key DSHS CA policy governing child fatality reviews. It also provides several case examples of final referrals screened out as "information only" preceding the death of a child. Four of these case examples are profiled here.

CASE EXAMPLES

The following four case examples of final referrals[26] were received on the child's family and screened out as "information" only preceding the child's death. More case examples are provided in our full report. For each of these referrals, we have provided the type of referent, the age of the child who died, a case overview, the cause and manner of death, the time elapsed between the final referral and the date of death, the allegations in the final referral, and excerpts from DSHS CA's Child Fatality Review to the extent it addressed intake or screening decisions. All the information provided in these case examples is taken directly from the DSHS CA Child Fatality Review team's summary which is available on the public website indicated after each case overview. In many of these cases, Child Fatality Review teams identified concerns regarding the final "information only" screening decisions and OFCO has provided excerpts of the team's concerns. CA's response also may identify "Action Taken" or "Recommendations."

Case 2

Referent: Social Services Professional

Age of Child at Time of Death: 3 months

Case Overview:[27] On November 15, 2008, CA Central Intake received a report that a 3-month-old baby was brought to the hospital by her parents with no pulse and not breathing. Medical staff was able to revive the child, however, prognosis was poor. On November 16, 2008, hospital staff notified CA that the baby was diagnosed with bilateral retinal hemorrhages and was brain dead. Medical consultation at the time confirmed the injury was consistent with shaken baby syndrome.

[26] OFCO uses "final referral" to mean that last referral received by CPS before the child died.

[27] The case overview is derived from CA's Child Fatality Review. The text of the case overviews presented here is largely verbatim but has been edited in some instances to delete unnecessary details, without changing the accuracy. Each case overview is followed by a link to the full child fatality review. In addition to providing details about the family history and circumstances of the child's death, the child fatality review typically identifies practice issues and corresponding recommendations.

Executive Child Fatality Review, Region 4,
http://www1.dshs.wa.gov/pdf/ca/LeingangECFR.pdf

Manner of Death: Unknown/Undetermined
Cause of Death: Anoxic encephalopathy of unknown etiology

Time Between Referral and Death: 5½ weeks

Finding Regarding Fatality: Founded for physical abuse and neglect. Criminal investigation remains open.

OFCO Attended Child Fatality Review

Allegations:[28] *In October 2008, an information-only intake was received reporting several vehicles at the family's residence, though no one answered the door when knocked. The referent was concerned because she could hear a child crying for about 10 minutes. The referent called to report her concerns as the mother had recently disclosed a prior drug problem and had two children removed from her care in the past. It was reported three children were now living in the home, ages 3½ years, 18 months, and 2 months (S.L.).*

DSHS CA Executive Child Fatality Review of Screening Decision: Executive Child Fatality Review Committee stated [that] taking into consideration the family's CA history when screening more recent intakes[29] (including above intake) warranted assignment of the intake based on high-risk factors alone. The Executive Fatality Review Committee made findings and a recommendation related to screening decisions:[30]

Findings:[31]

- A family's complete alleged child abuse and neglect history, including information-only intakes were not considered when intake screening decisions were made. Considering the complete alleged child abuse and neglect history, regardless of previous intake screening decisions, ensures a comprehensive review of all information available to assess risk and child health and safety. Attention to chronicity (recurrent episodes of alleged abuse or neglect over time) and severity (degree of abuse) helps to identify if there is a pattern of alleged child maltreatment over time rather than assessing an isolated incident.
- A family's history in which parental rights had been terminated in the past should elevate the standard by which a new intake is assessed and subsequently screened for investigation.

Recommendation: The supervisory review of intakes should include a review of the intake history of the family including both assigned and screened out intakes. The review should be used when considering assignment of the intake based on allegations of child abuse/neglect meeting the Washington Administrative Code 388-15-009 definition [of child abuse or neglect] or the presence of risk factors.

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[28] Italicized text in this case example, and in the others provided, indicates the allegations text is quoted from CA's CFR, which summarizes the referral. It is not a direct quote from the referral history in CAMIS, but OFCO reviewed the original referral history in CAMIS as well.

[29] The term "intake" is interchangeable with "referral." Since Famlink went into effect, DSHS CA is using the term "intake" in lieu of "referral."

[30] The Executive Child Fatality Review made other recommendations and findings not related to screening/intake that are not included here.

[31] The findings and recommendations presented in these case examples are findings and recommendations made by the child fatality review team.

CASE 4

Referent: Medical Professional

Age of Child at Time of Death: 3 months

Case Overview: The child's 16-year-old mother was placed by the Tribal Nation in the home of a relative. On November 21, 2006, the mother left for several hours one evening leaving her baby in the care of two teenage girls who also lived in the home. At one point, one of these teenagers found the child not breathing. An ambulance was summoned and CPR was performed but was unsuccessful. There was no evidence at the scene that the death was suspicious. The cause of death after autopsy was determined to be acute pulmonary bronchial pneumonia due to a bacterial infection.

Child Fatality Review #06-46, Region 3, http://www1.dshs.wa.gov/pdf/ca/CFR2qtr2008.pdf at page 8.

Manner of Death: Natural/Medical

Cause of Death: Acute pulmonary bronchial pneumonia due to bacterial infection.

Time between Referral and Death: 6 weeks

Finding regarding fatality: No investigation

Allegations: *There was one prior referral on this mother. Her baby (then 6 weeks old) was hospitalized to correct an intestinal birth defect. She developed an infection while in the hospital. Medical staff questioned the mother's ability to care for her infant. The mother had difficulty waking to the baby's cries and had to be repeatedly prompted to hold bottles upright to prevent the baby from swallowing air. There was also a concern that the mother was [not] feeding the child enough formula for the infant to make adequate weight gain. This referral was not screened in for investigation.*

DSHS CA Child Fatality Review of Screening Decision:

Issue: When infants are born to women who have dependent children or born to young women who are dependent themselves, there is currently no system in place in this DCFS office to alert the unit supervisor of the birth and the need to assess the safety of the infant. In this case, although the assigned social worker did address the issue of the safety of the newborn with the Tribe, there is no documentation that the unit supervisor was aware of the birth and concurred with the decision.

Recommendation: The review team, including the AA of this office, agreed that such a system would be helpful in ensuring that these situations receive the attention they need. The office intends to direct its intake staff, when they receive information of a birth to a young woman who is dependent herself or who has other children that are dependent, to document that according to policy and provide a written copy to the assigned worker and to the supervisor of that unit.

CASE 7

Referent: Educator

Age of Child at time of death: 3 months

Case Overview: The mother reported to law enforcement that she had gone to bed with her infant sometime around 10:30 the evening of November 27, 2008. The infant, mother and her boyfriend (presumed father) were all sleeping in the same bed. The boyfriend awoke around 4:30 a.m. and went back to sleep in another room in the house. The mother fed the infant at around 6:30 a.m., burped her, and then laid her across the mother's stomach in the prone position (on stomach with face turned towards mother). They both went back to sleep. The mother said she later awoke with the infant in the same position as when they fell asleep, but the child was blue and cold to the touch. Fire and Rescue was dispatched to the scene as the parents attempted to revive their

daughter. The child was pronounced dead at 9:44 a.m. Law enforcement was notified and arrived on scene around 10:00 a.m. There is a reported discrepancy in the events. A responding fireman told police that the mother went back to sleep with the boyfriend around 6:30 that morning and both adults were in same bed when the baby was found not breathing and blue in color. This information conflicts with the mother's later statement to law enforcement that the baby's father was sleeping elsewhere at the time the baby was discovered unresponsive.

Child Fatality Review #08-72, Region 5, http://www1.dshs.wa.gov/pdf/ca/08-72.pdf

Manner of Death: Natural/Medical

Cause of Death: Interstitial pneumonia

Time between Referral and Death: 19 days

Finding regarding fatality: No investigation

Allegations: *On November 6, 2008, a teacher called CPS intake and reported that the deceased child's mother had relapsed on methamphetamine. The mother told the referrer she and her children had lost their housing and were going to live in a car. The family moved around to various friends' homes. The deceased child's 8-year-old brother has Attention Deficit Hyperactivity Disorder (ADHD) and is developmentally delayed. The referrer reported he was not in school for three weeks. This referral was screened as information only.*

DSHS CA Child Fatality Review of Screening Decision:

The decision to screen out this referral appears reasonable. There were no specific allegations being reported. While there were identified risk factors, none singularly or cumulatively appear to have represented imminent risk of serious harm at the time of the intake. Just over two weeks later, CPS intake received by mail the hardcopy school report from the original call made to intake. The same intake worker who processed the call-in also reviewed the mail-in report. The worker noticed information on the hardcopy school report that had not been originally presented at the time of the call-in, and the worker documented the additional information in a Service Episode Report case note. The panel was unable to review the hardcopy school report. According to the Service Episode Report by the intake worker, the school report was discarded due to there being no previous CA case file. This was an error as there had in fact been a CPS investigation conducted previously and a case file for the family existed at the time of this intake.

The worker did document in the Service Episode Report that according to the school, the mother admitted to drug use. Additionally, it was being reported that an unnamed live-in boyfriend was involved with making and selling methamphetamine (not specified if such was occurring at the home or elsewhere). The fact that the intake worker compared the details from the hardcopy school report with what had been documented in CAMIS-GUI reflected good practice. However, the panel review members were in full consensus that the additional information found in the mailed-in school report should have generated at least further discussion with the intake supervisor about a possible screening revision or generating a new referral based on the additional information of the methamphetamine manufacturing and selling. Minimally, the intake worker might then have been directed to re-contact the referent to find out who was the primary source of the information being reported.

Recommendation: None

Action Taken: The AA overseeing regional intake has agreed to address with the intake supervisor and intake worker for general feedback the specific intake issues discussed during the Child Fatality Review. Regarding this referral, it will be used as a training opportunity during the next scheduled DCFS intake unit meeting. Primary focus will be on discussing consultation and shared decision making following additional information received on an already completed intake.

CASE 8

Referent: Social Services Professional

Age of Child at time of death: 3 months

Case Overview: On June 3, 2008, law enforcement was dispatched to the family home of this deceased child on a report that she was not breathing. Officers attempted CPR. Officers spoke to the mother who said that she found her husband sleeping on the couch, her daughter lying on his body with her face toward his arm. The deceased child's mother pulled her from her husband and noticed that she was not breathing. She called 911.

Child Fatality Review #08-27, Region 6, http://www1.dshs.wa.gov/pdf/ca/08-27.pdf

Manner of Death: Unknown/Undetermined

Cause of Death: Probable positional asphyxia

Time between Referral and Death: 3 months

Finding regarding fatality: Inconclusive

Allegations: *On March 13, 2008, staff at a hospital reported to CPS intake concerns about the behavior of the father toward his newborn daughter (the deceased child). The referrer reported the father was seen feeding the deceased child and said, "Come on, just eat the food!" The father's affect at the time was impatient and not playful. The father handled the baby roughly. The child's mother told hospital staff she had a baby die of SIDS about one year prior. The parents had good family support at the hospital. The baby was fine medically. There was no suspicion of drug or alcohol use by either parent. The Women, Infants, and Children (WIC) program was already involved with this family. The parents refused referrals to other local services. This referral was screened as information only.*

DSHS CA Child Fatality Review of Screening Decision:

Issue: [32] This referral was screened appropriately based on the information received at intake. The review team felt that further questioning of the caller may have provided more specific information regarding the parent's apparent rough handling of his infant. The AA has talked with the intake supervisor regarding follow up questions by intake when given vague information.

OFCO RECOMMENDATIONS

FOR AGENCY OFFICIALS AND POLICYMAKERS:

- **Authorize WSIPP to further study the effect of intake worker and regional variations (identified by WSIPP as the strongest predictors of risk assigned to a referral) in screening decisions on outcomes for families and children.** Specifically, examine what effect new intake procedures adopted with the implementation of Famlink has had on these variations.
- **Ensure strong quality assurance through improved training and review:**
  - Increase collateral contacts and active questioning by intake workers so that information necessary to make appropriate screening decisions is obtained.
  - Require review at a higher level by two supervisors or more if a referral is to be downgraded.

[32] This discussion of DSHS Child Fatality Review of Screening Decision is taken from an AIRS Fatality Review, which is not accessible on a public Web site.

- **Train intake workers not to rely on mandated reporters (e.g. educator at school) as a safety factor that justifies screening out a referral** when the mandated reporter who is presumed to be the "safety factor" is alleging concerns about abuse or neglect.
- DSHS CA should coordinate with Northwest Infant Survival Alliance, medical examiners and coroners, DOH and other appropriate professionals to **consider risk factors identified by statewide child death reviews in further refining CPS intake protocol on referrals pertaining to infants**. Require intake workers to gather information about the sleeping environment (to determine if there is a safe sleeping arrangement), the parent's substance abuse history even when an infant is not born with a positive toxicology screen for drugs, and the gestation of the infant to help determine the risk the caregivers pose to the child.

CONCLUSION

OFCO's data collection and analysis was facilitated by the work of many. We wish to thank WSIPP for its significant contribution to this report by analyzing outcomes of referrals to CPS. We also want to acknowledge that DSHS CA has made steady improvements over the past several years in its record keeping and documentation of data on child fatalities. We drew heavily from this data in preparing this report. We commend the Legislature's work toward making the child fatality review process more transparent and accessible to the public by requiring child fatality review team reports be posted on a public Web site. Greater transparency will lead to necessary improvements in the child protection system.

It is our hope that OFCO's report will be a first step toward providing the Legislature, DSHS CA and the public with data to support a further look at worker and regional variations in screening decisions; closer examination of characteristics to consider when CPS screens referrals on infants; and revised training of intake workers to ask more clarifying questions and make collateral contacts more frequently.

SUMMARY OF COLVILLE INVESTIGATION AND DSHS CA RESPONSE

BACKGROUND

"This is an incredible investigative accomplishment which I believe can be particularly important to those of us who are not in Colville, but deal with serious trust issues in relation to a variety of Court team players, providers, policies, changes in the law as well as foster parents, relatives, social workers, medical professionals, Child Protection Teams, law enforcement, judges, supervisors and our Agency."

–DCFS Administrator

"We are taking action immediately to improve the practice of the Colville office and reaching out to community partners to better serve the children and families in the area."

–Interim Assistant Secretary, May 21, 2009

In June 2008, the Ombudsman was asked by DSHS, in response to concerns expressed by Representative Joel Kretz, to examine child welfare practice in Colville, Washington. Between June 2008 and May 2009, OFCO met with and interviewed concerned stakeholders in the Colville area. We spoke with frustrated parents, overworked DSHS social workers, administrators and CASA volunteers; disillusioned foster parents and relative care givers, service providers, attorneys, court administrators and others about their experience with the child welfare system in the Colville area. We also investigated case-specific complaints prior to this formal request for a regionally focused systemic investigation.

Between January 1, 2007, and March 31, 2009, OFCO received 62 complaints regarding child welfare practice in the Colville, Republic, and Newport DSHS, DCFS offices. A total of 44 out of 62 complaint investigations were closed when our investigative report was released on May 6, 2009. Since then, 59 out of 62 investigations have been completed. Three remain open for investigation.[1]

In May 2009, OFCO released the results of its investigative report.[2] We found child welfare cases in which DCFS did not comply with law or policy – but perhaps even more challenging to address – our investigation revealed a culture of pervasive distrust between parties and stakeholders, poor communication and a lack of collaboration among professionals which infects day-to-day decision making and case planning for dependent children. This culture leads to unnecessary placement changes, delays in permanence for children and action or inaction that put children and families at risk of harm.

At the conclusion of our review and investigation, we understood with certainty that the Colville community cares deeply about its children and desires to improve its child welfare system. The community recognizes that as the system currently functions, it is putting children at risk of harm because of the contentious atmosphere surrounding decision making. The relationship between Colville DCFS and community professionals is sorely strained and this has an adverse impact on the quality of social work being delivered to families and children.

[1] A number of our investigative findings regarding Colville area cases are described in this report. See the "Responding to Complaints" section on page 28. Note: some adverse findings discussed in the Colville investigative report were made prior to this reporting period and are not described in this report. (Our annual reporting period is September 1 through August 31.)

[2] A copy of the full report is available at http://www.governor.wa.gov/ofco/reports/colville_investigation_2009.pdf

Colville DCFS and the Stevens County CASA program have had an unhealthy relationship that needs work. The relationship between DCFS and the medical and mental health community in Stevens County is also in need of repair. These entities openly acknowledged these problems during the course of our investigation and were candid and cooperative with the Ombudsman in pinpointing specific areas of concern.

The following case summary is an example of one of the high-profile cases in which OFCO intervened to help reunite a grandchild with the child's grandparents. This child has since been adopted by them.

The grandparents of a 3-year-old, non-dependent child contacted DCFS requesting assistance with protecting the child from her drug-involved mother and with daycare. The grandparents had cared for the child for 2½ years at the request of their daughter, a young mother who was not ready to parent her baby. The mother would show up periodically and disrupt the child's stability. The agency accepted the grandparents' request for services for daycare and gradually added other services to assist them in managing the child's difficult behaviors, including in-home parenting coaching, counseling for grandparents and child, and a bonding assessment. When the in-home counselor recommended a physical restraint technique that seemed overly restrictive in relation to the child's behavior, the grandparents refused to continue services with this provider. This service refusal, coupled with the agency's perception that one of the grandparents was behaving erratically and possibly experiencing mental health problems, led to the agency staffing the case with the Child Protection Team. The Child Protection Team recommended removing the child. The agency filed a dependency petition based upon abandonment of the child by her mother and the grandparent's "escalating potential for catastrophic harm to the child." The child was placed in foster care and psychological evaluations on the grandparents were ordered.

The grandparent's psychological evaluation found no evidence of clear mental health concerns. However, the in-home counselor had reported that the grandparent was taking multiple medications. The agency consulted with their regional medical consultant who reported that many of these drugs could have interactions that affect thinking and functioning. The evaluating psychologist recommended further assessment of the grandparent's medication regimen. CWS therefore contacted the family physician for further information. The physician stated there was no basis for the agency's concerns about overuse of medications and possible drug-seeking behavior.

Within three months of the child's removal, visits with the grandparents had been reduced to two hours a month, despite CPS's finding that the allegations of neglect by the grandparents and abandonment by the mother were inconclusive. Within another month, visits were stopped altogether after the child's therapist recommended no contact based on concerns about the grandparent's ability to maintain appropriate boundaries and about emotionality during visits. The grandparents did not have any contact with the child for 18 months. By then, the child had been placed in three different foster homes. The grandparents filed three motions to intervene in the dependency matter, denied each time by the court. They were therefore unable to respond to the allegations made against them in court.

The Ombudsman's investigation revealed much contradictory and incomplete information. OFCO made several requests at various decision points in the case that the agency seek clarifying or additional information. The Ombudsman ultimately found the child's removal and prohibition of contact had been clearly unreasonable given that there had been no founded finding of abuse or neglect by the relatives, nor evidence of clear risk of maltreatment. The Ombudsman requested a full review of the case by CA HQ, with a view to re-establishing visits and reconsidering returning the child to the grandparents. After an extensive case review, the agency changed its position. Visits were granted by the court, but the CASA recommended against returning the child. Although the court initially concurred with the CASA, over the course of the next nine months, the court agreed to transition the child to their care. The child has now been adopted.

OFCO RECOMMENDATIONS

Impartial advice and consultation from outside the local child welfare community is needed:

a. Use an outside professional mediation service that is mutually agreed upon by DCFS, the CASA program and the medical community to help rebuild trust, encourage dialogue and address specific issues needing repair.
b. Create a diverse community advisory board including members who are not connected to the child welfare community to provide advice to DCFS.
c. Improve collaboration by requiring significant stakeholders to continue to participate in the Table of 10 court improvement project[3] and other opportunities for multidisciplinary training.

Judicial leadership can assist in restoring trust and accountability:

d. Encourage the judiciary to take a leadership role in addressing accountability and information sharing by creating a culture of compliance, encouraging a dialogue about mutual accountability as a shared responsibility, and spearheading training on conflict of interest considerations among parties. Provide specific training to judiciary on availability of sanctions under the law to enforce court orders and compliance with other law, policy and procedure.
e. Encourage judiciary to conduct monthly operations meetings between significant stakeholders to encourage regular communication and help set a tone of civility and respect among stakeholders.
f. Judiciary should enforce requirement under the law that parties select a "mutually agreed upon provider" and if a provider cannot be agreed upon, the judge selects the provider so that parties in a dependency action have a level field. This will encourage parents to comply with services and help neutralize allegations that DCFS is "shopping" for providers who are supportive of their objectives.

Roles, rights and responsibilities must be clarified:

g. Provide improved and ongoing training to DCFS workers and supervisors, including at Academy, and to CASA on respective roles, rights and responsibilities of parties and other stakeholders to a dependency.
h. Clarify the investigative power of CASA to ensure CASA is not interpreting its investigative powers beyond statutory intent and standards established by the state CASA program. DCFS and CASA should develop a mutually agreed upon and legally permissible protocol on the scope of CASA's independent investigatory power.
i. Create clear standards by mutual agreement between local CASA and DCFS offices with input from statewide CASA program and Attorney General's office on what information CASA is entitled to from the DCFS case record and establish clear protocol for DCFS to provide clear

[3] In August 2008, Tim Jaasko-Fisher, Director of the Court Improvement Training Academy (CITA) conducted a "Table of 10" two day training session bringing together significant players in Stevens and Ferry counties. CITA's mission is to: "create a learning community comprised of judges, lawyer, and other professionals involved in the juvenile court dependency process. This learning community will bring together innovative research and practical solutions to improve the operations and decision making in courts deciding actions under RCW 13.34." http://www.uwcita.org/CITAv1008/tablesoften.html

and timely notice to CASA and other parties if certain information will not be released, the basis for that decision and the agreed upon process for parties to further seek such information.

The power imbalance between DCFS and parents must be addressed through effective and compassionate social work and meaningful services:

j. DCFS must communicate clearly and consistently with parents and providers not only the services which are court ordered, but the concerns which they are designed to address.
k. The judiciary and parties must ensure that services ordered are specifically designed to address the parental deficiencies which led to the need for removal of the child from the home.

Adequate notice and other aspects of due process must be followed and parents, relatives and foster parents must be treated fairly and with dignity:

l. Provide all care providers (foster and relative) with a minimum of 5-days written notice of DCFS intent to remove child from home unless there is imminent risk of harm. Notice should include a clear explanation of the reasons for the agency's decision to remove a child.
m. Require DCFS to convene a sit-down, face-to-face meeting with a care provider who is the subject of a child abuse or neglect referral that could lead to removal of the child, explain the nature of the allegations and give care provider a reasonable opportunity to respond to the allegations.
n. Prohibit DCFS from removing children from relative care providers unless CPS has made a finding that the relative has abused or neglected the child, clearly violated a court order or that the child is at imminent risk of harm.
o. Provide relatives with the right to an administrative review of agency decision to remove a dependent child when child has been in their care for six months or longer.
p. Require DCFS to inform parent both verbally and in writing what relatives the agency has considered for placement and the outcome of that consideration. Also require DCFS to consistently inform relatives with a written explanation why a child will not be placed with them.
q. Require DCFS and enforce duty of agency to adhere faithfully to notice requirements, ensure parents are represented by an attorney, treat families with dignity and respect even when it may take more time to do so, and address parents' concerns by communicating with them in a clear, compassionate manner.

The importance of relatives must be recognized:

r. Encourage DCFS to promote visitation between relatives and dependent children by incorporating into Academy training research-based teaching on current best practice for decision making regarding contact between relatives and dependent children and facilitating regular and beneficial contact. Incorporating relative and child testimonials on this subject could be a powerful teaching tool.
s. Allow relatives who have an established relationship with a dependent child in out-of-home placement to petition the court for visitation when visits are mutually agreed to by the child and relative.

Community professionals must be treated with respect and receive accurate information:

t. Amend DCFS policy and procedure to require Colville DCFS to use local community resources unless a mutually agreed upon provider agrees in writing that there is a compelling reason for use of resources outside the local community. If local resources are consistently found to be insufficient, efforts should be made to identify funding to augment local resources so they can be developed sufficiently over time to meet the capacity and needs of the community.
u. Require DCFS to provide CPT members with source documentation from service providers on cases subject to consultation and provide legal basis for withholding information if it is not being shared.
v. The AGO should collaborate with defense bar and statewide CASA program to conduct improved and ongoing training of DCFS on confidentiality requirements under the law as they relate to dependency process. Encourage DCFS workers and supervisors to staff issues of confidentiality with AGO if uncertain whether information may be shared.

Resources and DCFS leadership must be sufficient to do the job:

w. Colville demands full-time local leadership to address problems. Require DCFS to appoint a full-time area administrator.
x. Provide resources to increase judicial officers, attorneys and CASAs so an added perspective can be brought to dependency and termination cases, cases can be heard on a timely basis and contested issues can be more effectively addressed. Also ensure that sufficient resources are available to allow parents to engage in services without delay.
y. Establish weighted caseloads for DCFS caseworkers to account for long distances travelled in rural areas.
z. When funds become available, require DCFS to provide additional support staff in local offices to assist caseworkers in ensuring that parties and care providers receive timely and consistent notice of hearings and meetings, copies of Individual Services and Safety Plans and timely discovery that is updated on a regular basis.

CHILDREN'S ADMINISTRATION RESPONSE

During OFCO's investigation, DSHS dispatched a team to the Colville area. This team also concluded that, "an environment of mistrust was affecting the working relationships between the Division of Children and Family Services office and some of its partners in the professional community."[4]

In response to OFCO's findings and recommendations, on May 21, 2009, Colville DCFS released 30-day and 60-day corrective action plans. The 30-day plan required CA to further review the internal CA report and OFCO's investigative report and issue a detailed response by June 15, 2009. On June 29, 2009, the Colville office provided its detailed Response and Implementation Plan. On September 28, 2009, Area Administrator Kris Randall, presented progress made on the corrective action plans to the Ombudsman, agency officials and other stakeholders in Colville. DCFS' 30- and 60-day action plan provided by CA to OFCO, a link to the agency's Response and Implementation Plan and status updates contained in Randall's presentation are set forth.[5]

[4] DSHS Press Release "CA releases corrective action plans for Colville office," May 21, 2009, available at http://www.dshs.wa.gov/mediareleases/2009/pr09087.shtml
[5] Presentation provided to OFCO, by Kris Randall, AA for Colville and Republic, Region 1, on September 29, 2009.

CHILDREN'S ADMINISTRATION
DIVISION OF CHILDREN AND FAMILY SERVICES (DCFS)
COLVILLE OFFICE

30- and 60-Day Action Plan[6]

After initial consideration of the internal (DCFS) and external (OFCO) reviews of the operations of the Colville Office, the following Action Plan will be implemented. The department takes seriously the findings of these reports and will take action immediately to improve practice of the Colville Office.

Several recommendations from the Ombudsman will require DCFS to work in partnership with professionals in the community to change the environment of mistrust. We are prepared to act in good faith and repair these necessary working relationships.

As reflected in this plan, we will reach out to community partners to listen, learn, communicate and collaborate to begin building a healthier partnership with the community we serve.

30-Day Action Plan

1. Review the internal CA internal report and the OFCO report and issue a detailed response by June 15, 2009. Work with Mary Meinig for additional input and to clarify concerns.
2. Re-establish the Child Welfare Overview Committee meetings and meet on a quarterly basis with judges, CASAs, public defenders, Kids First Director and social workers for education, with the purpose of collaboration, communication, information sharing and cross training.
3. Continue to participate in the Table of 10 meetings that include CASAs, Stevens County Public Defender, Kids First Director, Assistant Attorney General and Court Administrator. Improve child welfare services within the community by focusing on cross training and collaboration with community partners. This group will also participate in regularly schedule brown bag lunch on June 15, 2009 and address DCFS contracting processes.
4. Area Administration will engage Dr. Leslie Waters, M.D. (part of the Colville medical community) regarding participation as the facilitator of the north county Child Protection Team.
5. Consult with Tim Jaasko-Fisher, assistant director, Court Improvement Training Academy, UW School of Law, on developing an agenda for a town hall meeting to give an overview of child welfare system to foster community meetings with stakeholders focusing on improving community relationships.
6. Area Administrator to continue meeting with Patty Markel, Stevens County CASA supervisor on a weekly basis to improve overall communication.
7. Hire an additional social worker III to reduce social worker caseload in Steven's County.
8. Collaborate with juvenile court personnel to define and outline the process for Family Reconciliation Services, Child in Need of Services, At-Risk Youth and providing packets to the court clerk and juvenile personnel defining this process.

60-Day Action Plan

1. AA assigned to the Colville Office on a fulltime basis.

[6] Verbatim 30- and 60-day action plan provided to OFCO by DSHS CA.

2. Conduct team-building meetings for the staff in the Colville and Republic offices to improve overall staff relationships and moral.
3. Request a mediator to work with the CASA and DCFS personnel to improve the overall working relationship.
4. Follow up with Mary Meinig to get additional input and suggestions for consultation.
5. Develop a Community Advisory Board as outlined by the Family-to-Family Program.
6. Recruit local providers for client services including medical, mental health, parent-child development, visitation and transportation for visitation and services.
7. Provide lessons learned training from previous fatality and critical incidents to community partners and CA staff.
8. AA to schedule individual meetings with other relevant community partners such as law enforcement, medical personnel, Department of Corrections (DOC), juvenile court, mental health, Head Start, grandparent parent group, public health nurse and chemical dependency to solicit feedback, build relationships, develop effective communication strategies and procedures to address concerns.

JUNE 29, 2009 RESPONSE BY CA TO OFCO'S COLVILLE REPORT

CA's response to the Colville report is available at:
http://www.governor.wa.gov/ofco/reports/colville_response_implementation_dshs.pdf

PRESENTATION HIGHLIGHTS FROM COLVILLE AREA ADMINISTRATOR DOCUMENTING CA PROGRESS ON CORRECTIVE ACTION PLANS AS OF SEPTEMBER 2009[7]

Child Welfare Overview Committee

Re-establish Child Welfare Overview Committee and meet on quarterly basis with Judges, CASAs, public defenders, Kid's First director and DCFS supervisors with the purpose of collaboration, education, communication, information sharing and cross training. Meetings were held on June 29 and September 14, 2009.

Table of 10

Continue to participate in the Table of 10 meetings that include representatives from CASA, Stevens County public defenders, Kids First director, AAG, court administration and DCFS administration. The purpose of the Table of 10 is to improve child welfare services within the community by focusing on cross training and collaboration with community partners.

Outcome of Table of 10

- Brown bag information-sharing sessions are being held each month and feature guest speakers from community agencies with a focus on existing resources within the community.

[7]These highlights are verbatim excerpts from the power point presentation from Kris Randall, prior Colville AA, documenting CA progress on corrective action plans provided by CA to Mary Meinig, OFCO Director Ombudsman on September 24, 2009. Ms. Randall presented this information to Ms. Meinig and other community members in Colville in September 2009.

- Table of 10 continues to meet on a regular basis to address identified goals.
  - Community stakeholder meetings – first held August 10, 2009, with Partners for our Children.

Bridges to the Medical Community

- AA to engage Dr. Leslie Waters, M.D. regarding participation as the facilitator of the north county Child Protection Team
- AA has met with both Dr. Waters and Dr. Bacon. Dr. Waters agreed to return to the Child Protection Team as an active member.

Community Stakeholder Meetings

- CA will consult with Tim Jaasko-Fisher, assistant director of the Court Improvement Training Academy of the UW School of Law, regarding the development of a community stakeholder meeting focusing on improving community relationships.
  - Meeting was held on August 10, 2009, with information presented by both Mr. Jaasko-Fisher and Mark Courtney, Partners for our Children.
  - Meetings were held in both Ferry and Stevens County.
  - 158 community members were identified and invited to attend; 81 community members attended meeting.

Improving Relationships with CASA

- AA will continue to meet with Patty Markel, CASA supervisor, on a weekly basis to improve overall communication.
- CPS and CFWS supervisor are meeting with CASA supervisor following each Child Protection Team Meeting to discuss staffing issues and difficult cases.
- To improve the overall working relationship between DCFS personnel and CASA, the AA will work with HQ practice consultants to arrange for mediation services.
  - Becky Berry, Family to Family Facilitator, provided a presentation to the CASA department
  - Through the Table of 10 Court Improvement Project an additional team building and mediation session is currently in planning phases.
- AA will work with HQ practice consultants to provide "lessons learned" training from previous fatality and critical incidents to CASA's, and CA staff.
  - Lessons learned and team building occurred on June 27-28, 2009, presented by Toni Sebastian and Marilee Roberts.

Reducing Social Worker Caseload Burden

- A new CPS social worker was hired June 1, 2009. This worker is an experienced social worker with prior experience in CA, Rural Resources Community Action Center and DSHS Community Services.
- All open positions in the Children and Family Welfare Services Unit have been filled.
- A fulltime employee returned to work assuming a half-time position which provides after-hours Child Protection Services for both Ferry and Stevens counties, alleviating the necessity of having day staff cover after hours.

Improving Juvenile Justice System

- Collaborate with juvenile court personnel to define and outline processes for Family Reconciliation Services, Child in Need of Services, and At Risk Youth.
  - Social Workers were re-assigned job duties.
  - CA staff compiled an informational brochure, letter and packets that were distributed to the Stevens County Courthouse giving detailed instruction on how to obtain services and petitions.
  - Communication is ongoing between CPS, Family Reconciliation Services and juvenile court supervisors.

Next Step to Improving Juvenile Court System

The current court calendar only allows juvenile proceedings two days every two months for scheduling contested matters. Dependency matters are often delayed due to lack of court time.

- With the reduction in the number of criminal cases being held the court has offered DCFS a potential of eight days per month to schedule contested matters.

Team Building for DCFS Staff

- Improve overall staff relationships and moral.
  - AA is working with HQ practice consultants in planning training in team building, lessons learned, and roles and responsibilities for DCFS and CASA staff.
  - Supervisors are organizing and implementing once-per-month, all-staff meetings to update staff on vital information and celebrate successes and milestones within the office.
- AA, Kris Randall, assigned to the Colville office on a fulltime basis.
  - AA reports to Colville DCFS office fulltime beginning May 18, 2009. AA's other responsibilities have been reassigned. AA has moved office from the Spokane to the Colville office.[8]

[8] OFCO was notified on December 7, 2009, via Email communication from Martin Butkovich, Region 1 RA, that "[b]ased on the organizational and program needs of Region 1," changes related to the Area Administrator Office and program oversight are effective December 21, 2009, as follows: **Brent Borg, AA,** will be responsible for the Colville and Newport Offices. He will continue to supervise Shannon Boniface, Chet Screeners and Lincoln County. **Kris Randall, AA,** will be responsible for the Colfax and Clarkston Offices. Kris will also be responsible for the two adoption units in the Spokane Office and regional adoptions.

Community Advisory Board

Develop a Community Advisory Board as outlined by the Family-to-Family Program Model.

- AA met with regional Family-to-Family program manager to discuss implementation of a Stevens County Community Advisory Board.
- Table of 10 met to discuss planning of a Community Advisory Board.
- Informational meeting held with identified community stakeholders: 41participants were invited to attend, 15 community stakeholders attended. Representatives from the medical, educational, Tribal, DOC, county commissioners, Head Start and law enforcement were not present.

Recruitment of Local Resources

- AA and regional business manager to devise strategies to increase local contracted providers for client services including medical, mental health, parent-child development, visitation and transportation for visitation/services.
- Community brown bag meetings allow for identification of existing resources and gaps in resources.

Community Partner Direct Feedback Sessions

AA and supervisors will meet with individual community partners such as law enforcement, medical personnel, DOC, juvenile court, mental health, Head Start, grandparents group, public health nurse, and chemical dependency providers to solicit feedback, build relationships, develop effective communication strategies and procedures to address concerns.

- Caregivers are being provided caregiver reports and notice of hearings to allow direct feedback to court regarding children placed in their care.
- Individual contact with community stakeholders has occurred by AA and office supervisors.

CONCLUSION

OFCO will continue to monitor progress in Colville's child welfare system and be involved as needed, on a case-by-case basis. The number of complaints received by OFCO relating to cases originating from the Colville area has declined over the past six months. We are hopeful that this trend will continue.

2009 LEGISLATIVE ACTIVITIES

OFCO facilitates improvements in the child welfare and protection system by identifying system wide issues and recommending responses in public reports to the Governor, Legislature and agency officials. Many of OFCO's findings and recommendations are the basis for legislative initiatives.

During the 2009 legislative session, the Ombudsman reviewed, analyzed and commented on several pieces of proposed legislation. Bills that OFCO provided written or verbal testimony on or those impacting OFCO directly are summarized below.[1]

Enacted Legislation

SHB 1303: Collecting child mortality reviews into a database.

(Effective July 26, 2009 - original sponsors Representatives Moeller, Green and Roberts)

OFCO highlighted concerns about the lack of a coordinated statewide child fatality review process in its 2005 Annual Report.[2] SHB 1303 recognizes the spirit of OFCO's concern. This legislation takes steps to coordinate data collection and dissemination of information from child mortality reviews. It requires the DOH to assist local health departments in their efforts to collect reports of any child mortality reviews. DOH must help local health departments enter reviews into a database and respond to requests for information from the central database. DOH is further required to provide technical assistance to local health departments and child death review coordinators and encourage communication among child death review teams.

ESHB 1782: Concerning parent participation in dependency matters.

(Effective July 26, 200 9 – original sponsors Representatives Goodman, Roberts, Walsh, Dickerson, Darnielle, Kagi and Nelson)

The Ombudsman expressed concerns about cases where poor communication between agency workers and families resulted in poor outcomes. ESHB 1782 takes concrete steps to communicate clear expectations to parents involved in the dependency process to promote their early engagement. It amends several laws[3] to expand the requirements for standard notice to parents regarding a shelter-care hearing to include:

- A description of the dependency process and DSHS' duty to create a permanency plan for the child;
- A statement encouraging parent to notify their attorneys and the court about where they would like their child to be placed, wishes regarding visitation and any service needs;
- A statement reminding parents that various hearings are legal processes with potentially serious consequences and failure to respond, participate in case planning and visitation,

[1] The Ombudsman's written testimony is available at http://www.governor.wa.gov/ofco/legislation/default.asp.
[2] See page 106 in this report for more information about child fatality reviews in Washington state.
[3] RCW 13.34.065; 13.34.145; 13.34.180; and 13.34.062 (reenacted and amended).

or comply with court orders may lead to the modification of parenting plan, entry of a third-party custody order, or the eventual permanent loss of parental rights.

This legislation also permits the court, in termination of parental rights proceedings, to consider the failure of a parent to have contact with a child for an extended period. The parent must have been provided an opportunity to have a relationship with the child by the department or the court, and must have received documented notice of the potential consequences of this failure. If a parent is not able to visit with a child due to mitigating circumstances, such as incarceration, then lack of contact does not in and of itself constitute a failure to have contact.

SSB 5510: Regarding notification in dependency matters.

(Effective July 26, 2009 - originally sponsored by Senators Stevens, Hargrove, Swecker and Shin)

This legislation expands notice requirements for parents involved in a dependency action. It adds to existing law[4] the requirement of a standard, single-page, written notice to parents regarding the consequences of failing to participate in services be attached to all Individual Services and Safety Plans prepared in children's dependency cases.

SSHB 1938: Considering post-adoption contact between siblings in adoption proceedings.

(Effective July 26, 2009 - originally sponsored by Representatives Roberts, Kagi, Angel, Walsh, Dunshee, Pettigrew, Green, Goodman, Haler and Kenney)

This legislation recognizes the importance of sibling relationships. It acknowledges that for children who have been removed from their homes due to abuse or neglect, a sibling can be a critical source of love and support. SSHB 1938 amends several RCWs[5] and requires a child's relationship with siblings and the potential benefit of facilitating post-adoption contact to be considered during the permanency planning process, and be discussed with prospective adoptive parents. When reviewing and approving an open adoption agreement, the court must encourage the consideration of the adoptive child's relationship with known siblings. The court must also inquire about the potential benefit of continued contact between siblings.

ESSHB 1961: Implementing the federal fostering connections to success and increasing adoptions act of 2008.

(Effective July 26, 2009; October 1, 2010 - originally sponsored by Representatives Roberts, Haler, Pettigrew, Kagi, Carlyle, Pedersen and Wood)

ESSHB 1961 amends several state laws[6] to implement the Federal Fostering Connections to Success and Increasing Adoptions Act of 2008, which OFCO urged the U.S. Congress to adopt.[7] This new legislation broadens youth's eligibility to remain in foster care or group care up to the youth's 21st birthday if the youth adheres to program rules and remains enrolled in

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[4] RCW 13.34.

[5] RCW 13.34.136; 26.33.190; 26.33.295.

[6] RCW 13.34; 13.34.234; 74.13.020; 74.13.031.

[7] OFCO also recommended it in its Group Care Report, and in its 2007 and 2008 Annual Report, that the Legislature should consider reauthorizing the Foster Care to 21 program in Washington state. Youth OFCO heard from during its group home site visits reported that the program had a positive impact on their lives.

a post-secondary program. Beginning October 2010, youth qualify for enrollment in the Foster Care to 21 program if they are: enrolled in a post-secondary program; participating in an employment program; working 80 hours or more per month; or incapable of participating in school, work or other activities due to a medical condition. DSHS may provide adoption support or relative guardianship benefits until age 21 on behalf of youth who achieved permanency through adoption or guardianship after age 16 if they meet the eligibility requirements listed above.

This legislation also establishes subsidized relative guardianships. It stipulates that relative guardianships must be designed to promote long-term stability and can be considered a permanent plan for dependent children.

SSB 5431: Regarding placement of a child returning to out-of-home care.

(Effective July 26, 2009 - originally sponsored by Senators Stevens, Hargrove, Regala, McAuliffe, Carrel, Brandland and King)

In our 2007 and 2008 Annual Report, OFCO highlighted long-standing concerns about the too-frequent practice of DSHS not placing children with available relatives or not returning them to former foster care placements, and made several recommendations to increase and maintain long-term placements with relatives.[8]

This legislation addresses shortcomings in placement practice that has had a detrimental impact on children and families. It adds to current law[9] that when a child is placed in out-of-home care on a dependency matter, the preferred placement of the child is with a relative or another suitable person. If the child has previously been placed in out-of-home care and DSHS cannot locate an appropriate or available relative or other suitable person, then the preferred placement for the child is in a foster home where the child was previously placed.

Enacted Legislation Impacting OFCO

2SHB 2106: Improving child welfare outcomes through the phased implementation of strategic and proven reforms.

(Effective May 18, 2009; July 26, 2009 - originally sponsored by Representatives Kagi, Roberts, Kenney and Morrell)

This legislation places an OFCO representative on the Child Welfare Transformation Design Committee. The committee is charged with selecting two demonstration sites that DSHS must contract out for all child welfare services, and developing a transition plan for implementing the performance-based contracts. The committee includes representation from a range of stakeholder groups and expires July 1, 2015.[10]

[8] OFCO's 2007 and 2008 Annual Report is available at http://www.governor.wa.gov/ofco/reports/ofco_07-08_annual.pdf

[9] RCW 13.34 and RCW 74.13.290.

[10] For a full description of the committee and provisions of this new legislation, see http://apps.leg.wa.gov/documents/billdocs/2009-10/Pdf/Bills/Session%20Law%202009/2106-S2.SL.pdf.

ESSB 5811: Concerning foster child placements.

(Effective July 26, 2009 – originally sponsored by Senators Hargrove, Stevens, Shin and Roach)

This legislation includes additions and amendments to several RCWs.[11] One provision impacts OFCO directly. It requires OFCO to provide DSHS with a written report of its findings regarding allegations of foster parent retaliation. (See page 86 for discussion of OFCO's duties and findings regarding foster parent retaliation.) DSHS must notify the Ombudsman within 30 days of receiving the Ombudsman's report of any personnel action taken or to be taken against the department employee who was found by the Ombudsman to have more likely than not engaged in the retaliatory action.[12]

Legislation Introduced but not Enacted

SB 5758: Requiring notification of the duties and responsibilities of the department of social and health services to dependent children.

This legislation was not enacted but its provisions were substantially included in ESSB 5811, which was enacted.

[11] RCW 13.34; 13.34.065; 13.34.130; 13.34.138; 13.34.145; 13.34.260; 74.13; 74.13.031; 74.13.109; 74.13.250; 74.13.133.

[12] For a full description see the session law at http://apps.leg.wa.gov/documents/billdocs/2009-10/Pdf/Bills/Session%20Law%202009/5811-S.SL.pdf

BRAAM UPDATE

In 2004, the Braam Oversight Panel was created to oversee a settlement agreement concerning specific, measurable and enforceable goals for children in the Washington state foster care system. The settlement agreement was the culmination of six years of litigation.[1] The parties to the settlement include the plaintiffs,[2] who filed the lawsuit and the state of Washington, respondents to the lawsuit.[3] Monitoring reports are due in September and March of each year, starting in 2009. These are available on the panel Web site. Barring enforcement proceedings, the settlement agreement ends July 31, 2011.

[1] Braam v. State of Washington, 150 Wn.2d 689, 712, 81 P.3d 851 (2003) (class action suit brought by current and former foster children who sought damages for harm suffered as a result of multiple placements while in the custody of DCFS).

[2] Plaintiff's Web site describing the history of the *Braam* case and current progress is available at http://www.braamkids.org/

[3] The Braam Oversight Panel's Web site, containing meeting schedules, notes and panel reports, is available at http://www.braampanel.org/reports.asp

APPENDICES

LETTERS FROM CA REGARDING IMPLEMENTATION OF DSHS CA REVIEW RECOMMENDATIONS PER 2SSB 6206

SUPERVISOR REVIEW OF CASE CLOSURE OR TRANSFER

FATALITY GRID

STATE OF WASHINGTON

OFFICE OF THE FAMILY AND CHILDREN'S OMBUDSMAN

6720 Fort Dent Way, Suite 240
Tukwila, WA 98188
(206) 439-3870 • (800) 571-7321 • FAX (206) 439-3877

September 15, 2009

Randy Hart
Interim Assistant Secretary
Children's Administration
Department of Social and Health Services
OB-2
Mail Stop: 45040
Olympia, WA 98504-5040

Re: **Implementation of DSHS/CA Child Fatality Review Recommendations per 2SSB 6206**

Dear Mr. Hart:

With the Legislature's 2008 enactment of 2SSB 6206, the Office of the Family and Children's Ombudsman (OFCO) is required to report on the status of implementation of Child Fatality Review (CFR) recommendations. OFCO recognizes that not all recommendations that arise from a CFR require implementation by the Department of Social and Health Services (DSHS) Children's Administration (CA). Some involve other agencies or entities. However, as you know, the majority of these recommendations contemplate action by DSHS/CA. For that reason, OFCO is requesting a response from DSHS/CA as to the status of CFR recommendations that pertain to your agency. We have enclosed a region-by-region breakdown of CFR and Executive Child Fatality Review (ECFR) recommendations from 2005 to 2008, taken from CA's Administrative Incident Reporting System (AIRS). It is our hope that providing this list of recommendations will assist your Regional Child Protective Service (CPS) Program Managers in responding to OFCO's request.

We would very much appreciate a written response as to the status of CFR recommendations as soon as possible, but preferably within 30 days because we intend to include this information in OFCO's 2008-09 Annual Report. If DSHS/CA is unaware of the status of a specific recommendation, then that is helpful to know as well. I appreciate in advance your work in providing us this information and look forward to continuing to work with you in the future.

Sincerely yours,

Mary Meinig
Director Ombudsman

Cc: Susan Dreyfus, Secretary of DSHS
Sharon Gilbert, Deputy Director, Field Operations, DSHS/CA

lmw 9/15/09

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
P.O. Box 45010, Olympia, Washington 98504-5010

December 14, 2009

Mary Meinig
Director Ombudsman
Office of the Family and Children's Ombudsman
6720 Fort Dent Way, Suite 240
Tukwila, WA 98188

Dear Ms. ~~Meinig~~: Mary

Thank you for the Office of the Family and Children's Ombudsman's (OFCO) preliminary adverse findings report for 2009. We are currently reviewing those cases, but given the volume of 101 cases it will take some time to review each case and the outcome. As part of our review, themes and patterns are also being identified. After we review these cases, we will provide a written response to you.

The Interagency Agreement that we just signed between our agencies establishes a better process for responding to OFCO's findings for the future. I understand that OFCO will now send a notice to our staff both in the field and here in Olympia when your office believes that we have violated a law or not followed a policy or acceptable practice. We can then respond to each case and OFCO's finding in a timely manner.

There are always lessons to be learned in these cases and it's important that those lessons provide learning opportunities for our staff as we all have a strong commitment to ensuring quality services and good outcomes for the children and families we serve. We will be tracking OFCO findings to evaluate patterns or trends in practice that need to be addressed in training or to determine if policy changes or clarifications are needed.

Again, thank you for helping to ensure best practice standards and accountability in our work.

Sincerely,

Susan

Susan N. Dreyfus
Secretary

cc: Denise Revels Robinson

CPS Investigation
Supervisor Review of Case Closure or Transfer

Investigator: **Case #:**
Date Assigned to SW: **Date Closed to SW:** **Date Sup Reviewed:**

☐ Contacted Referent ☐ Call Back indicated

☐ Updated address, phone numbers, parties to case, CA/N codes, school/daycare, work info

☐ Family face sheet

☐ Law enforcement contacted, when applicable

☐ Initial face to face completed for **all** alleged child victims Missed victim? Yes:
Timely? <Insert time>:

☐ Pictures taken of child/ren and in file, labeled clearly

☐ Pictures collected (taken by others, e.g., LE, family) of child/ren and in file, labeled clearly

☐ Audio recording completed and in file, when applicable (Sex & Physical Abuse Disclosures)

☐ Safety Assessment / Plan (if indicated, ***or*** if not indicated but needed) in file

☐ Updated Safety Assessment / Plan in file, when applicable

☐ Home visit completed - Unless credible collateral contacts clearly indicate that neglect is not occurring, make a home visit in cases of child neglect and in other cases when a home visit is necessary to complete a risk assessment of the family.

☐ Notified parents, guardian, or legal custodian of a child of any CA/N allegations made against them at the initial point of contact & did not jeopardize the safety or protection of the child or the integrity of the investigation process. RCW 26.44.100

☐ Notified the alleged perpetrator of the allegations of CA/N at the earliest point in the investigation that will not jeopardize the safety or protection of the child or the course of the investigation.

☐ Subject(s) interviewed ☐ in person ☐ by other means, state why:
☐ Subject refused to be interview – documented in case note

☐ Referred for Substance Abuse Evaluation, when applicable

☐ Relative/Professional Collateral Contact(s) made More cc's needed:

☐ Absent Parent info/notification attempted or made

☐ ICW information documented on person card, Tribal Ethnicity Identity request form (DSHS 09-761) with both parents in file, when possible

☐ Completed LEP form, when applicable

☐ Medical exam or well-child check needed on child ☐ Medical exam completed

☐ Medical records in file

☐ Medical consultation with the Child Abuse & Neglect Physician completed, when applicable

☐ Consultation with a pharmacist on prescribed or non-prescribed medications - Washington Poison Control Center at **1-800-222-1222**

☐ Child age 0-3 identified with a developmental delay referred to ITEIP (within 2 business days) **1-800-322-2588** or through the ITEIP web site http://www.dshs.wa.gov/iteip/

☐ Dental exam needed on child ☐ Dental exam completed

☐ Dental records in file

☐ Child age 0-3, NCAST Assessment completed (bonding & attachment), when applicable

☐ Plan of "Safe Care" completed, when prenatal substance exposure evident at birth contains:
(Note: This is mandatory on affected newborns)
- ☐ Medical care for the newborn.
- ☐ Safe housing
- ☐ A plan of child care if the parent(s) is employed or in school <safety>.
- ☐ A list of phone numbers and contacts for the parent(s) to call, including
- ☐ Emergency care for the newborn
- ☐ Help with parenting issues
- ☐ Help during a crisis
- ☐ A referral for the parent to necessary services (e.g., local Chemical Dependency Professional, Substance Abuse Assessment/treatment, or Mental Health Assessment/treatment).
- ☐ A referral to other resources that may be of support (e.g. First Steps, Safe Babies Safe Moms (*CPS clients are a priority population*), Parent Child Assistance Program, Public Health Department, Women, Infant and Children (WIC), etc.).

☐ Domestic Violence referral or information shared, when applicable
Statewide DV Hotline #: **1-800-562-6025** Statewide DV website: www.wavawnet.org

☐ Parent(s) and all caregiver(s) of child 0-3 provided copy of "Have a Plan" video and brochure regarding "Shaken Baby" and also given brochure on SIDS.

☐ Background Checks completed and in file: ☐ NCIC-"C" ☐ CAMIS ☐ FAMLINK ☐ Local LE ☐ ACES ☐ eJAS ☐ RSO Registry ☐ Other:

☐ Police Reports in file ☐ Court Orders in file

☐ Documented contact with CSO Caseworker, when client is involved with welfare dept.

☐ Contacted Child's school/daycare and records in FAMLINK & file

☐ Closure Summary case note completed, including justification for findings

☐ Investigative Assessment completed – Feedback:
☐ within 45 days ☐ extension required, completed within <days>:

☐ Chronology of Case – if 3 or more referrals

☐ Services offered to reduce safety threats and risk factors – Example: daycare, DV referral completed. More needed?:

☐ Sent CAPTA letter by certified mail to subject(s)

☐ Referral made on new allegations and incidents of CA/N, when applicable

☐ Hardcopy file is clean – does not contain hand written notes or doodles

Sexually Aggressive Youth (SAY) Case

☐ Assessed for:

- ☐ Whether or not the youth has been abused or neglected.
- ☐ The youth's potential for re-offending.
- ☐ The parents' willingness to protect, seek and utilize services, and cooperate with case planning.

☐ Offered family SAY services Referral made for SAY services:

☐ Filed a dependency petition as parents refused to accept or failed to obtain appropriate treatment or services under circumstances that indicate that the refusal or failure is child abuse or neglect, the department may pursue a dependency action as provided in chapter 13.34 RCW

Protective Custody or Pick-up Order

☐ Provided parent(s)/guardian(s) copy of:

- ☐ Parent's Guide to CPS
- ☐ Transfer of Custody
- ☐ Consumer Rights

☐ Reason(s) for out-of-home placement documented in case note.

☐ Documentation of Child Placement Information form provided to Foster Parents/Relative Caregiver in FAMLINK & file

☐ Relative Search or "Other Suitable Person" Search process began – Using DSHS 15-330

Voluntary Services

- [ ] Signed Voluntary Service Agreement
- [ ] Relative Search or "Other Suitable Person" Search process began – Using DSHS 15-330
- [ ] Visit completed with child within one week of case being assigned to SW
- [ ] Visit completed with caregiver(s) within one week of case being assigned to SW
- [ ] Family Assessment

VPA Placement Checklist

- [ ] Signed VPA form in file
- [ ] Visit completed with child within one week of case being assigned to SW
- [ ] Visit completed with caregiver(s) within one week of case being assigned to SW
- [ ] Documentation of Parent's receiving, "Parent's FamLinkde to CPS" in FAMLINK & file
- [ ] Documentation of relative/absent parent search in FAMLINK & file
- [ ] Reason(s) for out-of-home placement documented in case note.
- [ ] Documentation of Child Placement Information form provided to Foster Parents/Relative Caregiver in FAMLINK & file
- [ ] Documentation of relative caregivers receiving "Relatives FamLinkde to CPS" in FAMLINK & File
- [ ] Documentation of relative caregivers receiving "Kinship Care Packet" in FAMLINK & File
- [ ] Visitation plan developed and 1st visit scheduled in FAMLINK & file
- [ ] Placement/legal action updated in FAMLINK
- [ ] CHET Screen referral made (first week of placement – when you know a placement is longer than 30 days)
- [ ] Documentation of Shared Planning or FTDM meeting in FAMLINK & File
- [ ] ISSP due – when placement is over 30 days
- [ ] 30 day Health and Safety visits

Before child returning home:

☐ CPT completed, when applicable

- Any case in which there is serious professional disagreement, including disagreement by the foster parent(s), regarding risk of death, serious injury, out-of-home placement of a child, or the child's return home as a result of a decision to leave a child in the home or to return the child to the home;
- In all cases prior to return home or dismissal of dependency, when the child is age six or younger and ANY risk assessment has resulted in a risk level of moderately high or high risk;
- Cases that are opened solely on the basis of risk of imminent harm following initial investigation where there are no allegations of abuse or neglect; and/or
- Complex cases where such consultation will help improve outcomes for children.

☐ Reunification Assessment

☐ Transition/safety plan

OFCO Issues and Recommendations[1]	Zy'Nyia Nobles DOD: May 27, 2000 Age: 3	Rafael Gomez DOD: September 9, 2003 Age: 2	Justice & Raiden Robinson DOD: November 14, 2004 Ages: 16 Months and 6 Weeks	Sirita Sotelo DOD: January 22, 2005 Age: 4
Assessment/ Evaluation (Lack of)	Case records showed that the DCFS caseworker had returned the children to their mother without obtaining a psychiatric/psychological evaluation or parenting assessment despite documented concerns about the mother's mental health and parenting capacity. OFCO asked the Community Fatality Team (Team) to consider this issue (see Mandated Reporting section).	The severity and chronicity of Rafael's injuries alone suggested the strong possibility of physical abuse. However, the CWS worker did not assess his parents' risk for physical abuse. The caseworker did obtain a "psycho-social" evaluation of both parents, but this assessment was inadequate as assessment tools designed to measure the risk for physical abuse were not used and the worker failed to provide sufficient background information on the parents to the psycho-social evaluator. The case record indicates that the mother experienced ongoing difficulties caring for this child and made frequent complaints to her service providers and DCFS caseworker regarding the child's behavior. The mother described the child as self-injurious, physically aggressive and possibly developmentally delayed. The mother stated that she was having difficulty understanding his behavior and that she needed more help caring for the child. There is no indication that these complaints caused the department to reassess the parents' ability to care for this child, or obtain additional evaluations of 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.	Require greater assessment of non-parent adult caregivers in the home who will likely be providing care for a dependent child on a regular basis. 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.
Caseworker Bias	OFCO asked the Team to consider how the system can better protect against caseworker bias. Bias occurs when a CW develops an initial belief about a person or event and then becomes resistant to altering that belief even with conflicting information.	The caseworker provided information to the court and the CPT that tended to accentuate the parents' progress and minimize deficiencies.		

OFCO Issues and Recommendations[1]	Zy'Nyia Nobles DOD: May 27, 2000 Age: 3	Rafael Gomez DOD: September 9, 2003 Age: 2	Justice & Raiden Robinson DOD: November 14, 2004 Ages: 16 Months and 6 Weeks	Sirita Sotelo DOD: January 22, 2005 Age: 4
System Checks and Balances	The Team was asked to consider how the system's checks and balances were overcome. The Ombudsman noted that inaccurate and incomplete information from the caseworker undermined oversight by the court and Child Protection Team. The guardian ad litem did not appear to fulfill his independent investigation and monitoring duties. There was no evidence that supervisory or prognostic staffings occurred after 1998.			
Mandated Reporting	The Team was asked to assess the system for reporting child abuse and neglect. Specifically whether: the categories of service providers required by law to report abuse or neglect should be expanded; mandatory reporters should be required to receive training on their reporting duties; and DCFS should modify its internal system for handling abuse reports made to caseworkers in open cases. There is no evidence that anyone involved with the family, including the caseworker and other individuals required by law to report child abuse or neglect, acted on documented concerns about the children's possible abuse in their mother's care.			
Supervision			CA policy should also require that the substance of supervisory reviews, including the completed checklist, be entered in CAMIS. CPS supervisors should not carry cases and conduct CPS investigations in addition to their responsibilities as a supervisor	

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			(**see** also Caseload section). The quality of supervisory reviews suffers when supervisors are also handling case investigations, as it does not allow adequate time for meaningful case reviews and worker support.	
Monitoring/ Health and Safety	The Ombudsman asked the Team to assess **the role of in-home service providers.** DCFS relies heavily upon in-home providers to monitor the safety of children. Yet**, many service providers do not see safety monitoring and reporting as part of their role in working with families.** **In-home services** and requirements to support the family and monitor the children's safety either failed or **were never put into place** by the caseworker.	**The CWS worker did not ensure that critical in-home support services were provided to the family upon the child's return home.** A public health nurse was not assigned to work with this family, as recommended in the parents' psycho-social evaluation. The parents were not required to utilize therapeutic daycare to help address Rafael's reported behavioral issues. It is also **unclear from the record if FPS and Home Support Service providers were sufficiently trained to address child safety issues** and mental health or personality issues identified in the mother's psycho-social evaluation.		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.
Alternative Response Systems			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. CA policy should require CPS to review ARS exit summaries and determine whether ARS intervention adequately addressed issues described in the CPS referral. CA should improve oversight and quality assurance of	The department should continuously assess the need for and implement appropriate services for as long as a case remains open for supervision.

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			contractors providing ARS services. A parent's participation with ARS alone should not be used as a sufficient basis to reduce the risk tag or change a CPS intake screening decision on a subsequent referral.	
	DCFS must monitor the family after return of a child to ensure that in-home services agency indicated would be in place to support family are, in fact, in place.			**Develop and implement policy requiring regular health and safety checks for children returned to a parent's care** CA Practices and Procedures Guide establishes standards requiring caseworkers to conduct health and safety checks of children residing in out-of-home care.[1] However, the current edition of the Practices and Procedures Guide is silent as to whether health and safety checks are required once a child is returned to a parent's care. Incorporate the following requirements into either the CA Practices and Procedure Guide, or the CA Case Services Policy Manual: • In 2001, CA implemented policy requiring in-home contact with the child twice a month during the first 120 days of in-home

[1] CA Practices and Procedures Guide, Section 4421

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				placement, for children age birth to 5 years. After the first 120 days, visits must occur at least monthly. • Expedite efforts by CA to address policy issues regarding health and safety checks of dependent children in a parent's care. CA is in the process of revising department manuals. • Assure that caseworkers and supervisors are aware of existing requirements regarding health and safety visits. Make requirements for in-home health and safety checks of dependent children returned to a parent's care incorporated in the revised manuals **at least** as stringent as the current standards set forth in CA Policy 01-02.

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Caseload			CPS workers' caseloads should allow them to meet department policy and "best practices" standards.	
			AAs and RAs should be required to monitor caseloads of line workers and develop a response plan when caseloads exceed an acceptable level.	
			CPS supervisors should not carry cases and conduct CPS investigations in addition to their responsibilities as a supervisor. The quality of supervisory reviews suffers when supervisors are also handling case investigations, becuause it does not allow adequate time for meaningful case reviews and worker support.	
Definition of Child Abuse/ Neglect			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	

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			which should be considered when determining whether conditions present a substantial threat of harm to the child.	
			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. Similar statutory requirements should exist to identify and treat mental health issues contributing to the neglect or abuse of a child.	
Child Protection Teams		**OFCO identified CPT membership, the decision making process and the timing of CPT meetings as issues of concern:** • The DCFS worker failed to provide complete information to the Child Protection Team (CPT) as it was deciding whether to support the worker's plan to return Rafael home. • OFCO was concerned whether the CPT was provided with all medical reports and findings regarding the child's injuries, and reports of maltreatment after the child was returned home. • Information to the CPT accentuated the parents' progress and minimized deficiencies.		
Services (Non-Compliance)	During the three-year period before the family was reunited, case records show the **mother had not completed court-ordered substance abuse services or parenting classes.** In addition, there was no evidence that she had completed or made progress in court-	The record indicates that the **mother consistently failed to comply with her out-patient treatment.** She also insisted on changing treatment providers whom she perceived as being critical of her progress. There is no evidence that this caused the DCFS worker to reassess his support for	CPS records indicate that mental health issues were a contributing factor to the mother's alcohol abuse and child neglect. **CPS did not assess or address these concerns** (See	

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	ordered mental health counseling. Yet, the caseworker returned the children to their mother.	returning Rafael to parent's care.	Assessment/Evaluation section).	
Screening and Investigation	The **caseworker** and others required by law to report child abuse or neglect **did not act on documented concerns about possible abuse by the mother** (see Mandated Reporting section**).**	Case records indicate that Rafael sustained several severe injuries while living with his parents. Reports about these injuries were either not investigated or determined to be inconclusive or invalid by CPS workers. Moreover, on one occasion, a DCFS Child Welfare Services **(CWS) worker documented a service provider's concern about the suspicious nature of one of Rafael's injuries, but did not forward the concern to CPS for screening and investigation.**	Strengthen supervisory review of CPS investigations. Institute a standardized process for reviewing and documenting CPS investigations. Develop and implement an Investigation Master Checklist, designed to aid workers and supervisors to track investigative tasks and time requirements. Use of a checklist would assist supervisors to complete reviews in an efficient, consistent manner, verify tasks completed and identify whether any further investigative action is required. Supervisors and workers should sign off on the checklist attesting that tasks have been completed. CA should develop and implement corrective/ disciplinary action if supervisors or workers fail to comply with investigation standards. 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. CA policy should require CPS to review ARS exit summaries and determine whether ARS intervention adequately addressed issues described in the	

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			CPS referral. A parent's participation with ARS alone should not be used as a sufficient basis to reduce the risk tag or change a CPS intake screening decision on a subsequent referral (see also section on Alternative Response Systems).	

"Without your help, my grandchild would have experienced yet another setback. Instead, he is happy with his life right now..."

-Complainant/Relative

"During our difficulties [the Office of the Family and Children's Ombudsman] were [among] several groups and individuals that were incredibly supportive and helpful to us and [our foster child]. Their efforts consistently reflected a professional, thoughtful and compassionate approach to [our foster child's] safety and well-being. Our story would be incomplete if we failed to mention them . . . OFCO was a frequent source of information, support and perspective."

-Complainant/Foster Parent

"Thank you to [the Ombudsman] because they made me feel confident in my concerns throughout a process that can leave you emotionally depleted!"

-Complainant

Office of the
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An Independent Voice for Families and Children

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