

17th Annual Children's Justice Conference

### The Ombudsman's Unique Role in Child Protection and Welfare Presented by Mary Meinig, Director Ombudsman Linda Mason Wilgis, Ombudsman April 6, 2009

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## Overview

- Origin of Office
- Statutory Authority
- Ombudsman's Role
- Inquiry and Complaint Profiles
- Ombudsman in Action
- Recommendations
- The Year Ahead

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# **Origin of OFCO**

### Established in Response to Systemic Problems in Child Welfare & Protection

Created in 1996

- After death of 3 year old Louria Grace
- Sexual Abuse at OK Boys Ranch



# Authority of OFCO

- Created by Legislature in 1996 to serve as an **independent voice** for families involved in the child welfare system & children residing in state care.
- RCW 43.060A is the authorizing statute.
- Established within the Governor's office.
- Subject to Legislative oversight.



# The Ombudsman's Role

- Independence
- Impartiality
- Confidentiality
- Neutrality v. Advocacy
- Investigate Complaints & Systemic Issues
- Monitor System
- Raise Public Awareness



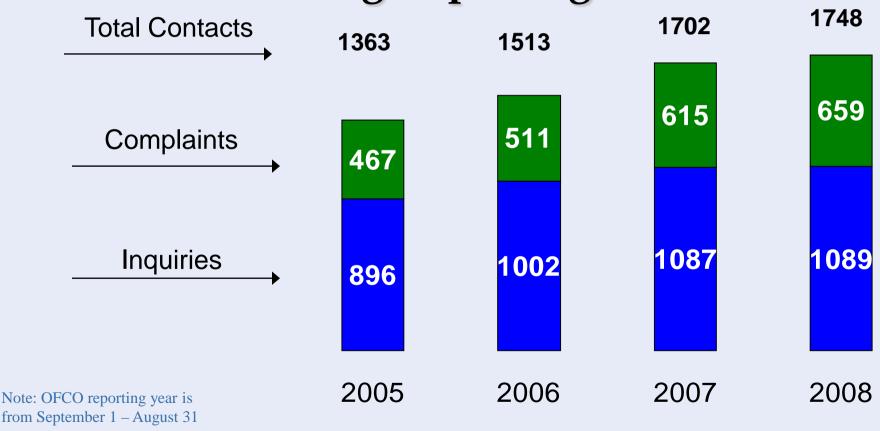
# **Investigation of Complaints**

- **Investigate** complaints: determine whether a violation of law, policy, or procedure.
- Monitor procedures practiced by the agency.
- Periodically **review facilities** and procedures of state facilities and homes serving children.
- **Recommend changes** in law, policy, and procedure to address needs of families and children.

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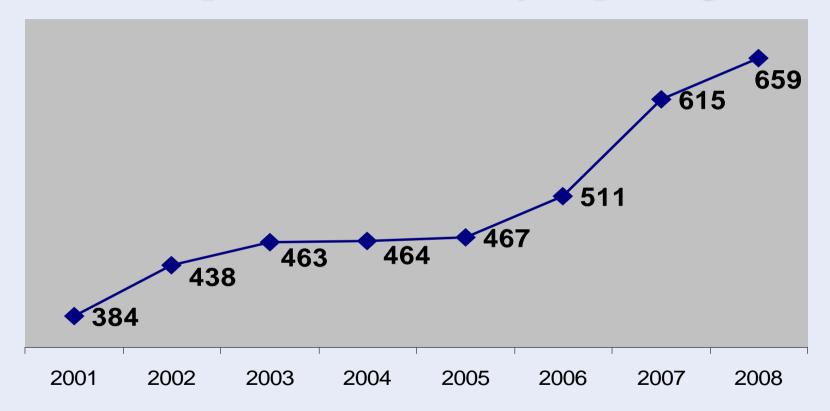
### Inquiries and Complaints Received During Reporting Year



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### **Total Complaints Received by Reporting Year**

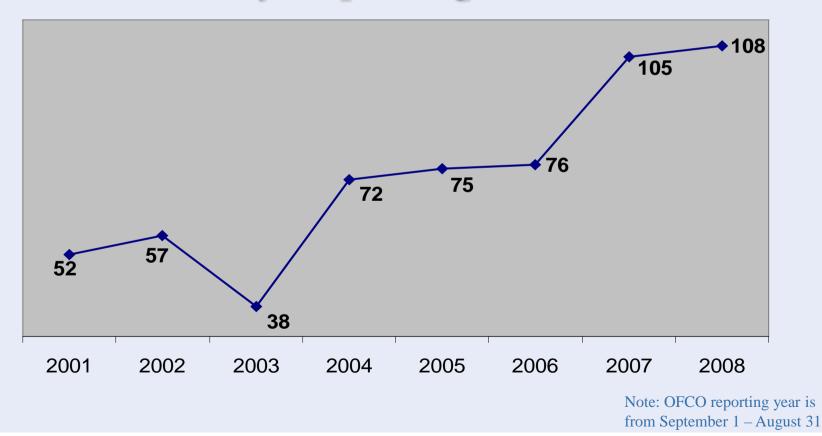


Note: OFCO reporting year is from September 1 – August 31

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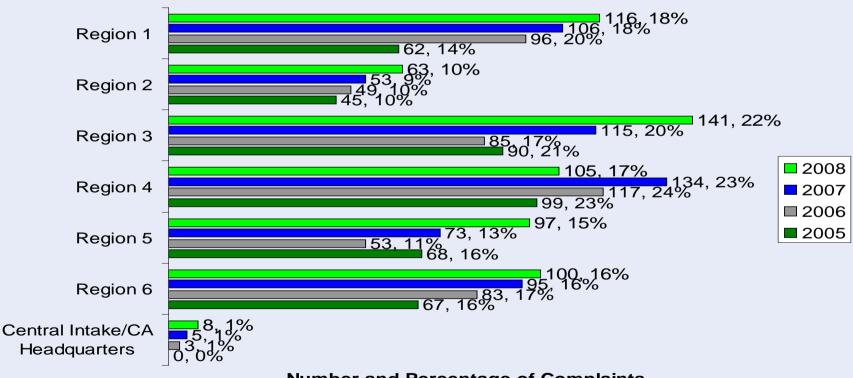


### Total Emergent Complaints Received by Reporting Year





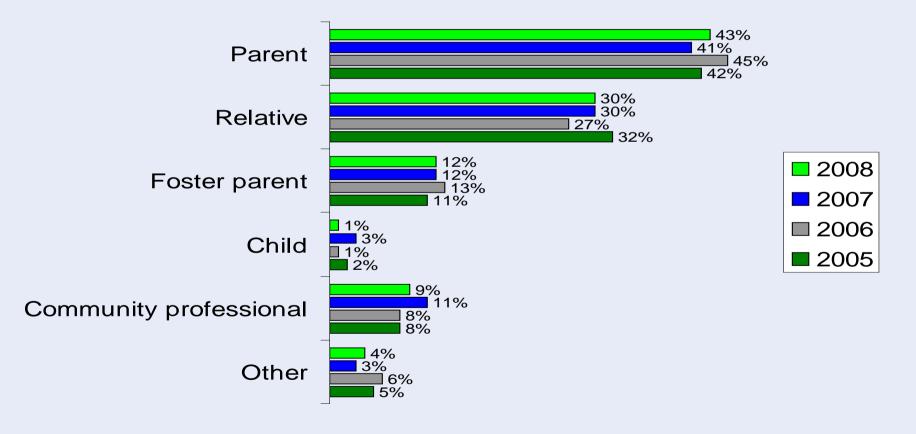
### **Complaints against the Children's Administration by DSHS Region**



Number and Percentage of Complaints

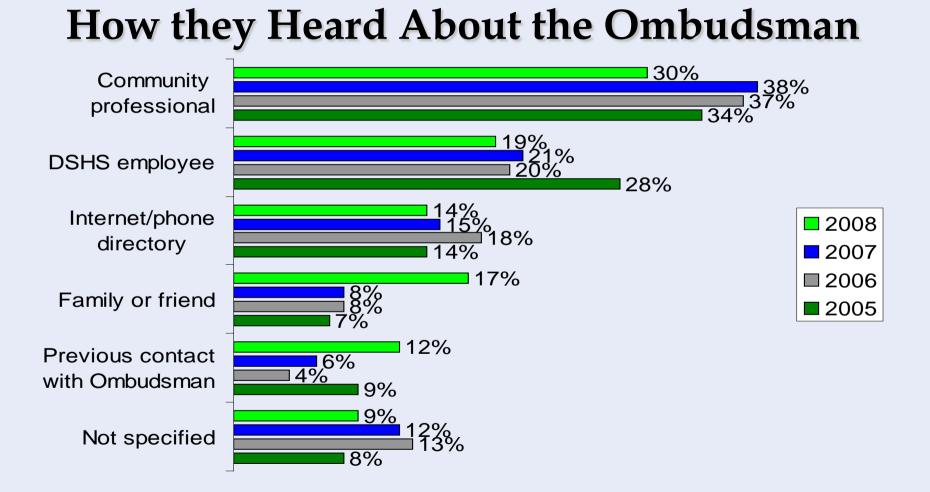


### Persons Who Complained to the Ombudsman



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Mact	of Con	OFCO	OFCO	WA State
Race/Ethnicity	2006	2007	2008	Census**
Caucasian	80.6%	80.2%	80.1%	85.0%
African American	8.6%	11.5%	9.7%	3.5%
American Indian/Alaska Native	9.0%	8.5%	6.7%	1.7%
Hispanic	3.9%	2.8%	5.0%	8.8%
Asian/Pacific Islander	1.4%	0.8%	1.8%	6.4%
Other	1.8%	0.5%	1.5%	
Multi-Racial	3.7%	4.4%	5.5%	3.0%
Declined to Answer ata adds up to over 100% because it allows po			5.6%	

\*\*Taken from US Census http://quickfacts.census.gov/qfd/states/53000.html



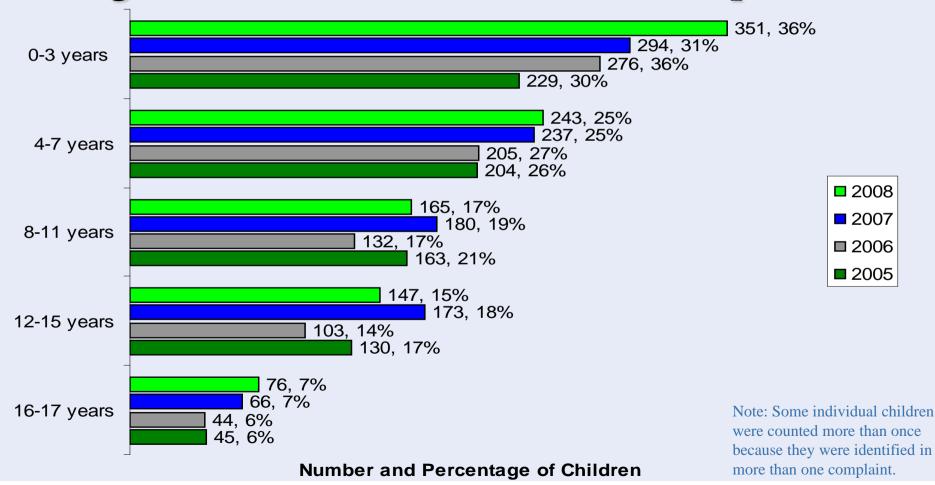
Race of Children*							
Race/Ethnicity	OFCO 2006	OFCO 2007	OFCO 2008	Children's Administration**			
Caucasian	78.9%	76.8%	80.8%	60.6%			
African American	14.7%	20.0%	17.2%	10.1%			
American Indian/Alaska Native	11.4%	11.1%	11.3%	12.2%			
Hispanic	11.7%	8.7%	12.5%	14.4%			
Asian/Pacific Islander	2.2%	1.4%	3.5%	1.5%			
Other	1.7%	1.6%	2.7%	3.5%			
Multi-Racial	9.3%	11.4%	15.5%	10.7%			
Declined to Answer		0.5%	0.1%	1.6%			

\*Data adds up to over 100% because it allows people to self-identify with multiple races \*\*Taken from Children's Administration Performance Report 2006 (http://www1.dshs.wa.gov/ca/pubs/2006perfrm.asp)

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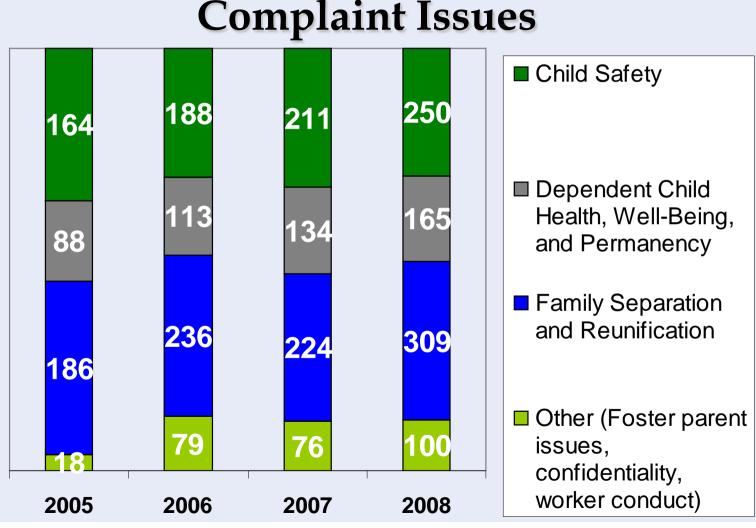


### **Ages of Children Identified in Complaints**



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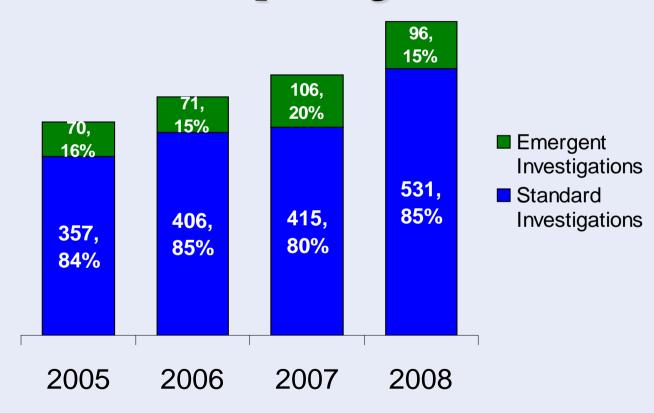


Note: Many complaints identified more than one issue.

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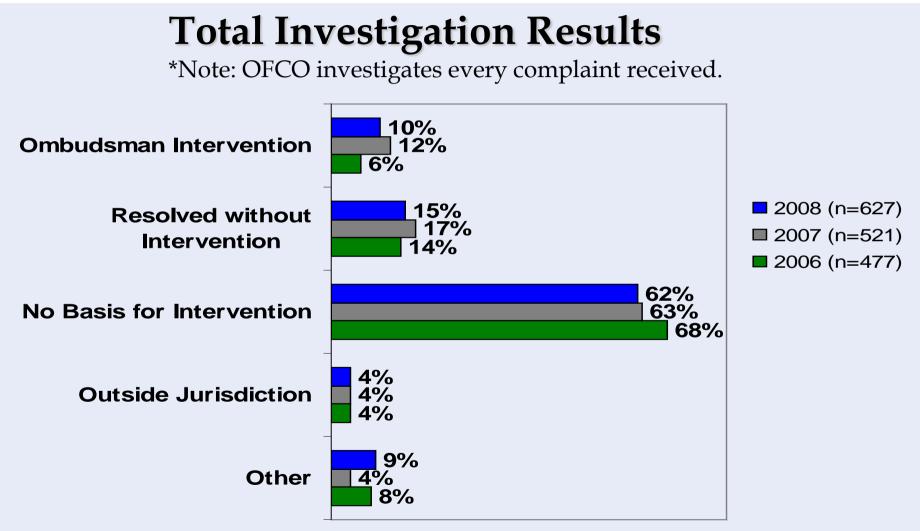


### **Completed Investigations in Reporting Year**



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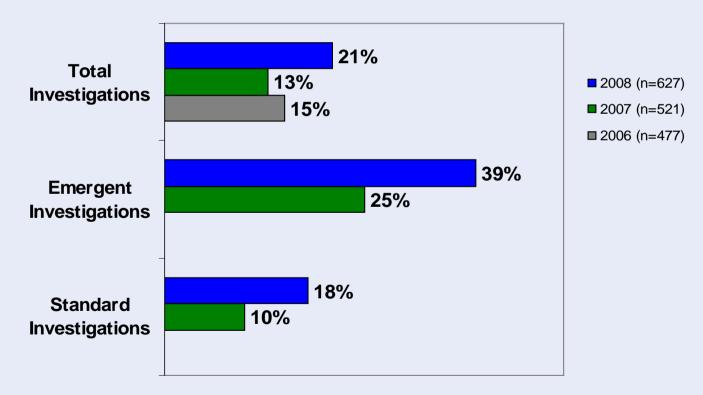


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### **Adverse Findings**

#### Percentage of Investigations with Adverse Findings





#### **Ombudsman in Action: Inducing Corrective Action** Case Example

Investigative Finding: Failure to screen in CPS referral

**Action:** CPS failed to screen in a *referral alleging abuse of a 16-year-old non-dependent youth by a sibling.* 

**Basis for agency action:** Referral did not contain specifics about the alleged abuse.

- **OFCO concern:** There was a clear allegation of abuse, and the named subject of the allegations had been charged with sexual molestation of other children in the past. The family history indicated the parents had been unsupportive of the youth's disclosure of abuse.
- **Ombudsman Action:** Requested screening decision be reviewed by CPS intake supervisor. Screening decision was upheld by supervisor. Ombudsman requested further review by the Area Administrator, who also upheld the decision.
- **Outcome:** The Ombudsman took the matter up to the Office of Risk Management at CA Headquarters. Based on their review of the referral and the family's CPS history, CA HQ directed that the screening decision be changed. The report of abuse was investigated and the family received assistance with needed services.



#### **Ombudsman in Action: Facilitating Resolution** Case Example

- **Investigative Finding**: CPS failed to screen in for investigation a *referral alleging neglect of a 2-year-old non-dependent child*. Report alleged parent was using methamphetamines and living in a truck (with the child).
- **Basis for agency action:** Agency screened out the referral based on the parent's exact whereabouts being unknown and due to no specific allegation of harm to the child.
- **OFCO concern:** The parent had a history of meth use, including usage during pregnancy with child, resulting in medical problems for the child.
- **Ombudsman Action:** The Ombudsman verified that the parent was receiving TANF and that DCFS had contact information for the parent and various relatives. OFCO requested that CPS make collateral contacts with relatives to determine whereabouts and well being of child.
- **Outcome:** CPS made collateral contacts with relatives which established that the parent had placed the child with a relative voluntarily. The child was now in a safe environment.



#### Ombudsman in Action: Assisting the Agency in Avoiding Errors and Conducting Better Practice

#### **Case Example**

- **Investigative Finding:** CPS closed a case after making a founded finding of physical abuse of a 15-year-old non-dependent child against a parent.
- **Basis for agency action:** Closure was based on the parent being charged with assault, and the child welfare agency's view that the court could order services and monitor the parent.
- **OFCO concern:** Poor practice. The parent had been investigated by CPS six times for physical abuse in the last two years, and had received two founded and one inconclusive finding in the last 5 months. Community professionals were expressing concerns about the youth's safety and well-being.
- **Ombudsman Action:** The Ombudsman requested review of the case by an Area Administrator.
- **Outcome:** The AA decided to reopen the case and offer the family voluntary services. Although the parent initially refused, further investigation by CPS revealed that the youth was at ongoing risk of harm by the parent. CPS filed a dependency petition, the prosecutor obtained a protection order, and the agency began working on placing the youth with the non-abusive parent, who was living out-of-state.



### **Ombudsman in Action: Preventing Future Mistakes** Case Example

- **Finding:** CWS failed to report injuries sustained by an 18-month-old dependent child in foster care, to the foster home licensor. The child sustained numerous injuries including a black eye, a cut on the nose, and other bumps and bruises.
- **OFCO Concern:** While abuse was not suspected, the level of supervision of the toddler was in question, and the recurring accidental injuries should have been investigated as a licensing complaint.
- **Ombudsman Action:** The Ombudsman requested a file review by the foster care licensing supervisor, to assess whether the injuries should have been reported for investigation either by the Office of Foster Care Licensing or DLR/CPS.
- **Outcome:** The supervisor found that the injuries should have been documented and reported to the licensor. To avoid future errors, the supervisor discussed the importance of making such referrals with the CWS caseworker and supervisor.



# Implementation of 2SSB 6206 (agency reviews re: child abuse, neglect, and near fatalities)

**Mandated Reporter Referral Report:** *OFCO* must analyze a random sampling of CA/N referrals from mandated reporters

**Child Fatality Recommendations:** *OFCO* must report annually to legislature on implementation of fatality recommendations.

**Notification of 3-Founded Referrals:** *DSHS CA* must notify OFCO of 3 or more founded reports on same child/family received within 12 months.

**Notification of Near Fatalities:** *DSHS CA* must notify OFCO of nearfatality of child in care of or receiving services of DSHS within last 12 months.



### Listening to Youth in Group Care

• Actively facilitate contact b/w youth & outside sources of support

•Empower youth by providing information & engaging in decision making

• Prioritize youths' needs for basic essentials

• Improve safety and quality of care through better staffing ratios and supervision

• Reauthorize Foster Care to 21 Program



### Maintaining the Family Connection

#### Recommendation: Increase Long-Term Placements of Dependent Children with Relatives

- **Stabilize and maintain relative placements** through greater scrutiny of agency decisions to remove children, and by improving communication & access to services
- **Improve access to services** by expanding the Kinship Navigator Program
- Develop and implement clear strategies to improve communication with relatives so that they feel valued and are clear on respective roles of agency and relatives in dependency proceedings



### Maintaining the Family Connection, cont.

- **Improve notice and opportunity to be heard** for relative caregivers
- **Provide adequate notice of shared planning meetings** and hearings
- **Provide relatives with a minimum of 5 days written notice** prior to a child being removed from their home and ensure that the notice explains the reasons for removal of the child
- Allow relatives who have an established relationship to play a meaningful role in the lives of dependent children



#### Live up to the Promise of Greater Permanence for Children

Recommendation: Comply with Permanency Timeframes in the Adoption and Safe Families Act (ASFA) of 1997

- **Implement consistent and improved state-wide tracking** and performance measures to ensure compliance with the Adoption and Safe Families Act. (Direct DSHS to coordinate with AGO.)
- Encourage fast-tracking termination of parental rights in cases with "aggravated circumstances."
- Remove from state law the discretion of the court to require reasonable efforts in cases with aggravated circumstances, except in those cases where the sole aggravated circumstance is "prior termination of parental rights to another child."



#### Live up to the Promise of Greater Permanence for Children, cont.

- Avoid consideration of alternate placements, even if a relative, where child has been in a safe, stable, nurturing pre-adoptive placement for 15 months or longer.
- **Appoint attorneys for children 12 and older** and retain CASA/GALs on cases involving legally free children until the permanent plan, such as the adoption decree, has been finalized and entered with the court.
- Require that all dependency cases in which a duplicative service is being ordered as to a parent be supported by a clear judicial finding on the record to support ordering such service.
- **Bolster court and agency training on "reasonable efforts"** so that services are front-loaded in the system and road-blocks to participation are eliminated.



### What's Ahead for OFCO?

### Upcoming in 2009:

- Colville Investigative Report
- In-depth Child Fatality Review Report
- Mandated Reporter Referral Report (2SSB 6206)
- Child Fatality Recommendation Implementation Report (2SSB 6206)
- Pending SB 5811 would *require DSHS to take immediate personnel action* against employee based, in part, on Ombudsman *finding of retaliation &* to *notify* Ombudsman *in writing* within 30 days of receiving the ombudsman's findings of any personnel action.