Office of the Family & Children's Ombudsman

An Independent Voice for Families and Children

18TH ANNUAL CHILDREN'S JUSTICE CONFERENCE

THE OMBUDSMAN'S UNIQUE ROLE IN CHILD PROTECTION AND WELFARE

May 10, 2010

Presented by Mary Meinig, Director Ombudsman

Protocol for Working Relationship between OFCO and DSHS

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- In November 2009, OFCO and DSHS entered into an inter-agency agreement that provides greater transparency in the work of OFCO and DSHS and accountability by DSHS in responding to OFCO findings and recommendations.

- The Agreement is available on our website: http://www.governor.wa.gov/ofco/interagency_ofco_dshs.pdf

Overview

Office of the Family & Children's Ombudsman
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- Inquiry and Complaint Profiles
- Responding to Complaints
- Ombudsman in Action
- SHB 3124
- 2SSB 6206
  - Child Fatality Recommendation Implementation
  - Recurrent Maltreatment (3-Founded reports)
  - Mandated Reporter Report
- 2SHB 2106
- Colville Report
- 2009 Annual Report available online at: http://www.governor.wa.gov/ofco/reports/ofco_09_annual.pdf

Inquiries and Complaints Received During the Reporting Year

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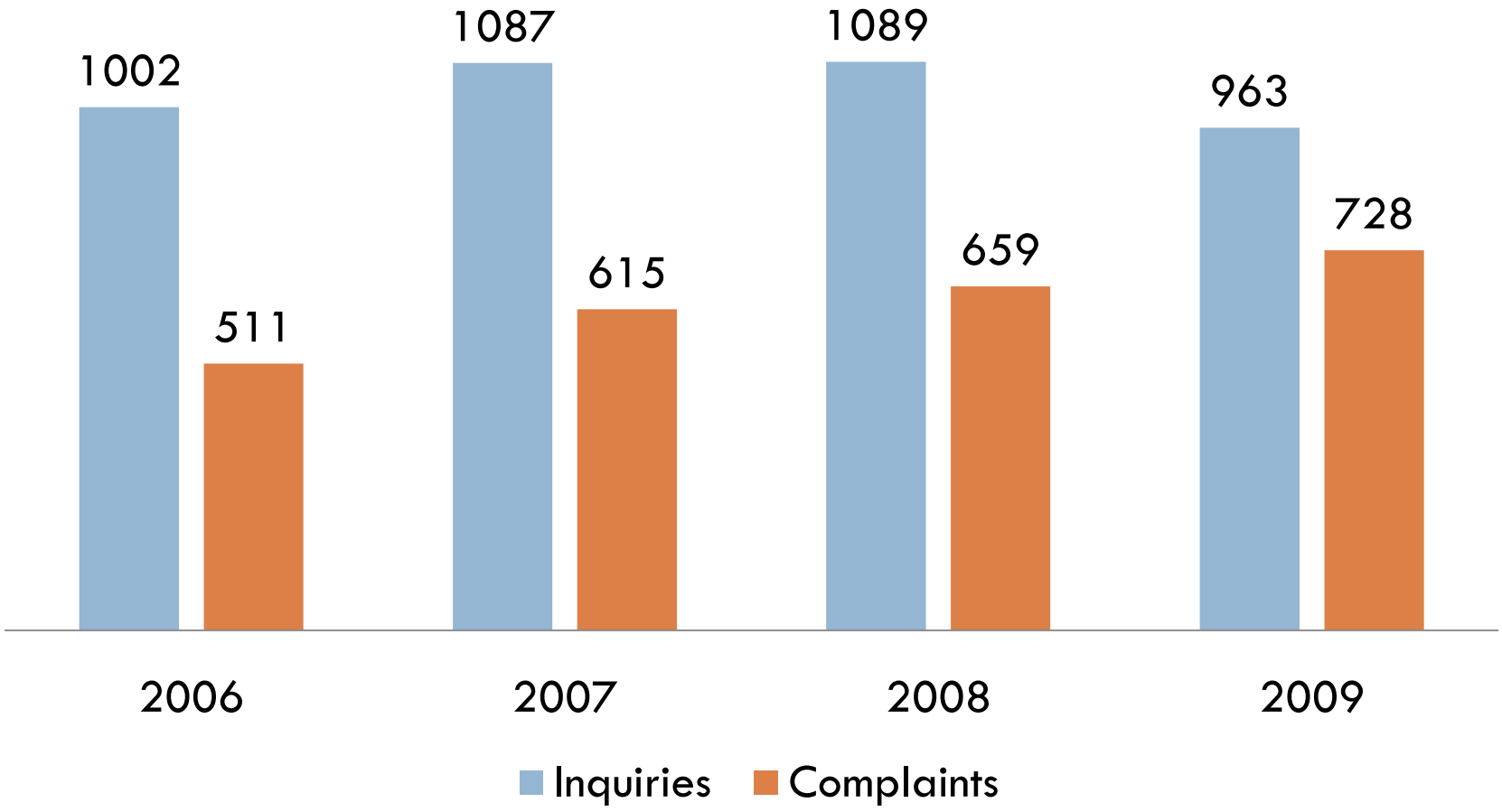

Note: OFCO reporting year is from September 1 to August 31

Total Complaints Received by Reporting year

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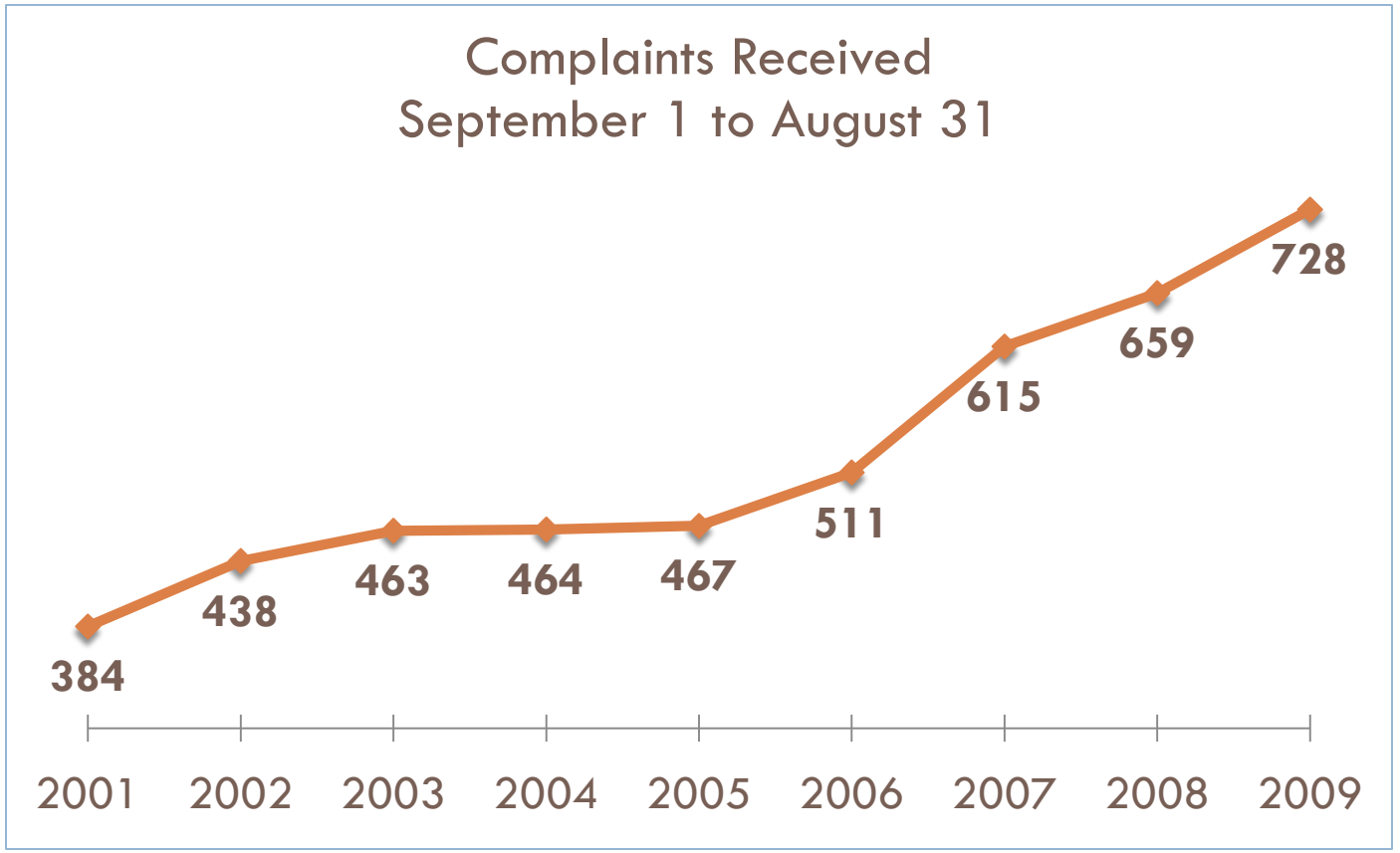

Total Emergent Complaints Received by Reporting Year

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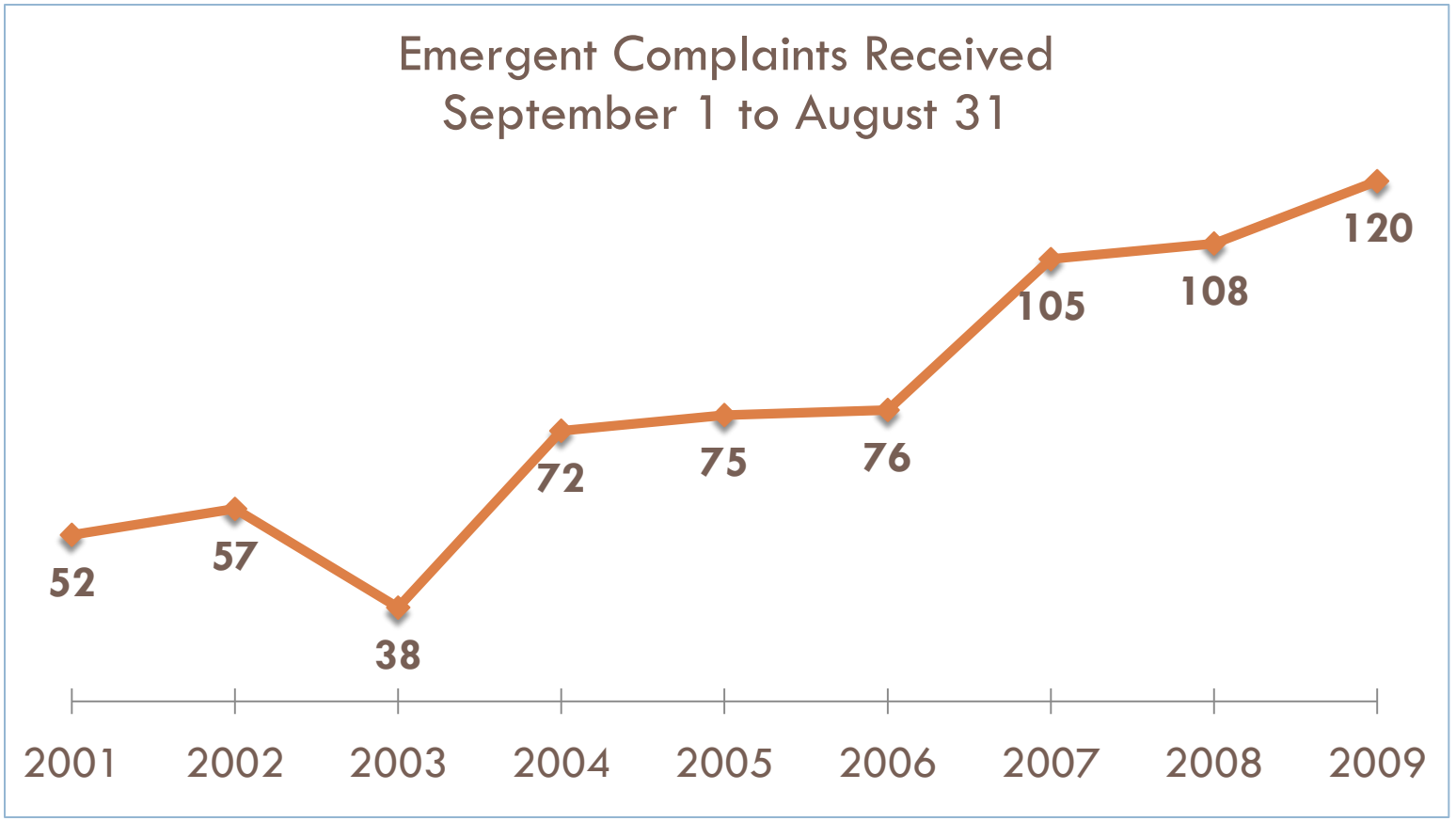

Complaints Against the Children's Administration by DSHS Region

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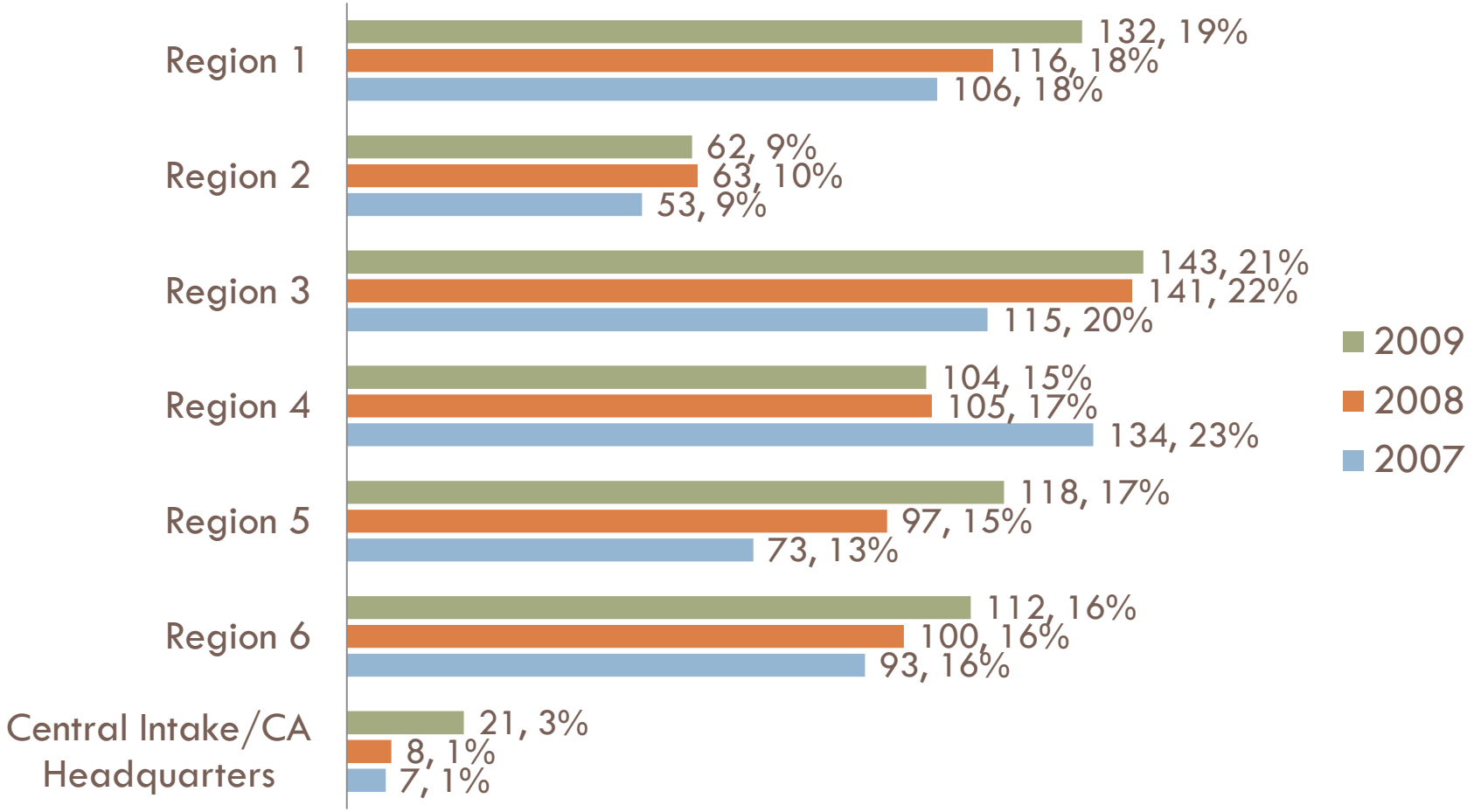

Current Open Complaints Against the Children's Administration by DSHS Region

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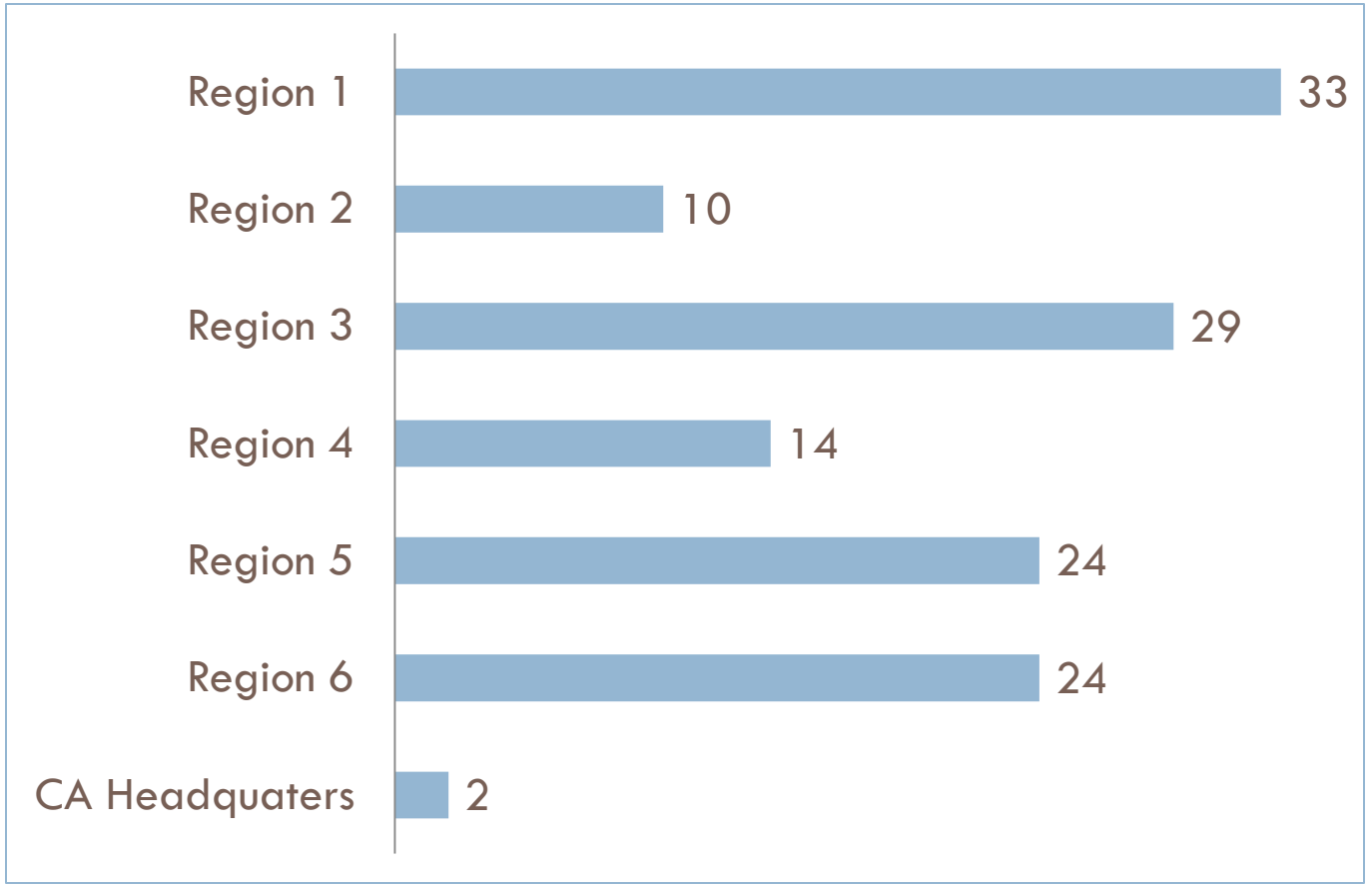

Persons Who Complained

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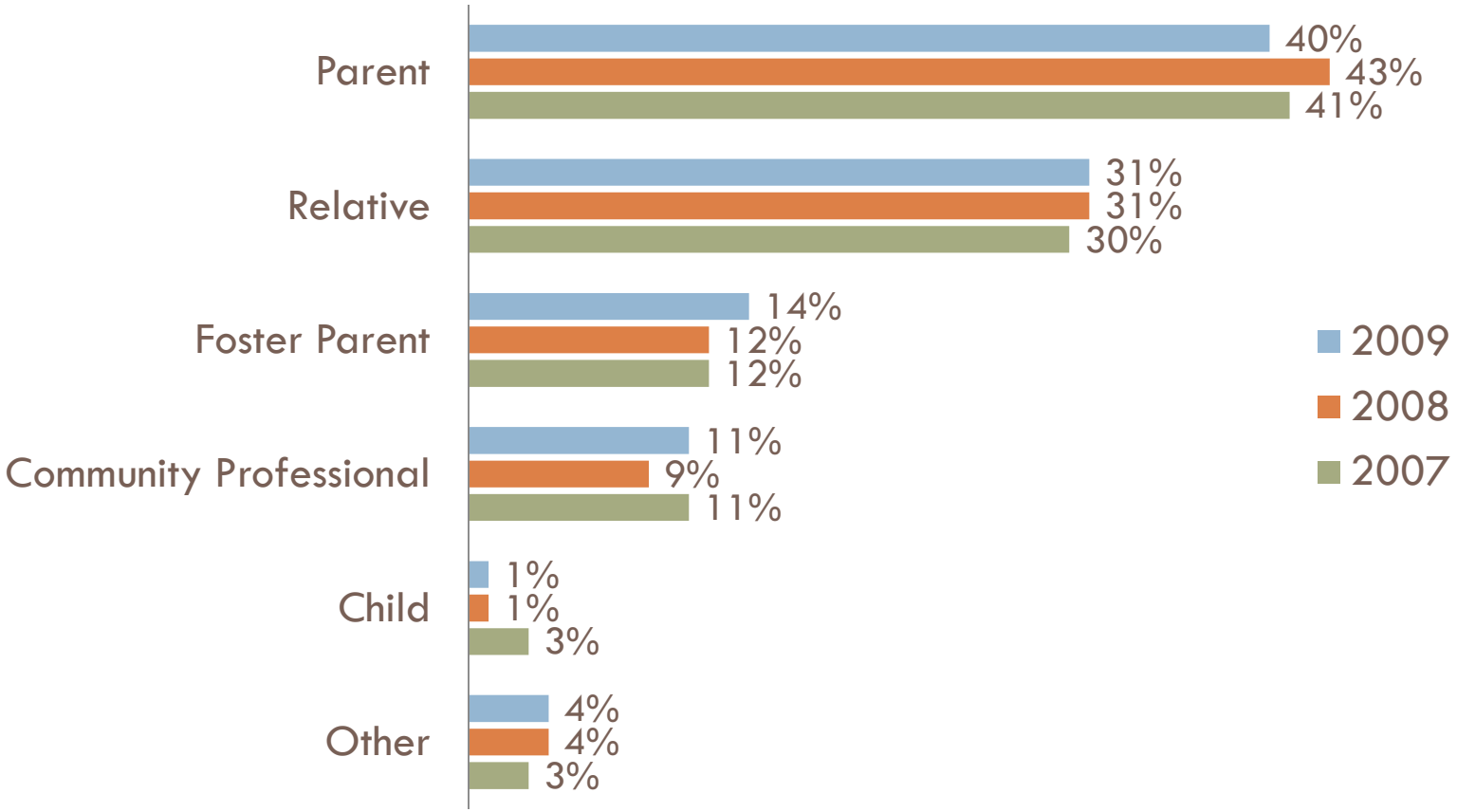

How they Heard About the Ombudsman

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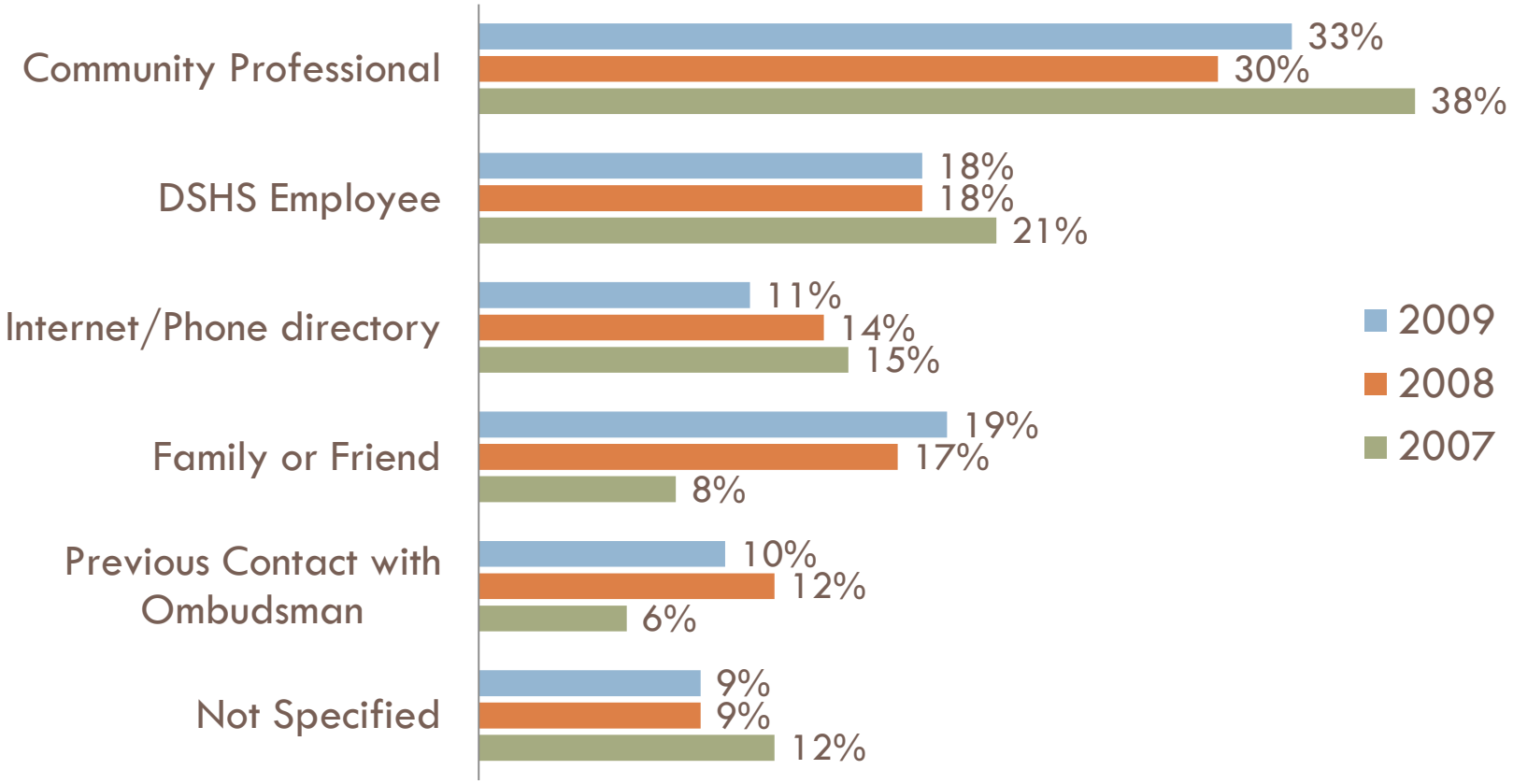

Race/Ethnicity of Complainant*

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Race/Ethnicity	OFCO 2007	OFCO 2008	OFCO 2009	WA State total pop.**
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%	3.7%
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% because people may self-report more than one race
**Taken from US Census 2008 estimates at http://quickfacts.census.gov/qfd/states/53000.html

Race/Ethnicity of Children*

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Race/Ethnicity	OFCO 2007	OFCO 2008	OFCO 2009	Children's Administration**	WA State child population**
Caucasian	76.8%	80.8%	78.8%	60.6%	80.9%
African American	20.0%	17.2%	15.8%	10.1%	4.3%
American Indian/ Alaska Native	11.1%	11.3%	12.0%	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%	3.3%	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% because people may self-report more than one race
**Race of children in placement and general child population, taken from Children's Administration Performance Report 2007
http://www.dshs.wa.gov/pdf/ca/07Report2Intro.pdf

Age of Children Identified in Complaints

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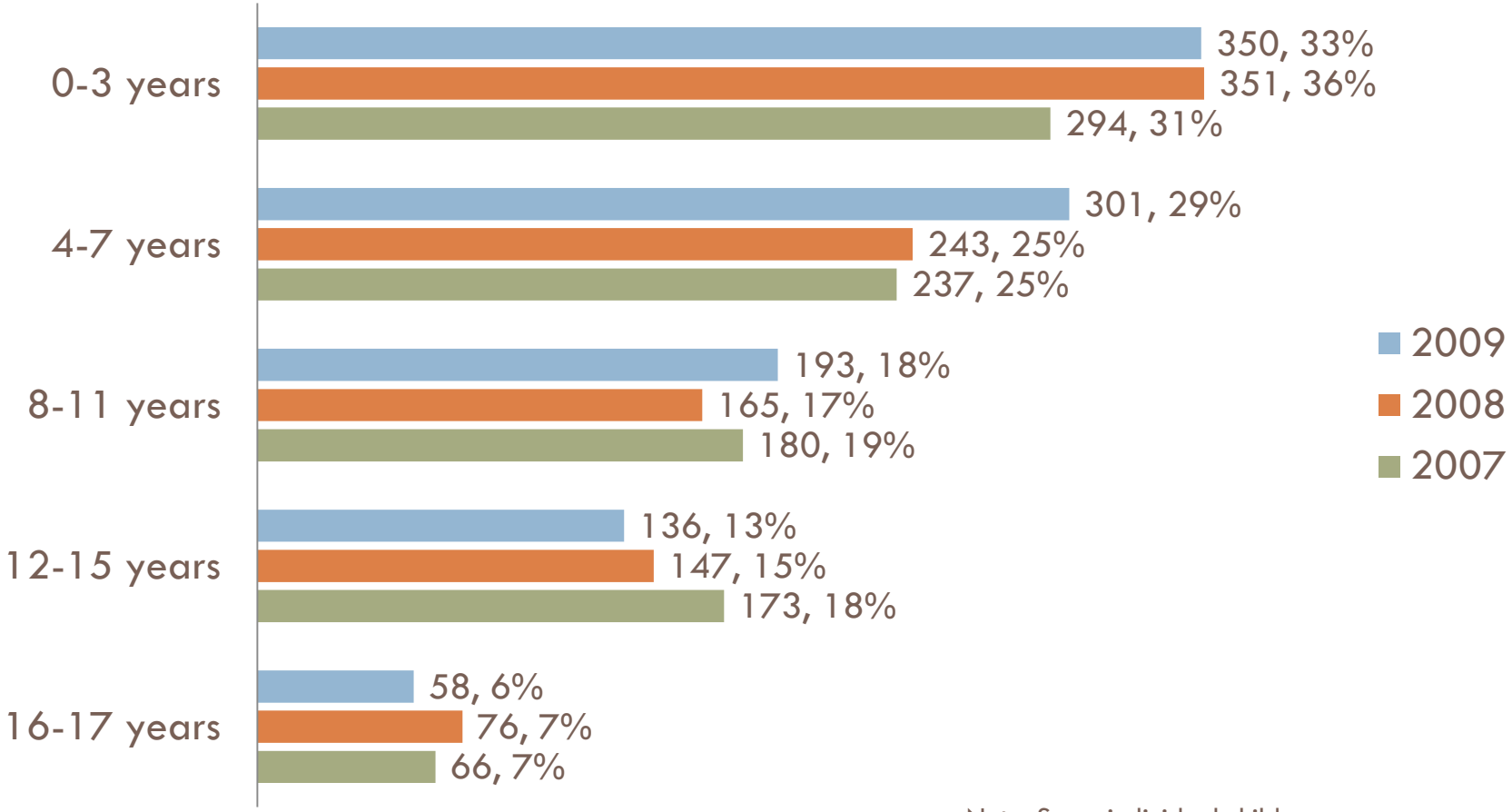

Note: Some individual children were counted more than once because they were identified in more than one complaint

Complaint Issues

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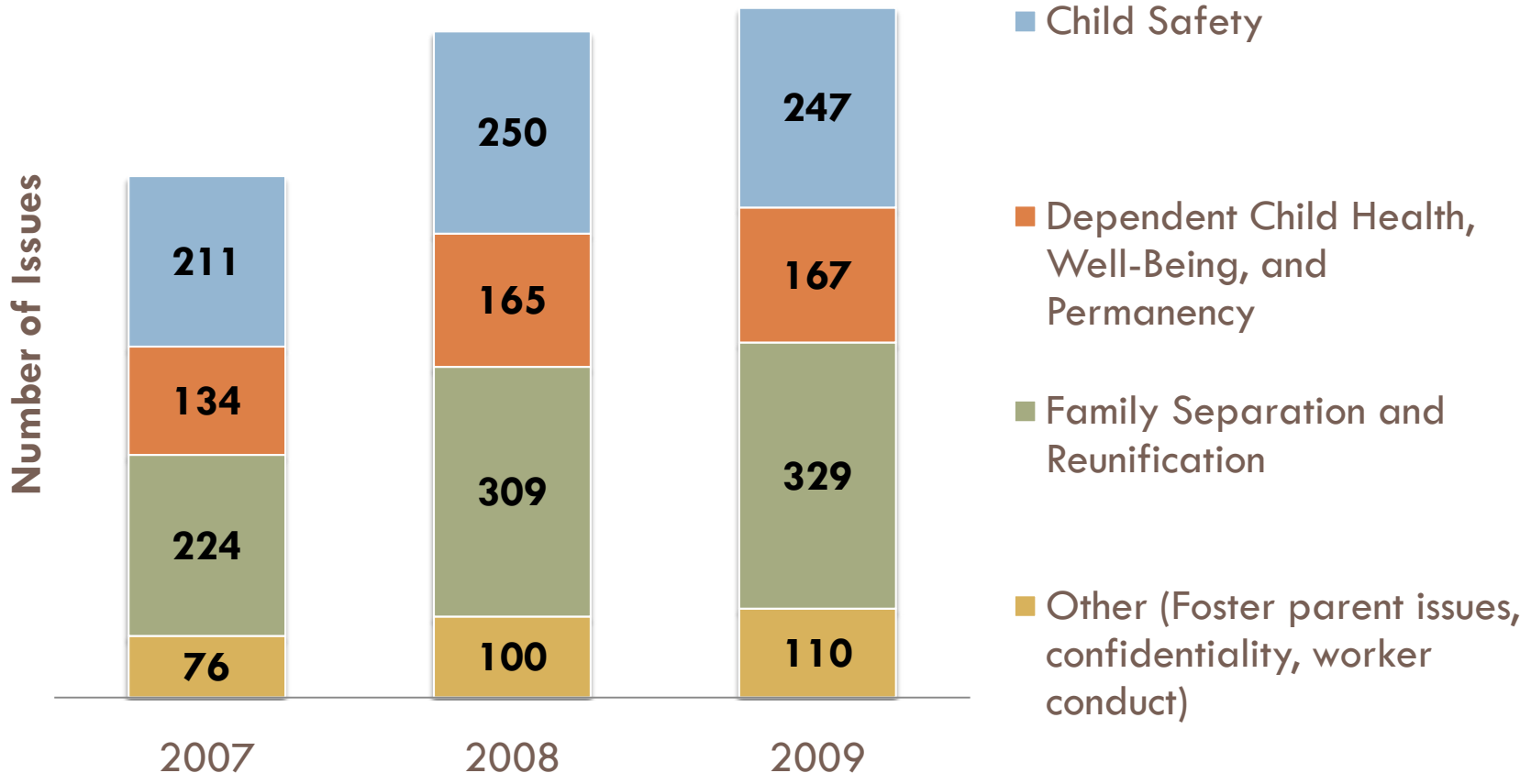

Note: Many complaints identified more than one issues.

Responding to Complaints: Completed Investigations by Year

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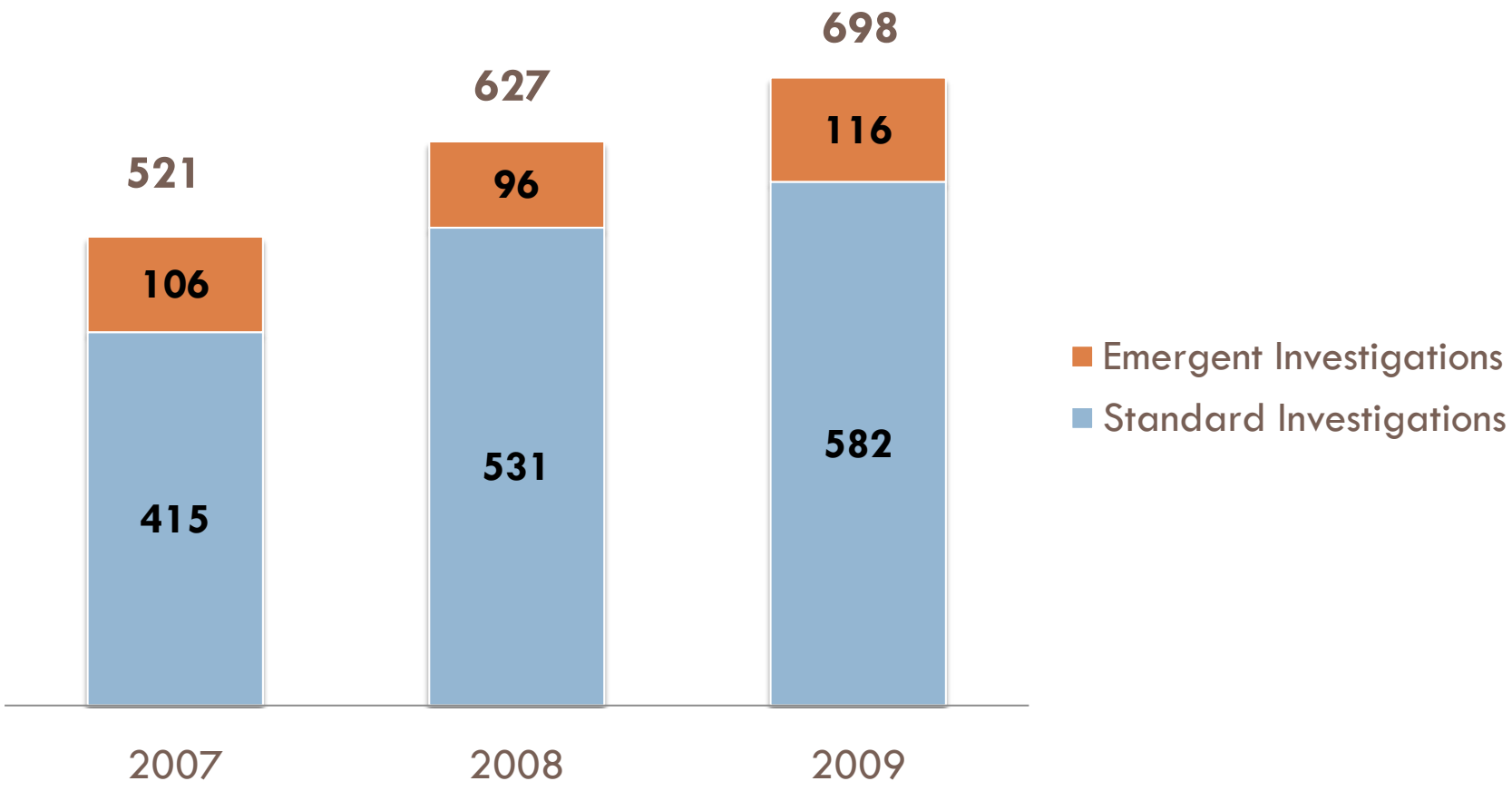

Total Investigation Results

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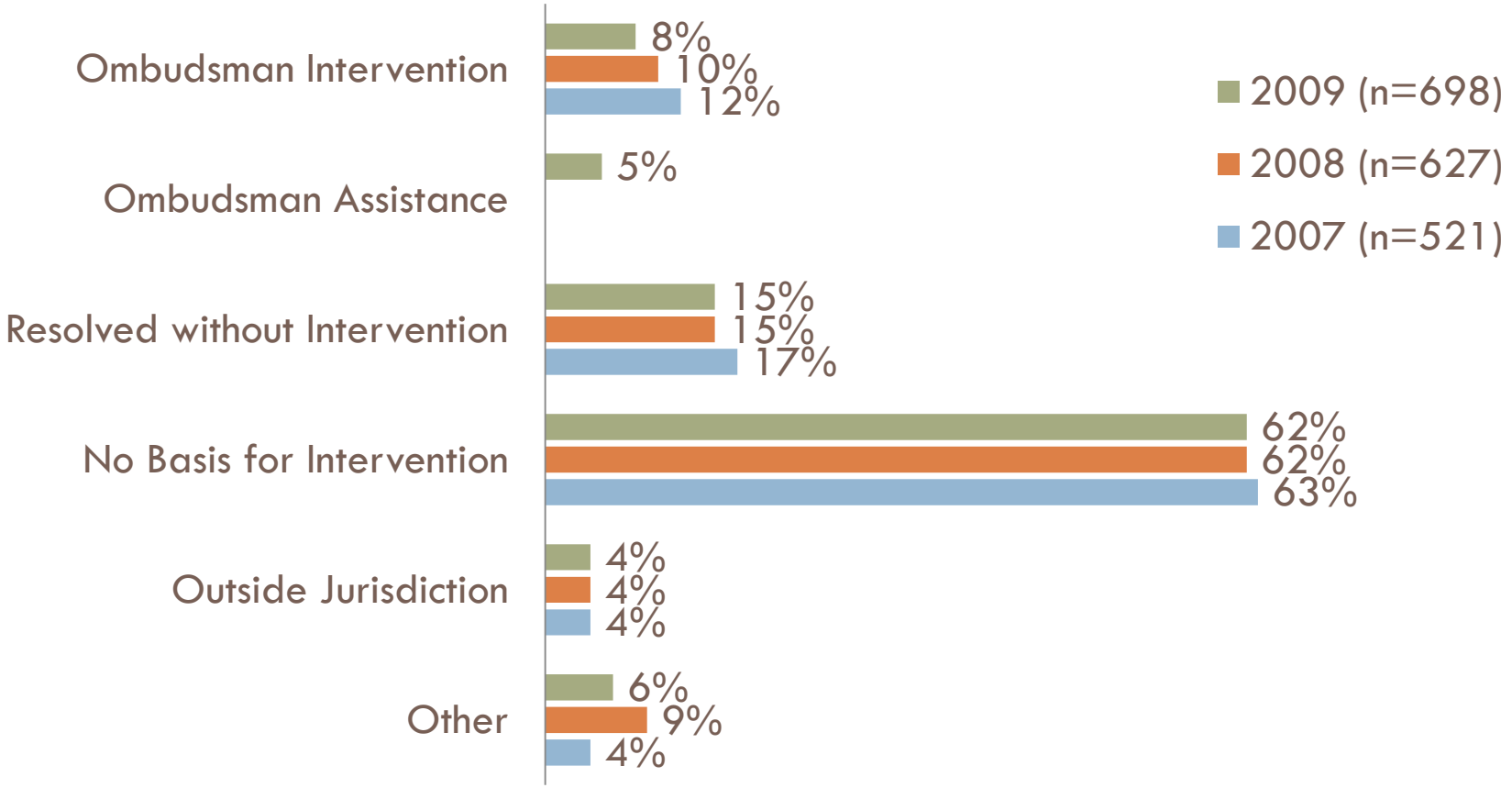

Adverse Findings

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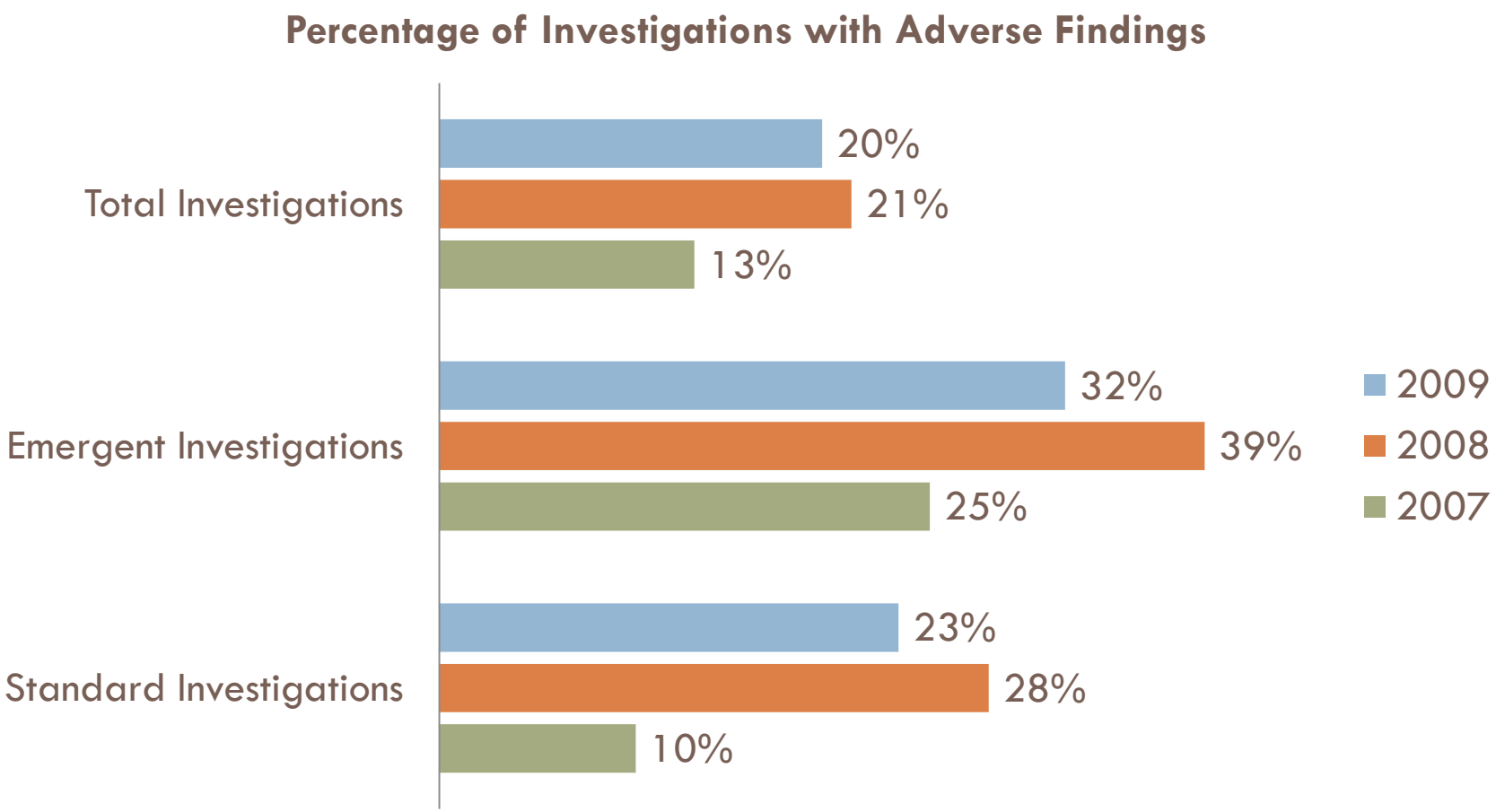

Adverse Findings by Region, 2009 Reporting Year

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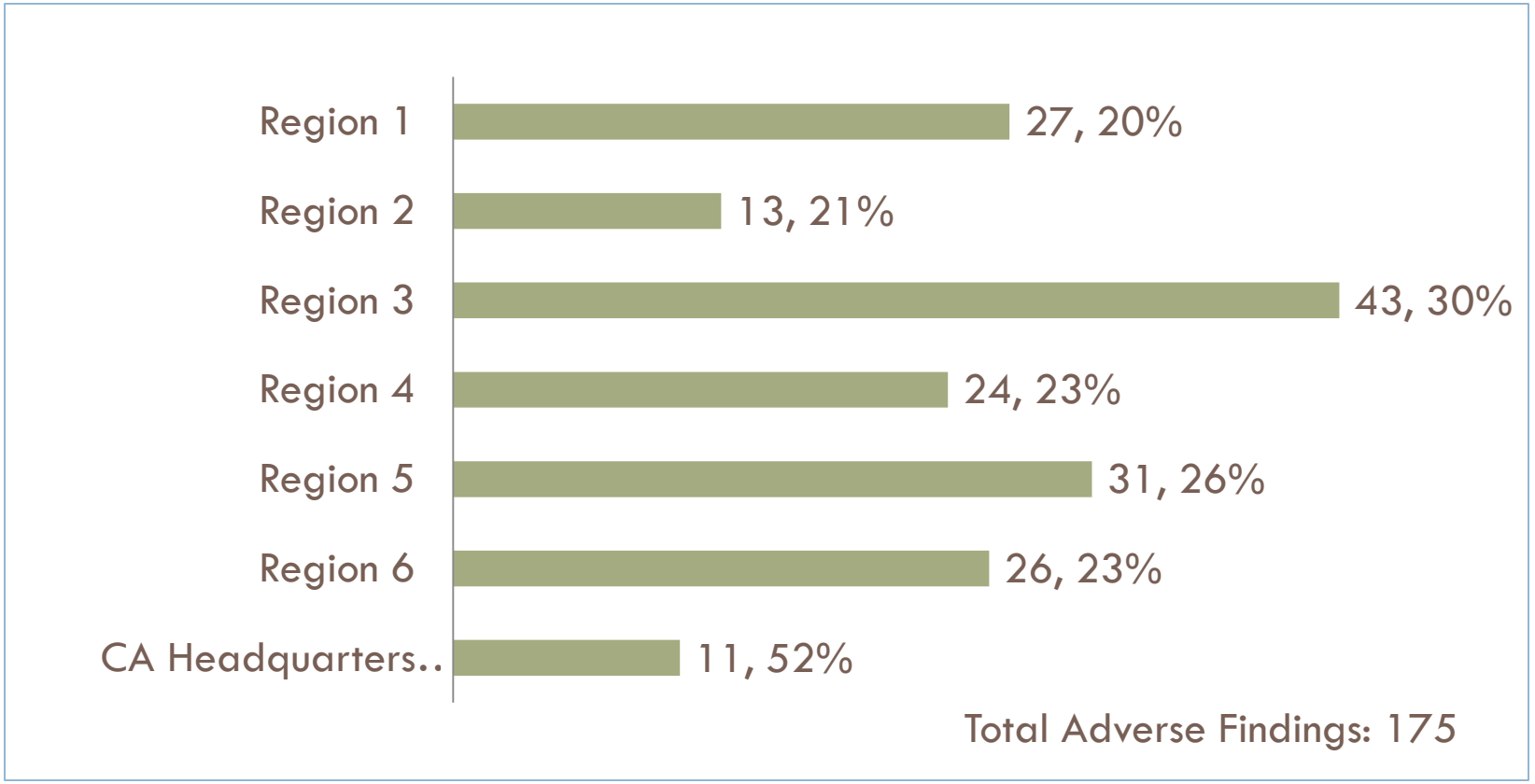

NOTE: Total Complaints by Region: Region 1-132; Region 2-62; Region 3-143; Region 4-104; Region 5-118; Region 6-112; HQ-21

Adverse Findings by Region, Specific Issues

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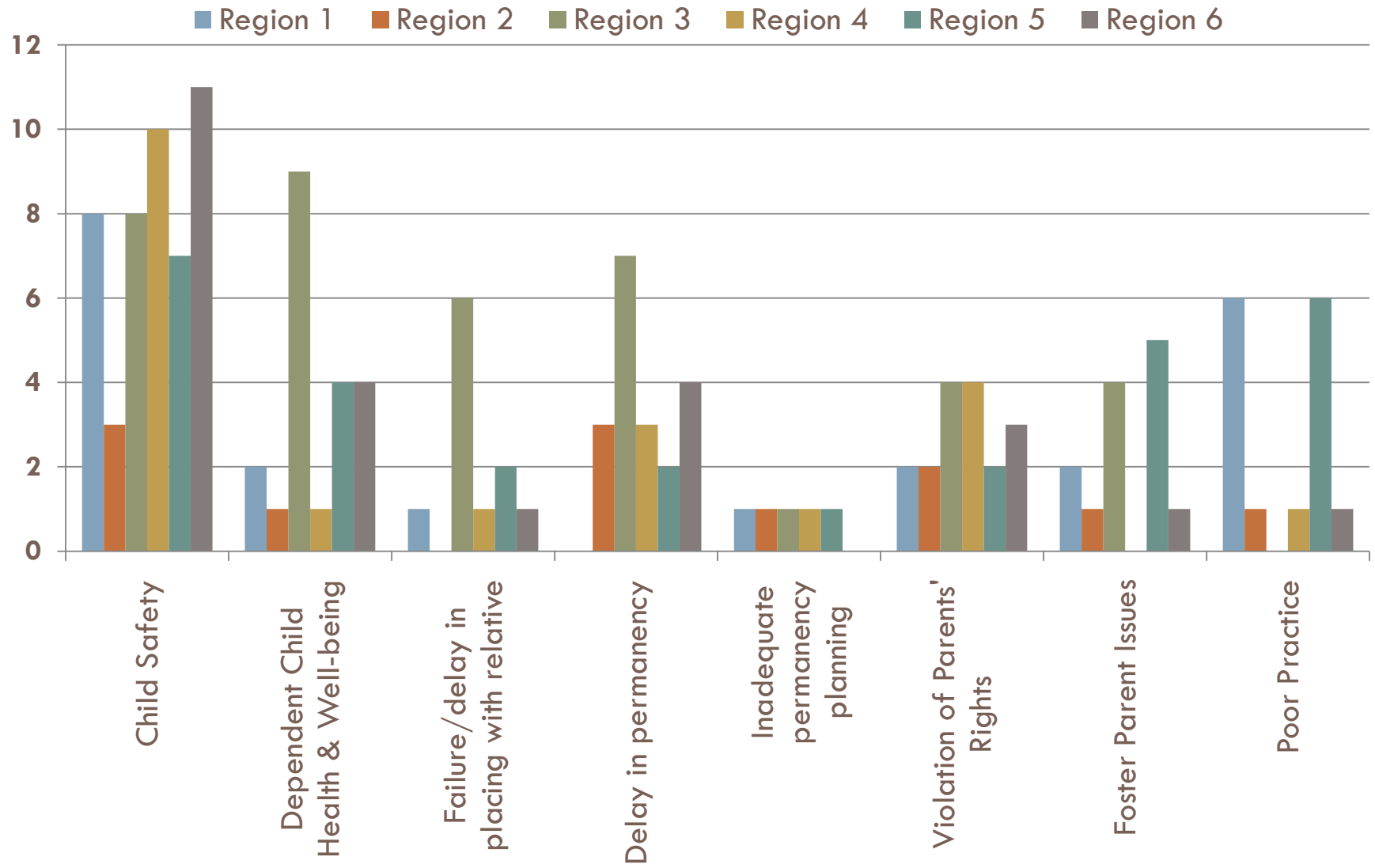

Ombudsman in Action: Inducing Corrective Action

Case Example

Investigative Finding: CWS failed to ensure that a 10-year-old dependent child had a guardian ad litem (GAL) appointed to represent the child's best interests in the dependency case. The child had been placed in 8 different placements in the past 2 ¼ years, was exhibiting serious behavior and mental health problems, and the permanency plan was unclear.

Ombudsman Action: The Ombudsman contacted the Area Administrator to request that CWS seek appointment of a GAL by the court.

Outcome: A GAL was appointed. Within two months, the child was returned to the parent and the dependency dismissed.

Ombudsman in Action: Facilitating Resolution

Investigative Finding: 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.

Ombudsman Action: The Ombudsman contacted the Area Administrator and requested that contact be reconsidered with the relative and youth's agreement that specific ground rules for the contact would be followed.

Outcome: The agency set up ground rules and allowed the contact to occur. The youth's placement was successfully maintained.

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

Investigative Finding: 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 3 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.

Ombudsman Action: The Ombudsman contacted the Area Administrator requesting that consideration be given to filing another dependency rather than relying on a voluntary agreement by the parent for placement of the child.

Outcome: The Area Administrator 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.

Ombudsman in Action: Preventing Future Mistakes

Investigative Finding: 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. Furthermore, the lack of a specific safety/supervision plan to address these behaviors may have contributed to sexual abuse of a child in foster care.

Ombudsman Action: The Ombudsman followed up with the Area Administrator regarding the apparent lack of clarity about procedures for informing foster parents about children's behavioral and other history at the time of placement.

Outcome: 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.

Ombudsman in Action: Foster Parent Retaliation

OFCO made an adverse finding of "suspicious for retaliation" in **three complaints about retaliation** against foster parents. OFCO received a total of **12 complaints of retaliation** against foster parents (about twice as many as in 2007 and 2008).

Ombudsman in Action: Foster Parent Retaliation

Example of adverse finding (and OFCO intervention):

The following actions occurred in the context of a great deal of conflict between DLR, DCFS, the foster parents, and the private licensing agency, regarding whether one of the 3 foster children placed in the home should remain there. The foster parents disagreed with the agency's plan to move the child based on the child's lack of a private bedroom in the foster home (i.e sharing a room with 2 older, same-gender foster youth).

- DLR re-screened a referral alleging lack of supervision of that child (age 12), for investigation of neglect, changing the original screening by intake as a licensing complaint about lack of supervision.
- The assigned DLR/CPS investigator originally made a finding of "unfounded" for neglect after completing the investigation. The investigator was instructed by supervisors to change the finding to "founded". None of the professionals involved in the case believed the child had been neglected.
- DLR planned to revoke the foster parents' license, as is required when a "founded" finding is made. The foster home was a BRS home and had provided excellent care (per agency records) to difficult adolescents with no history of CPS referrals.
- The Ombudsman **requested a review of the finding** by the Assistant Secretary. **The finding was changed to "unfounded".** The foster care license remains intact.

OFCO Workload:
CA Notifications to OFCO

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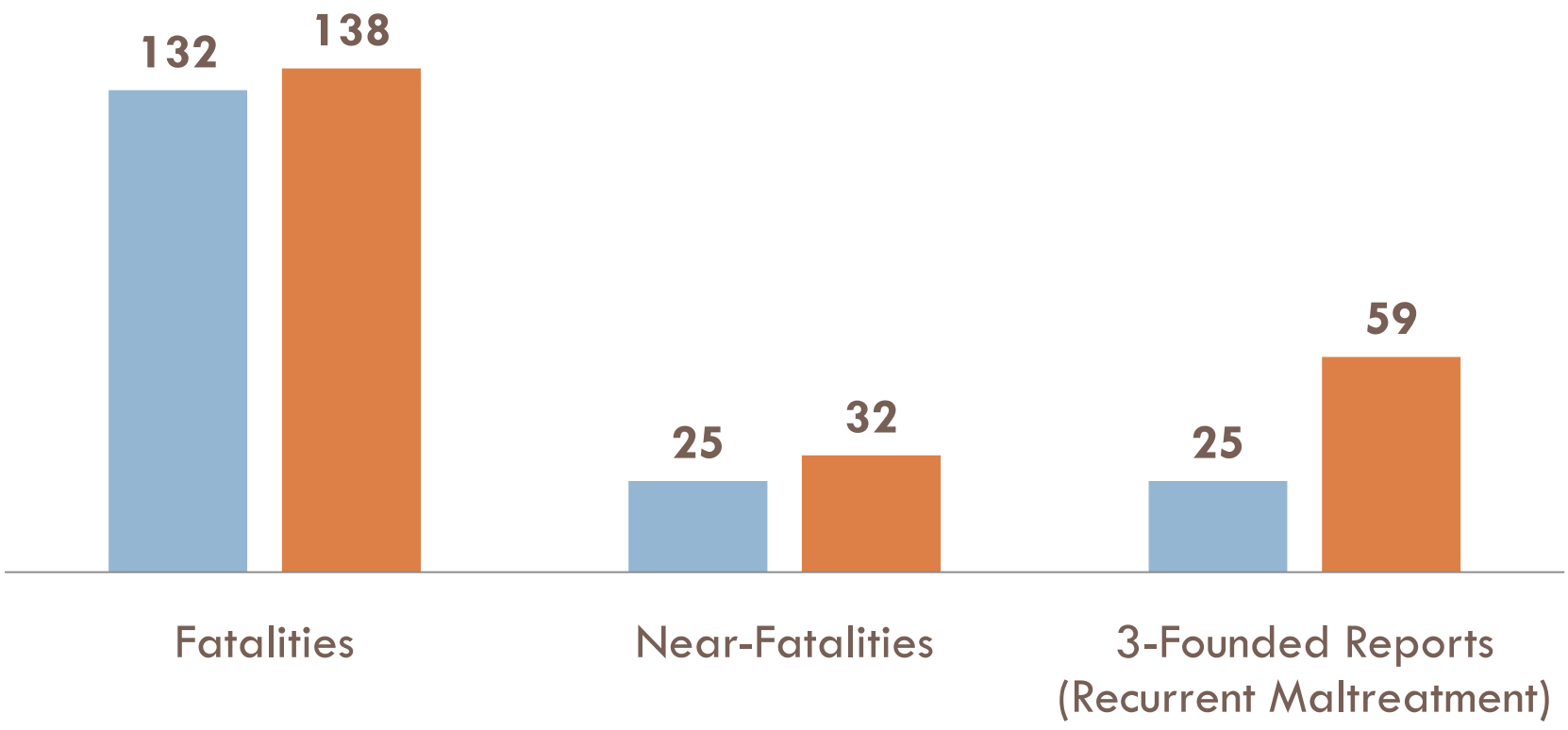

Note: OFCO reporting year is from September 1 to August 31

Ombudsman in Action: Child Fatalities Reviewed by OFCO

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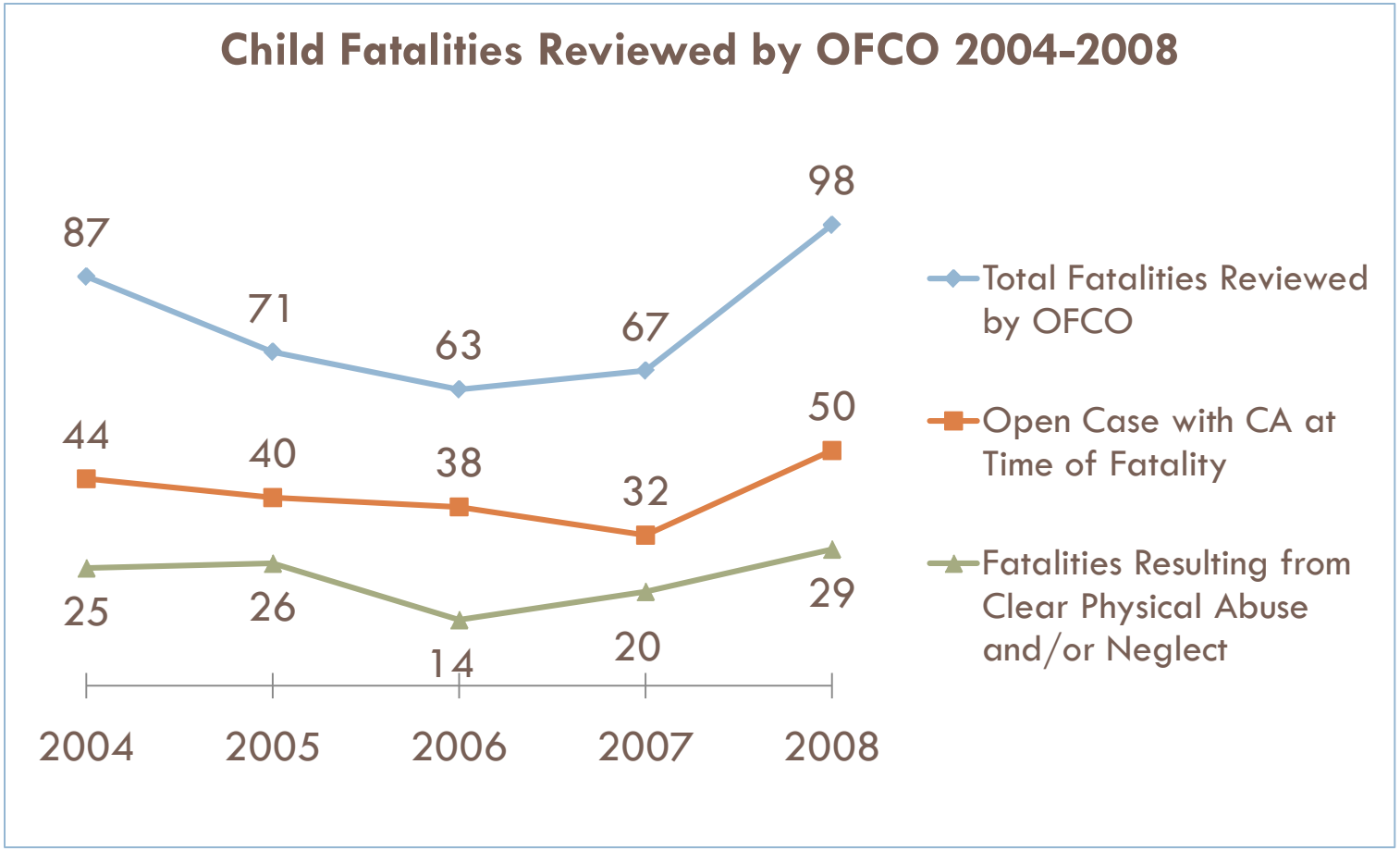

Ombudsman In Action: Child Fatalities Reviewed by OFCO

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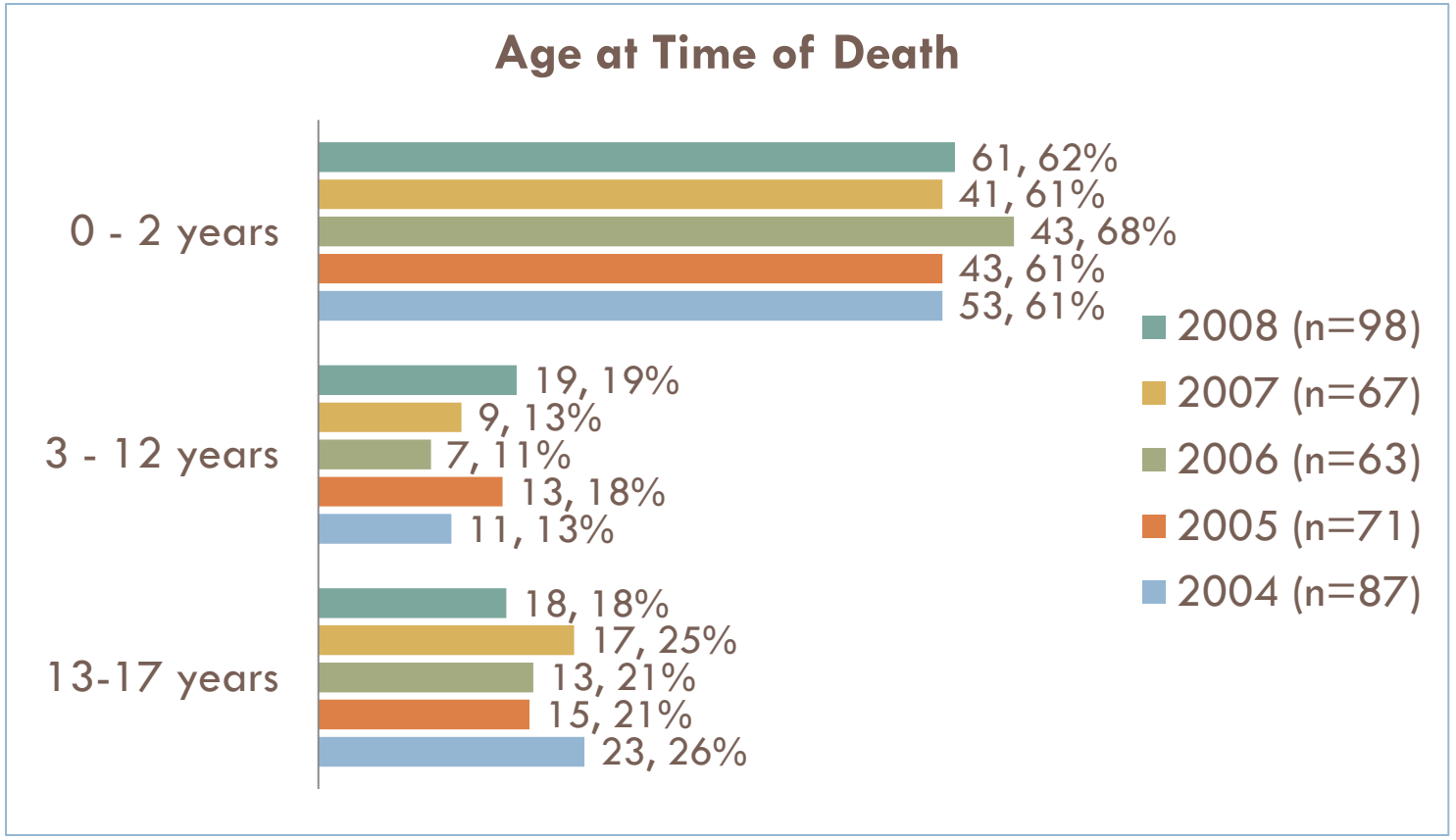

Ombudsman in Action: Child Fatalities Reviewed by OFCO

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Sleep Environment

- 44% of fatalities reviewed by OFCO documented unsafe sleep environment at time of death
- Approximately 1/3 of deaths reviewed by OFCO documented bed-sharing at time of death
- Percentage of fatalities that document bed-sharing increased in 2008

Ombudsman in Action: Child Fatalities Reviewed by OFCO

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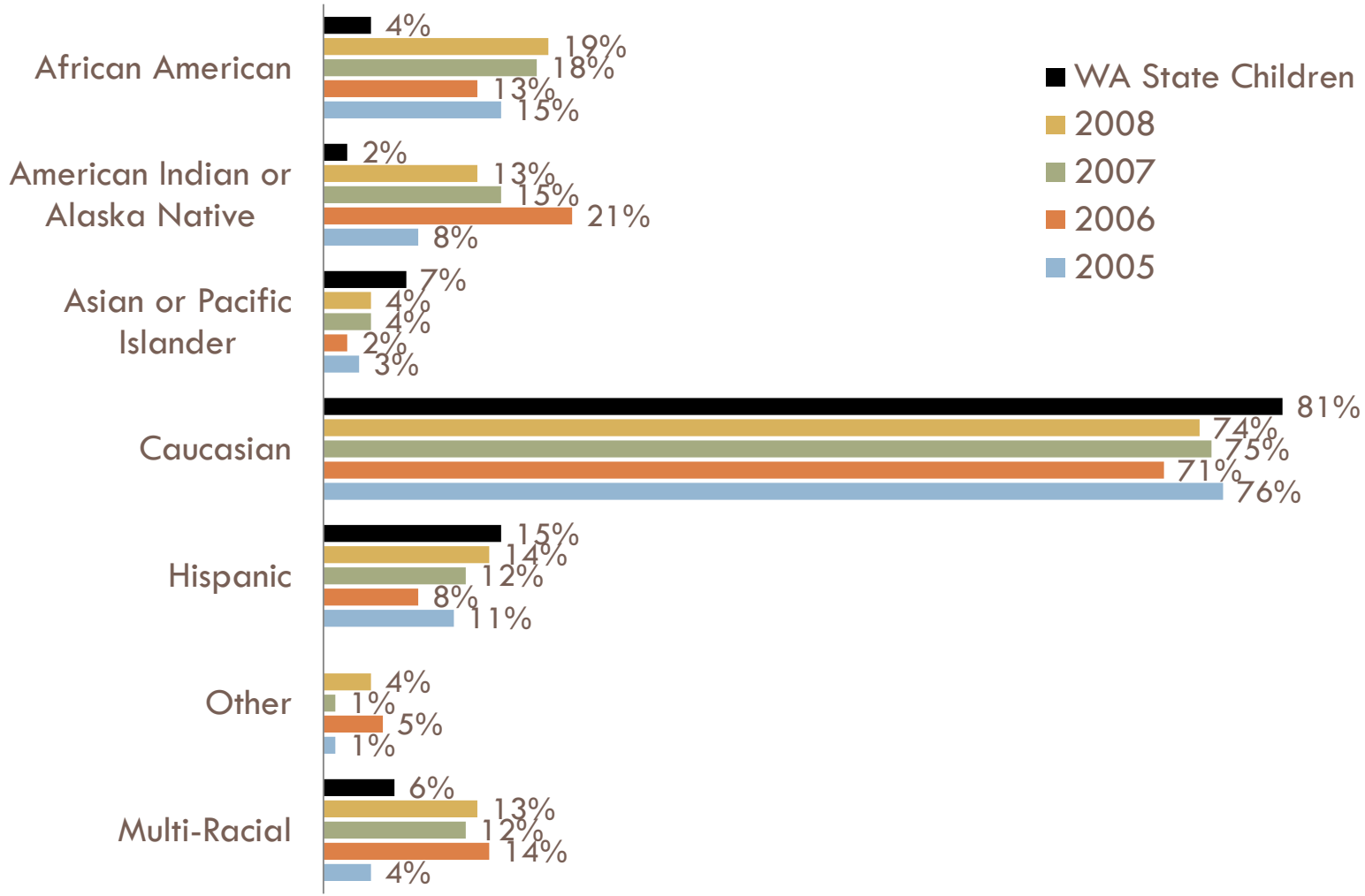
Race of Child by Year Compared to State Population



SHB 3124

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- **Brief Description:** Requiring a report to child protective services when a child under 13 years of age is present in the vehicle of a person arrested for driving or being in control of a vehicle while under the influence of alcohol or drugs.
- For more information: http://apps.leg.wa.gov/billinfo/summary.aspx?bill=3124&year=2009

2SSB 6206

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2SSB 6206 Implementation

- Child Fatality Recommendation Implementation
- Notification of 3-Founded Referrals
- Mandated Reporter Referral Report

Implementation Status of OFCO Child Fatality Recommendations

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OFCO Review or Report	Count of Implementation Status
2004-05 Annual Report	**16**
Complete	3
Partial	9
None	4
Gomez Fatality Review (no report)	**1**
Partial	1
Robinson Fatality Report	**5**
Complete	1
Partial	3
None	1
Sotelo Fatality Report	**3**
Complete	3
2006 Annual Report	**1**
Partial	1
Total	26

Implementation Status of CA Child Fatality Recommendations

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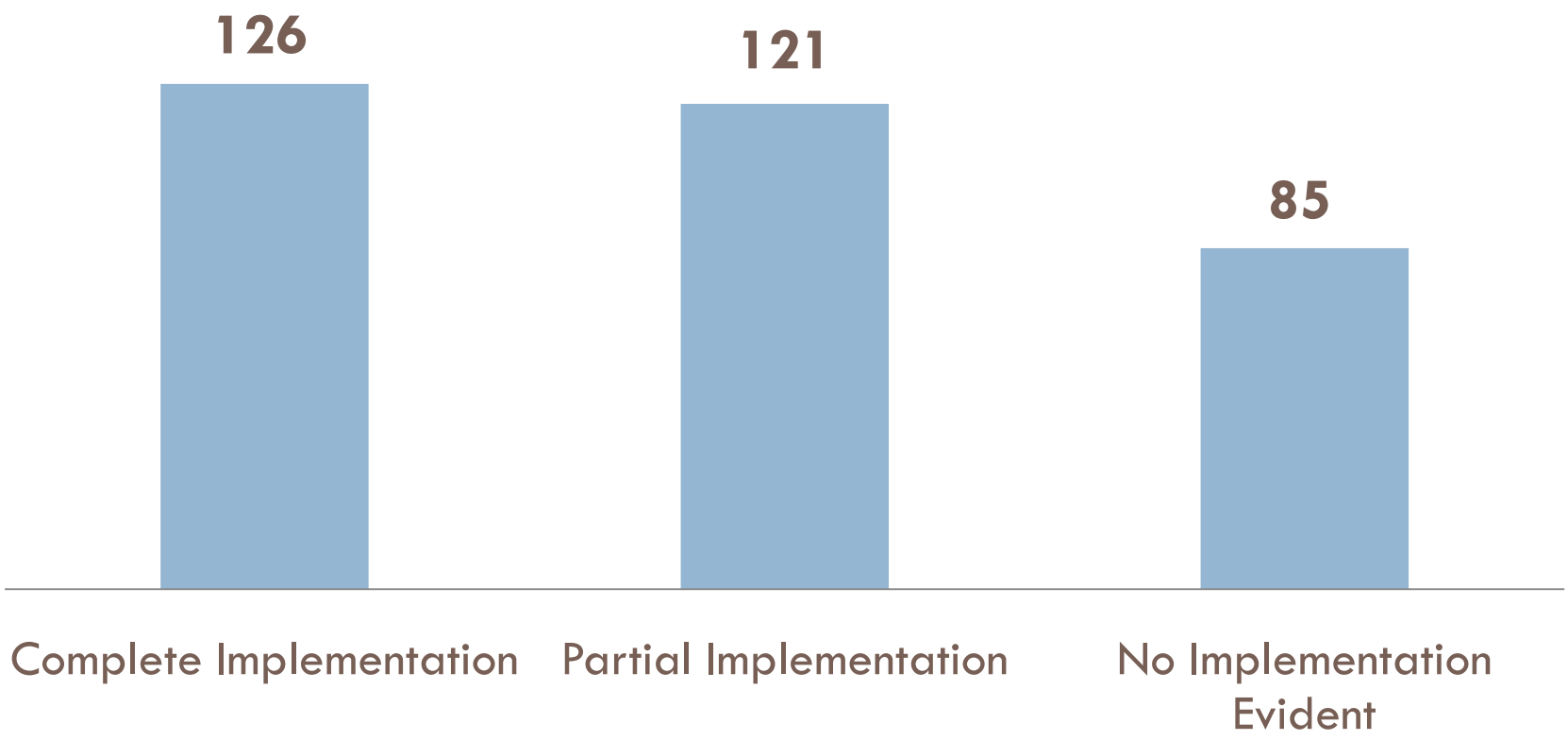

OFCO Recommendations To Address Barriers to Implementation

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- Make the Administrative Incident Reporting System (AIRS) more user-friendly.
- Establish written guidelines on how to draft effective recommendations.
- Create a designated pathway for CFR recommendations so that recommendations are reviewed and evaluated, and steps toward implementation are clearly defined. Specifically designate who or what is responsible for implementation.
- Improve tracking and implementation of child fatality recommendations and the status of implementation.
- Develop a protocol for timely and consistent transfer of knowledge learned from fatality reviews among regions.

Implementation of 2SSB 6206: Recurrent Maltreatment

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In 2008, the Legislature enacted law, RCW 26.44.030(13), that provides:

> If a report of alleged abuse or neglect is founded and constitutes the third founded report received by the department within the last twelve 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.

Implementation of 2SSB 6206: Recurrent Maltreatment

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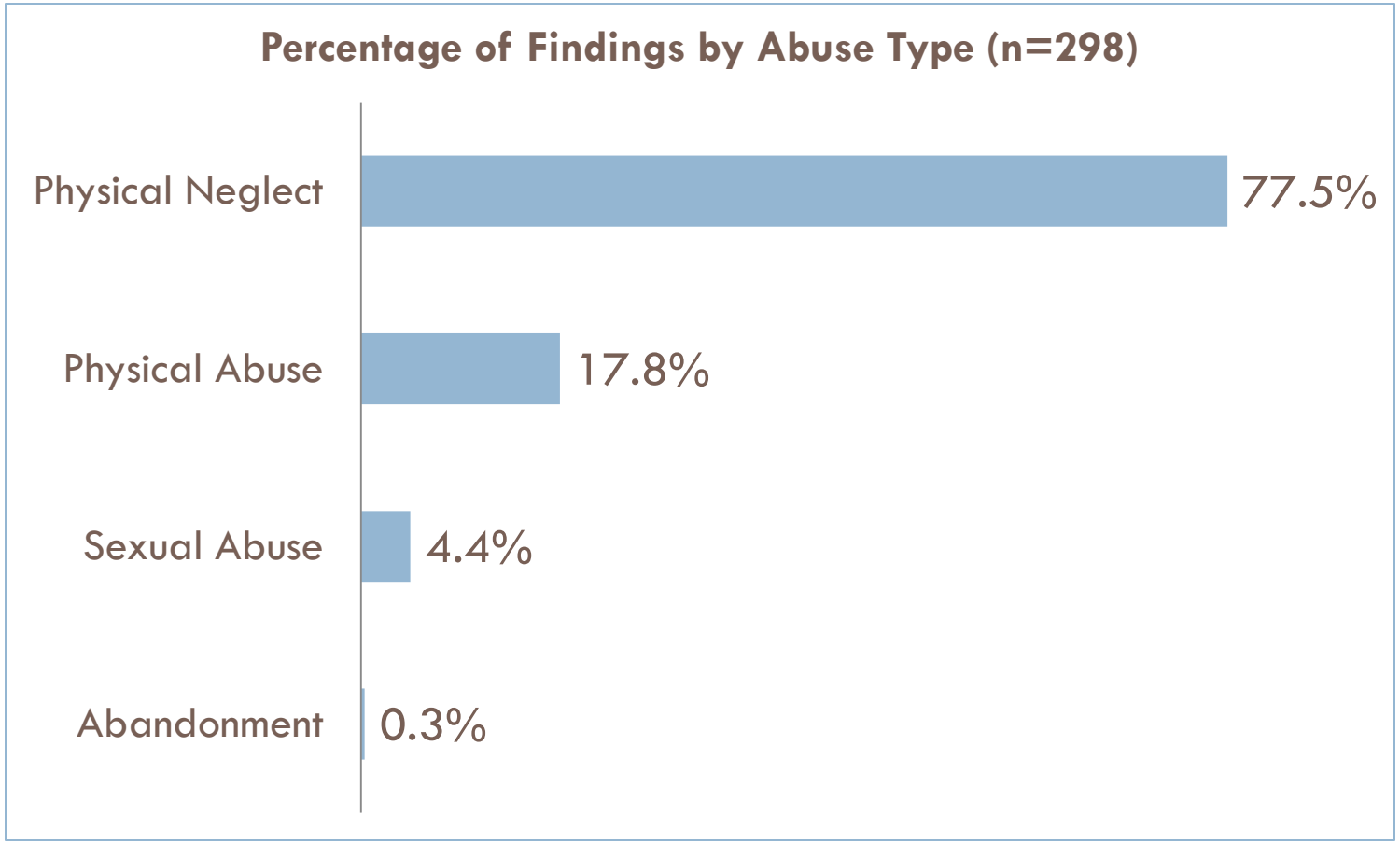

Implementation of 6206: Recurrent Maltreatment

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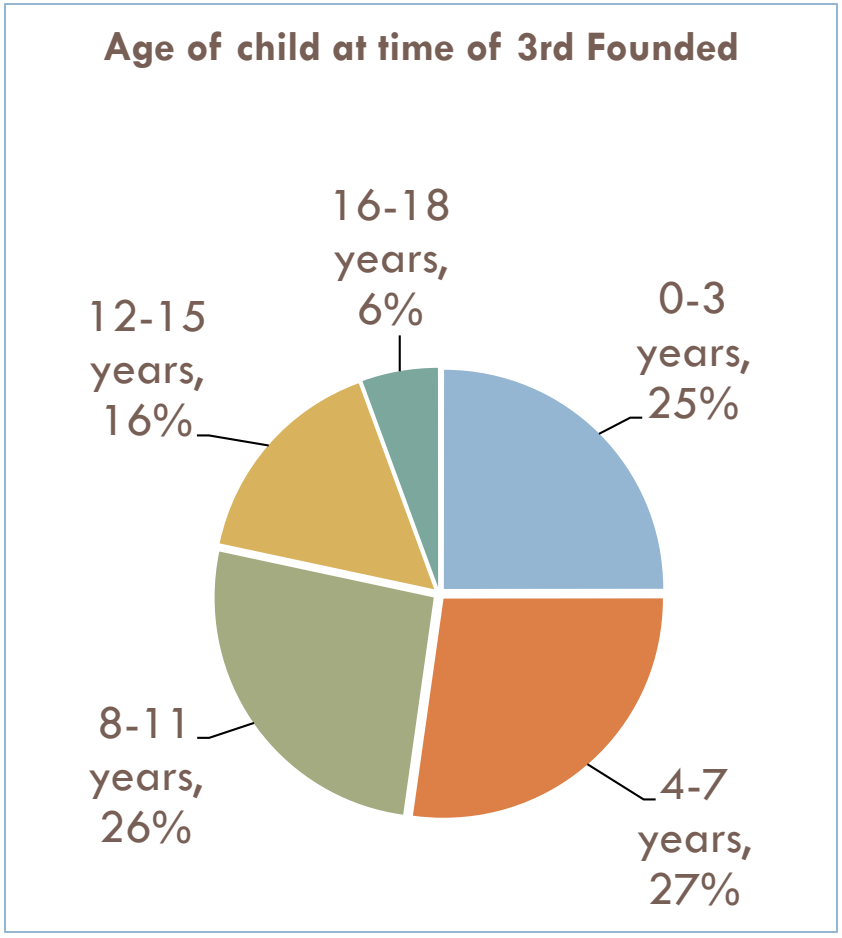

Implementation of 6206: Recurrent Maltreatment

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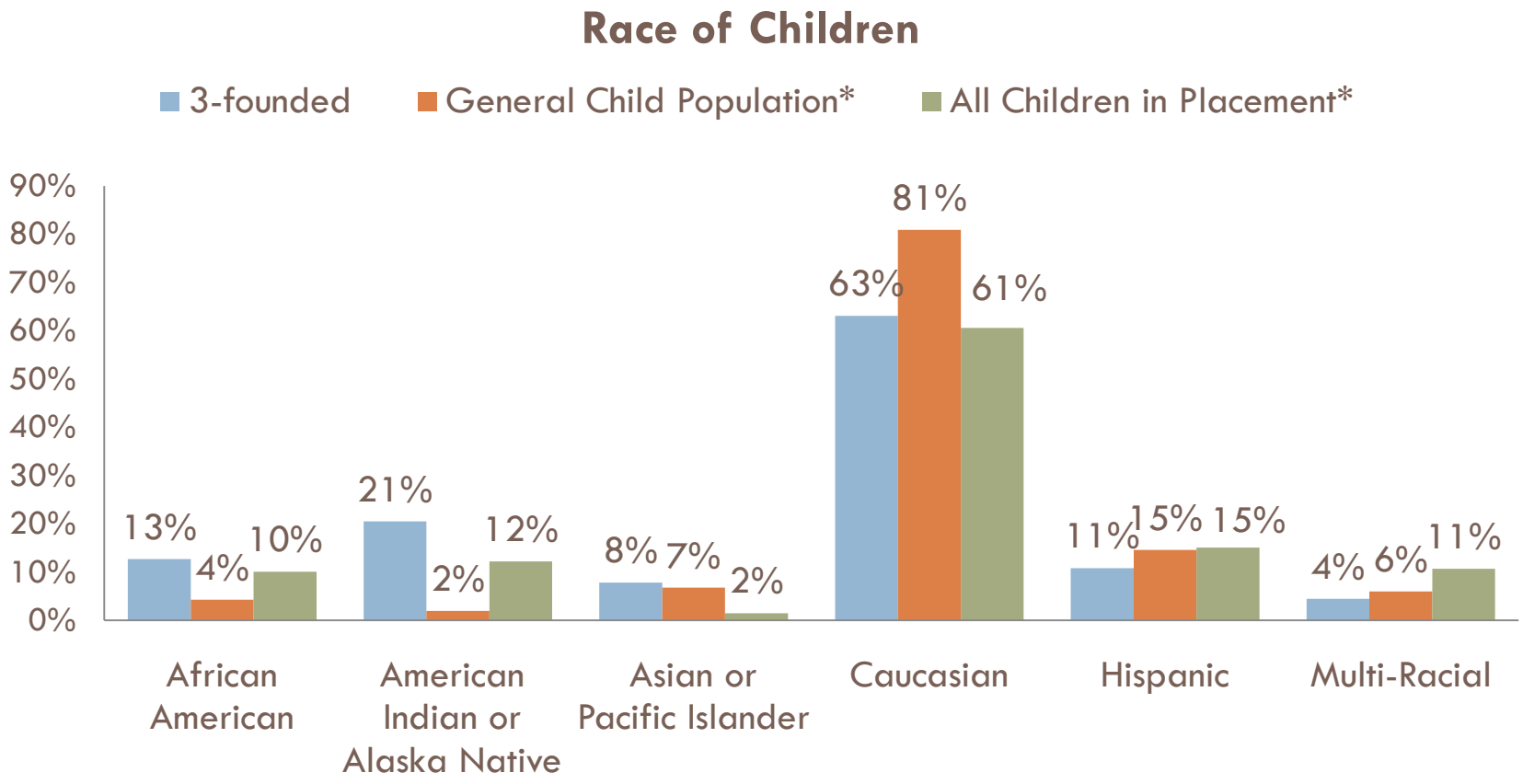

*Race of children in placement and general child population, taken from Children's Administration Performance Report 2007 http://www.dshs.wa.gov/pdf/ca/07Report2Intro.pdf

Implementation of 6206: Recurrent Maltreatment Example

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Issue of Concern: Three founded reports regarding 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. After the 3rd founded report, the social worker felt that CPS should file a dependency petition based on the cumulative effects of the chronic neglect. However, the Attorney General's Office had advised CPS that the facts were insufficient to support filing for dependency.

Ombudsman Action: OFCO contacted the Area Administrator (AA) and requested that the AA review the case and consider higher-level review by Attorney General's office.

Outcome: 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 failed 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.

2SHB 2106

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- Phase One – Organize contracts and Performance measures
- Phase Two – Demonstration sites and Private providers

Patterns in Mandated Reporter Referrals 2006-2008

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- OFCO released report July 2009. Full report available at http://www.governor.wa.gov/ofco/reports/mandated_reporter_referrals_2006_08.pdf
- 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 one 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.

Recommendations from Patterns in Mandated Reporter Referrals 2006-2008

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- Authorize WSIPP to further study the effect of intake worker and regional variations in screening decisions on outcomes for families and children.
- Ensure strong quality assurance through improved training and review.
- Train intake workers not to rely on mandated reporters as a safety factor that justifies screening out a referral when the mandated reporter is alleging concerns about abuse or neglect.
- DSHS CA and others should coordinate to consider risk factors identified by statewide child death reviews to refine CPS intake protocol on referrals pertaining to infants to assess risk. 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, and gestation of the infant.

Colville Investigation

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- OFCO report released May 2009. Full report available at http://www.governor.wa.gov/ofco/reports/colville_investigation_2009.pdf
- CA Response