Office of the Family & Children's Ombudsman

An Independent Voice for Families and Children

2011 ANNUAL REPORT

The full report is available online at http:www.governor.wa.gov/ofco/

Presentation to the Children's Legislative Oversight Committee

January 26, 2012

Presented to the Committee
By Mary Meinig, Director Ombudsman

Overview of Presentation

Office of the Family & Children's Ombudsman
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- Inquiries and Complaints
  - Complaint Investigations
  - Adverse Findings
- Critical Incident Review
  - Child Fatalities and Near Fatalities
  - Recurrent Maltreatment
- Status of Implementation of Child Fatality Review Recommendations
- Child Abuse and Neglect in Adoptive and Other Permanent Placements

Inquiry and Complaint Profiles

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- 608 complaints received in 2011 reporting year
- An additional 810 inquiries received in 2011
- Majority of complaints come from parents and other family members (as in past years)
- 62% of children identified in complaints are age 7 or younger
- Top issues: **Separation and reunification of families** and the **safety of children living at home or in out-of-home care** (as in past years)

Complaints Received by Reporting year

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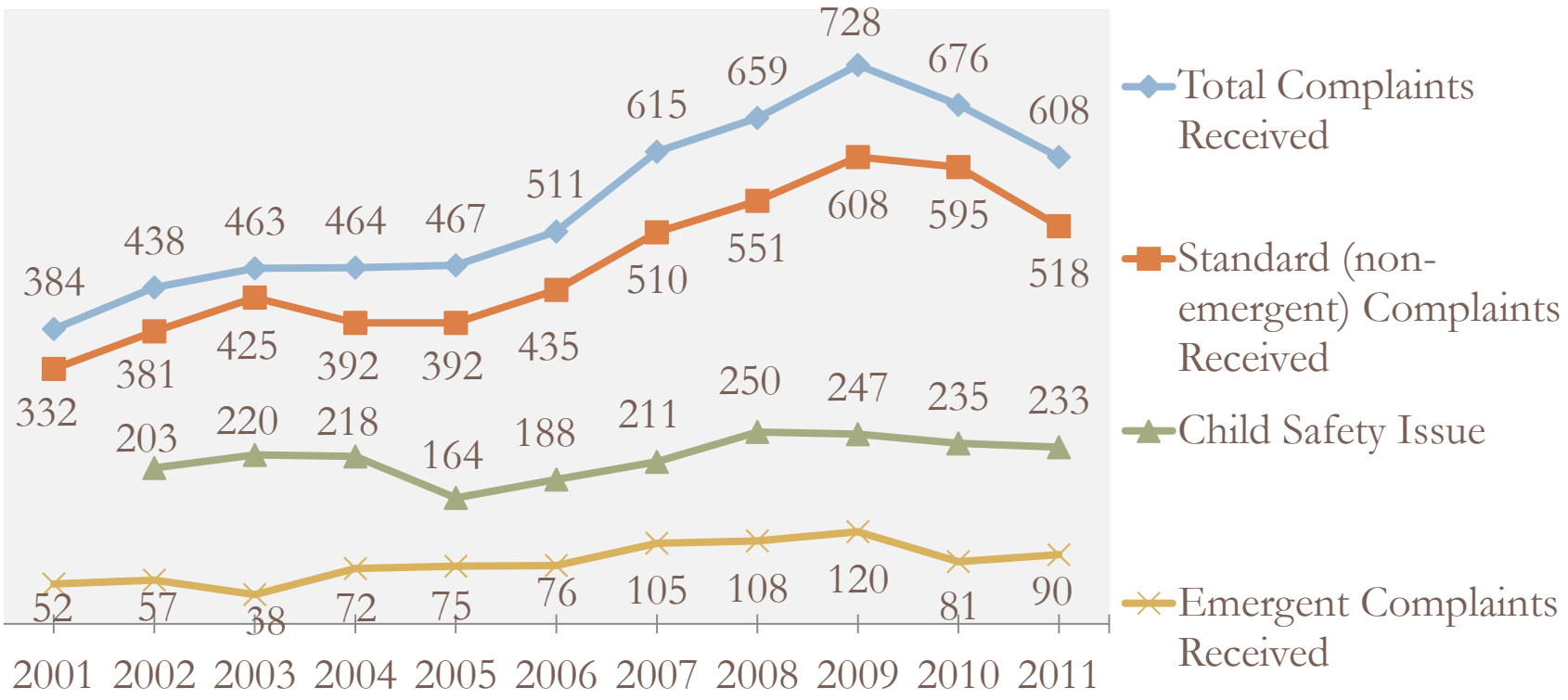

Persons Who Complained

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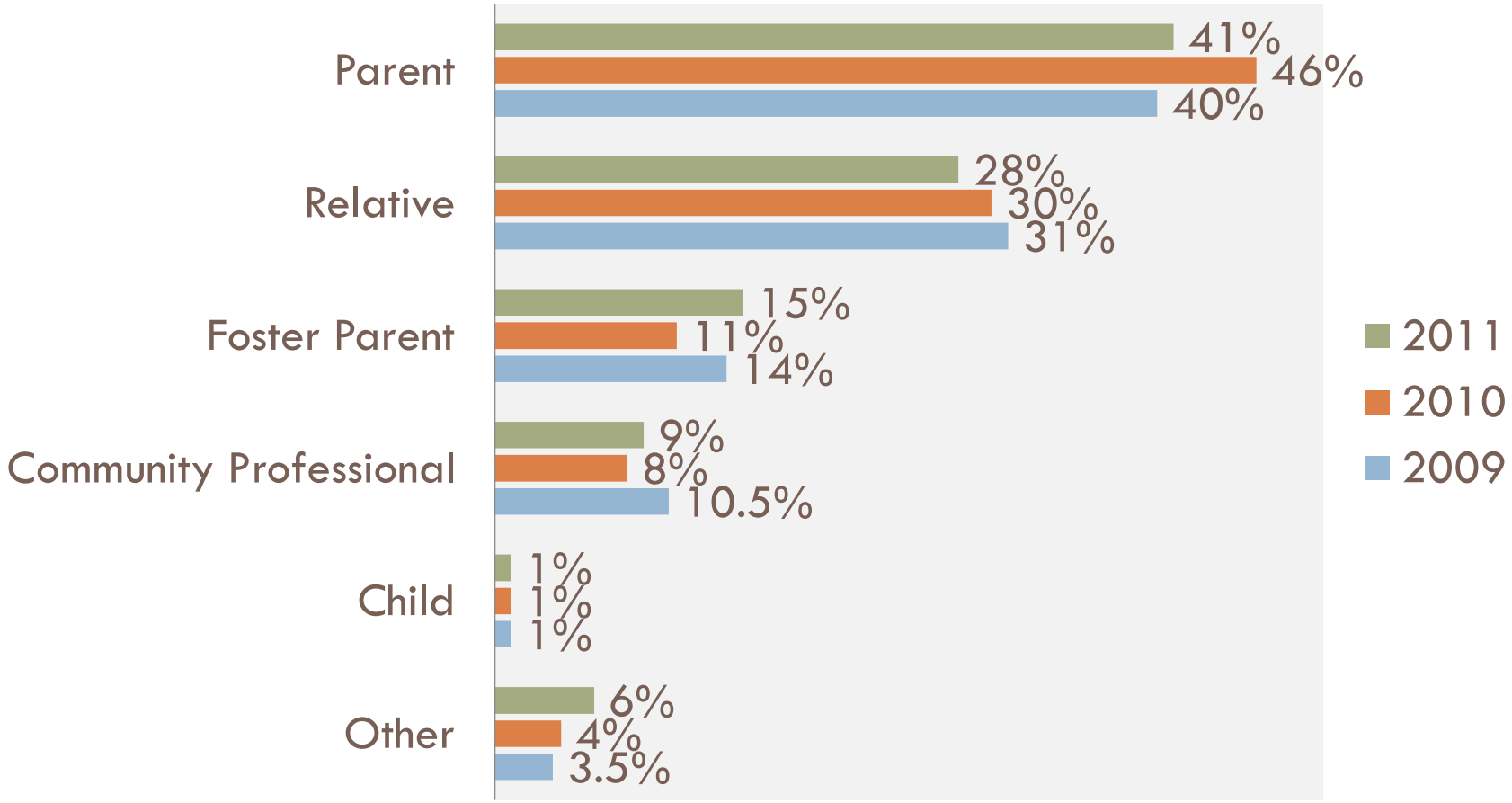

Age of Children Identified in Complaints

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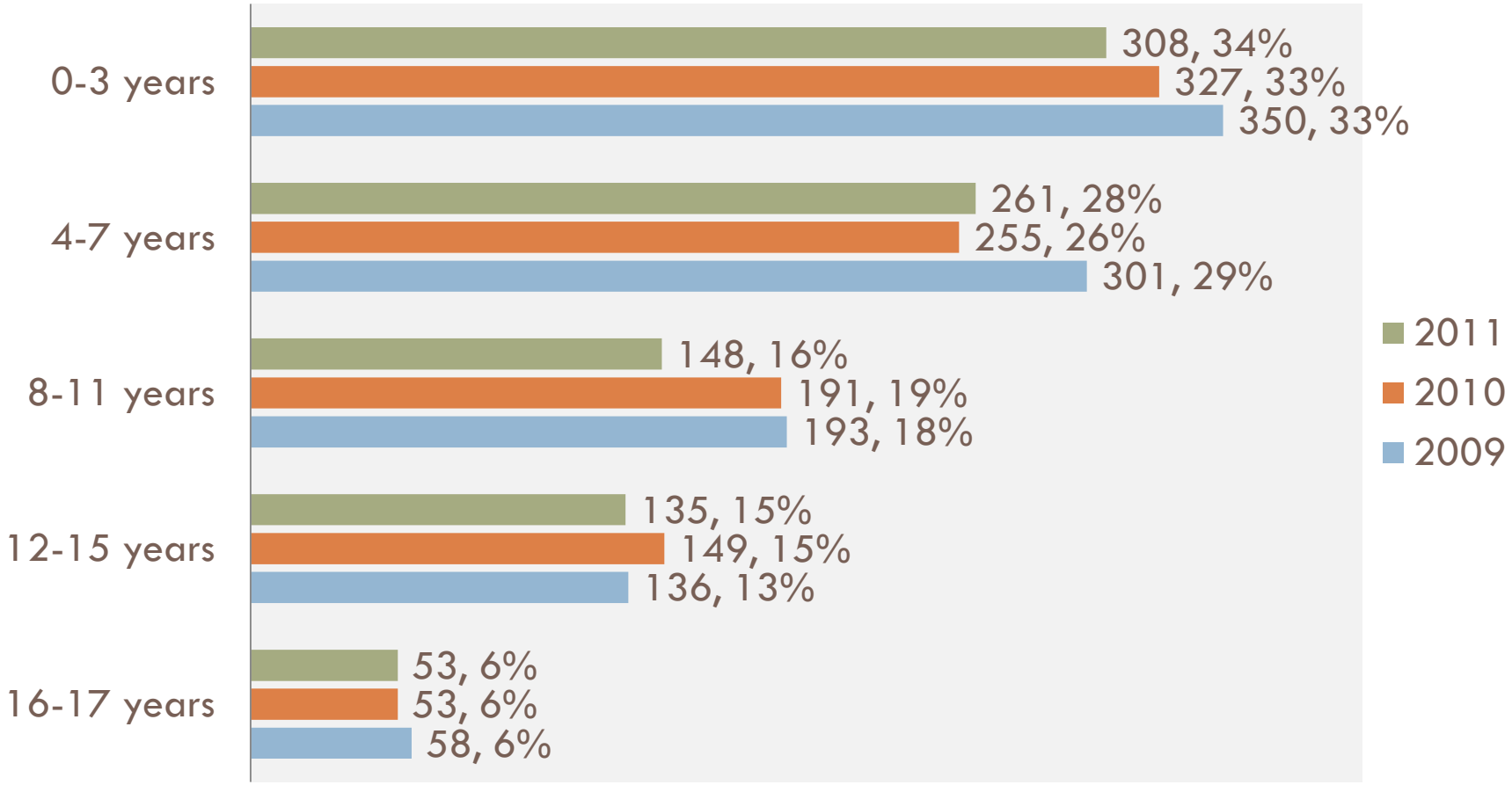

Note: Some individual children were counted more than once because they were identified in more than one complaint

Complaint Issues

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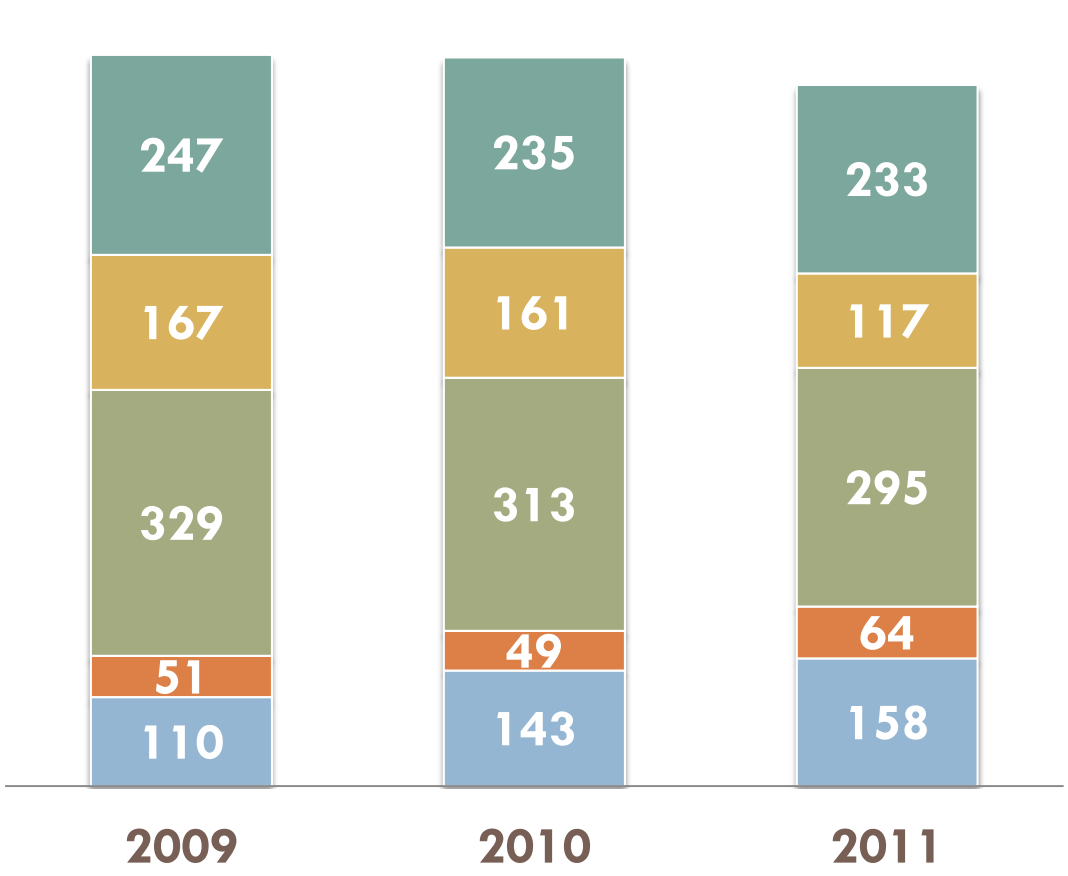

Note: Many complaints identified more than one issues.

Complaints Against the Children's Administration by DSHS Region

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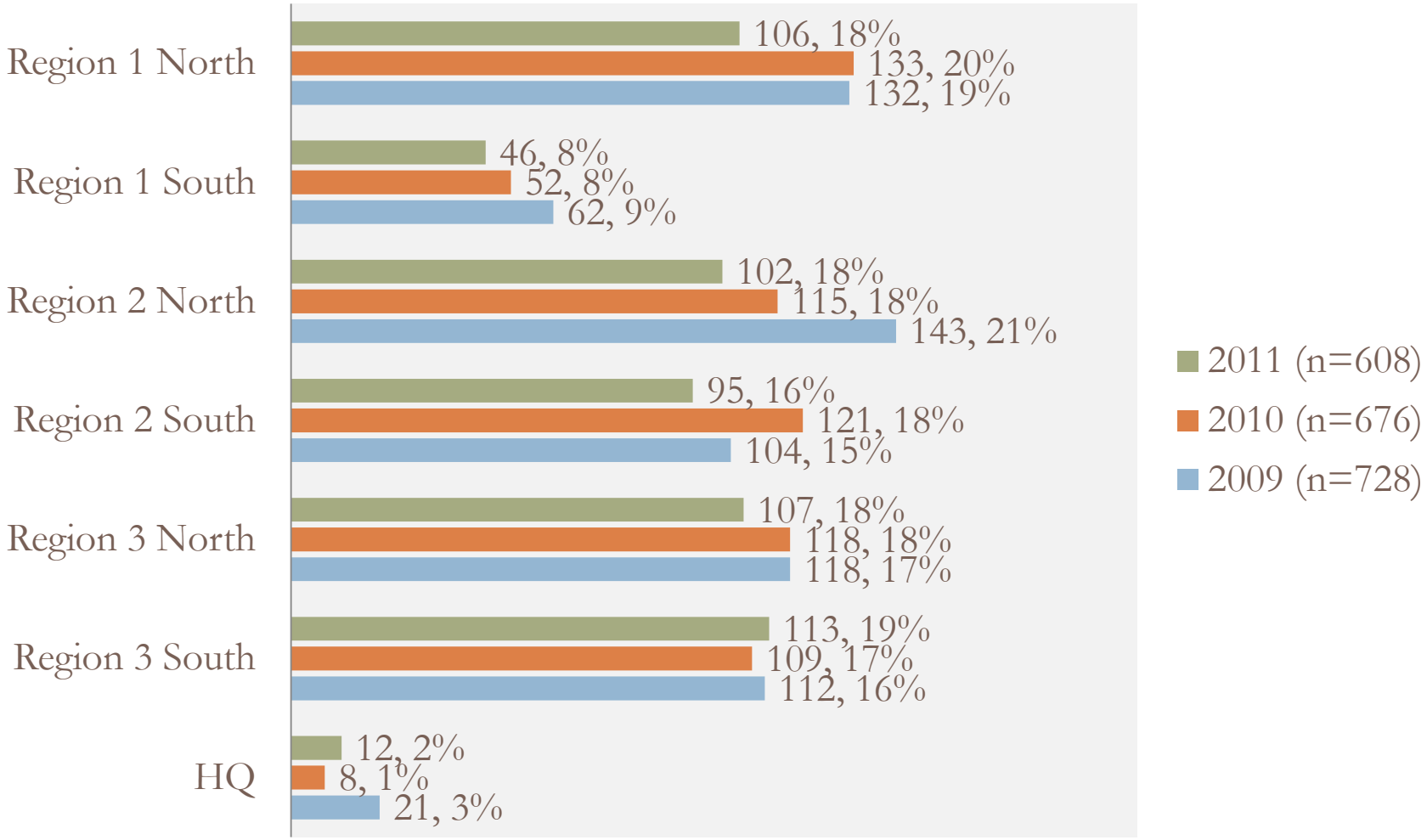
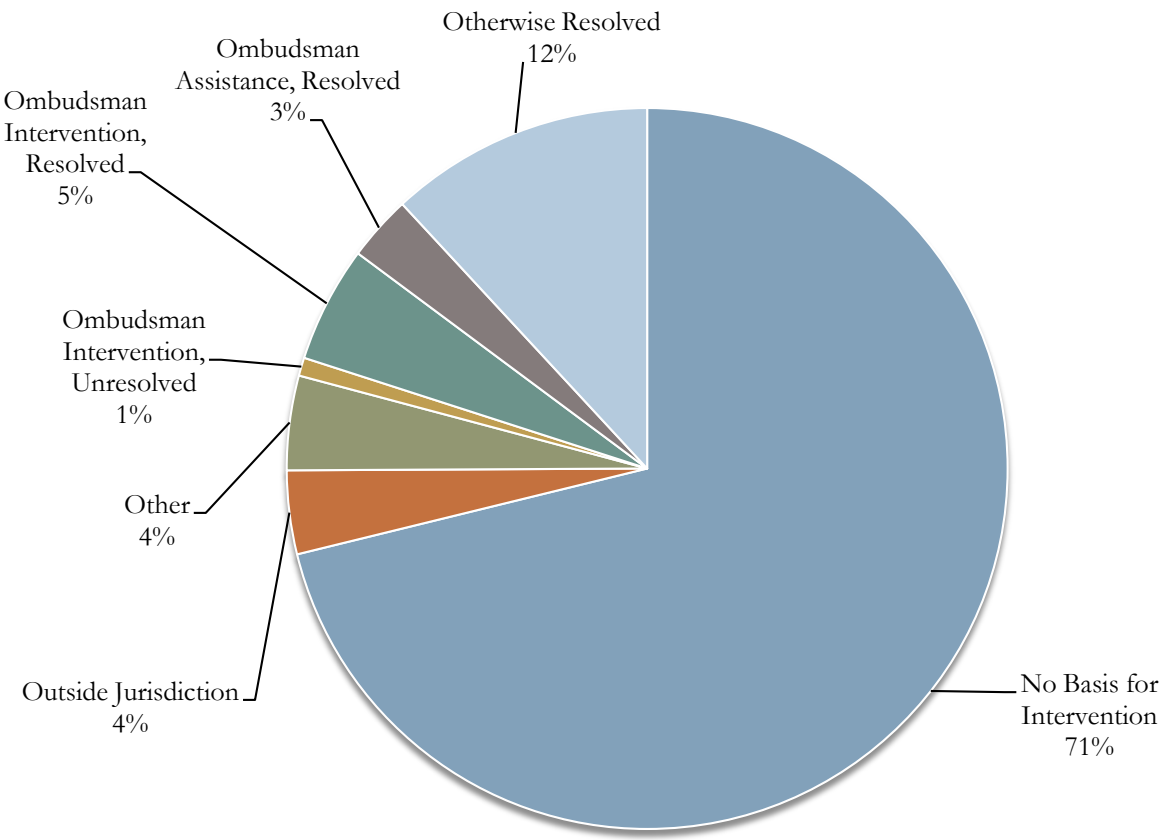


Complaint Investigations

608 Completed Investigations



Adverse Findings

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- Of 608 completed investigations – **65 adverse findings** (5 investigations with 1 or more adverse finding).
- **Top issues** for adverse findings:
  - Child Safety (12 findings)
  - Parents' rights (14 findings)
  - Poor practice resulting in harm (8 findings)
  - Foster parent issues (7 findings)
  - Dependent child health/well-being (5 findings)
  - Dependent child permanency (6 findings)
  - Family Separation and Reunification (6 findings)
- **New Interagency Agreement** – Enhanced Transparency and Accountability
- OFCO received 6 **requests from CA to modify the finding;** 2 of these resulted in **some modification** of the finding.

Ombudsman in Action: Inducing Corrective Action

Investigative Finding: CFWS authorized a transition home with an increasing schedule of overnight visits between two dependent children, ages six and three, and a parent despite a recent recommendation by the CPT that the children remain in out-of-home care with continuing day visits until further progress was demonstrated. The Ombudsman found that the CPT recommendations were reasonably based upon concerns for the children's safety and well-being.

Ombudsman Action: The Ombudsman contacted the Area Administrator to question this plan in light of the CPT's concern about the children's safety and well-being in the overnight care of the parent.

Outcome: The visitation schedule was scaled back to one overnight visit a week until further court order.

Ombudsman in Action: Facilitating Resolution

Investigative Finding: CPS failed to serve the subject youth in a dependency petition (age sixteen) with the petition and notice of the court hearing. The youth was a victim of physical abuse and wanted to inform the court of her fear of the parent. Due to the lack of notice, the youth missed the opportunity to attend the shelter care hearing, and was unaware of her right to be represented by an attorney.

Ombudsman Action: The Ombudsman contacted CPS and requested that this information be provided as soon as possible.

Outcome: CPS informed the youth about the petition and her rights the following day.

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

Investigative Finding: CFWS failed to create a meaningful transition plan for two legally free children, ages three and four, who were being moved from their foster home to a relative placement. The children had never met the relatives, and the plan allowed for only one overnight visit prior to the move. A Foster Care Assessment Program evaluation had recommended that any planned move for the four year old be slow and planned. No shared planning meeting was held to discuss the plan.

Ombudsman Action: The Ombudsman contacted the CFWS supervisor and area administrator to request that a more appropriate transition plan be considered, with input from the foster parents and professionals involved with the children.

Outcome: A shared planning meeting was held and professionals, the foster parents, and relatives provided input. The transition plan was extended several weeks from the original plan.

Child Fatalities- OFCO Case Review "Maiya"

CA specifically requested that OFCO conduct an independent child fatality review.

- 1 yo child killed by blunt force trauma to the abdomen.
- Mother's boyfriend charged with homicide
- Previous dependency resulted in guardianship of older sibling with a relative.
- 3 months prior to child's death, CPS received a referral alleging injury to-lack of supervision of Maiya; physical abuse of the older sibling; concerns about the mother's mental health; and neglect of Maiya.

Child Fatalities- OFCO Case Review "Maiya"

OFCO Findings- CPS did not adequately investigate allegations of CA/N:

- Failure to Contact Referrer
- Failure to Contact Professionals
- Failure to Investigate Allegation of Physical Abuse of older sibling
- Lack of Adequate Supervisory Review
- Failure to Complete an Investigative Risk Assessment
- Failure to Document Case Investigation Activities in a Timely Manner

Child Fatalities- CA Executive Case Review "Maiya"

CA also conducted an ECFR of this case:

- ECFR findings mirrored OFCO findings
- ECFR identified workload issues compromised the CPS SW's ability to meet investigation standards, and impeded the supervisors ability to provide consultation, advise and guidance.
- ECFR recommendations addressed FamLink notification to supervisors, 30 day visits and training issues.

Child Fatalities Reviewed by OFCO

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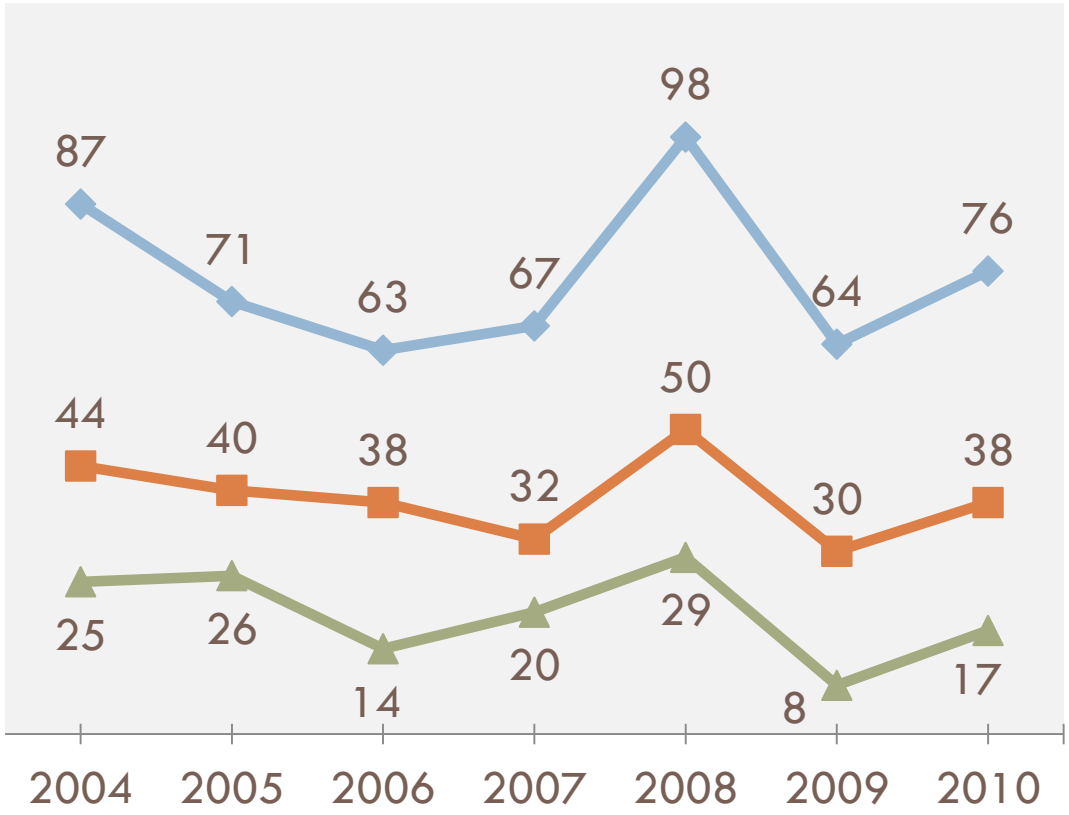
Child Fatalities Reviewed by OFCO 2004-2010



Child Fatalities

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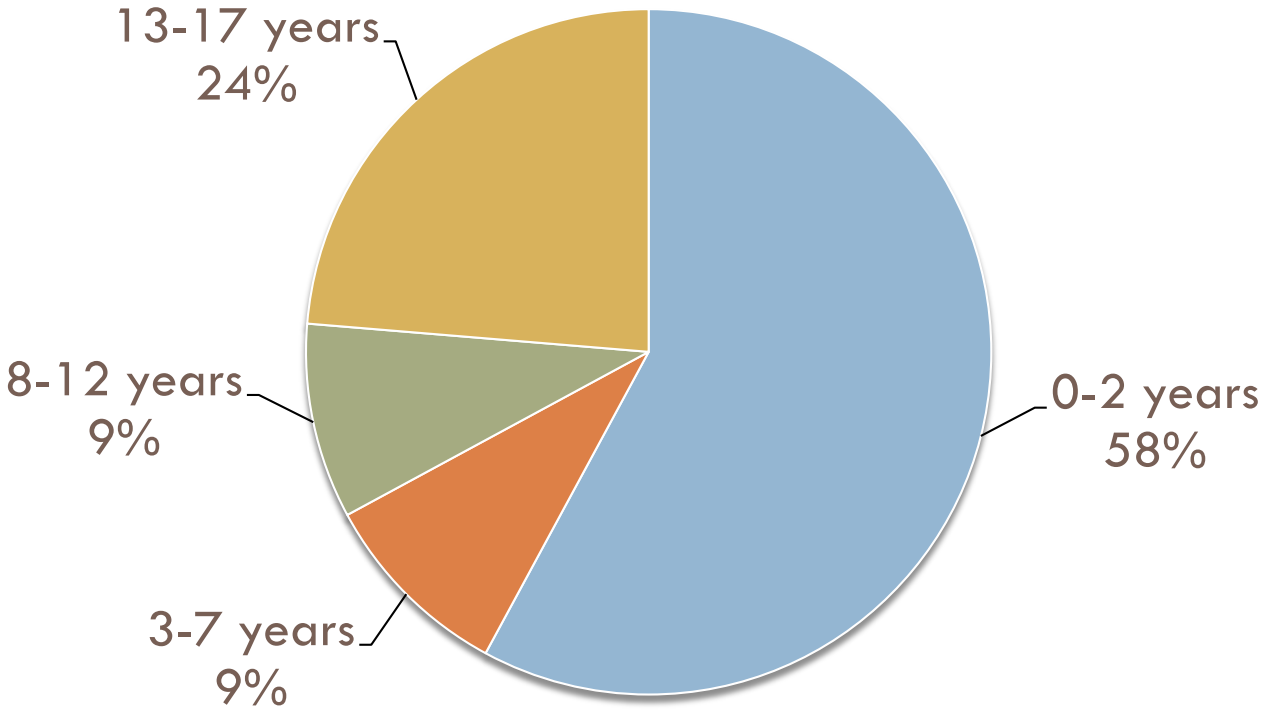
Age at Time of Death: 2010



Race/Ethnicity of Child Fatalities, 2010

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	2010 Fatalities	Children in DCFS placement	WA child population
African American	9%	10%	5%
American Indian or Alaska Native	9%	12%	2%
Asian	5%	1%	7%
Caucasian	62%	58%	81%
Multi-Racial	13%	12%	6%
Caucasian and American Indian or Alaska Native	*9%*		
Caucasian and African American	*3%*		
Caucasian and African American and Other	*1%*		
Unknown or Other Race	1%	3%	0%

Hispanic	21%	16%	16%
Caucasian, Not Hispanic	47%		

WA State Children populations taken from Children's Administration Performance Report 2008
http://www.dshs.wa.gov/pdf/ca/08Report1.pdf

CHILD FATALITIES

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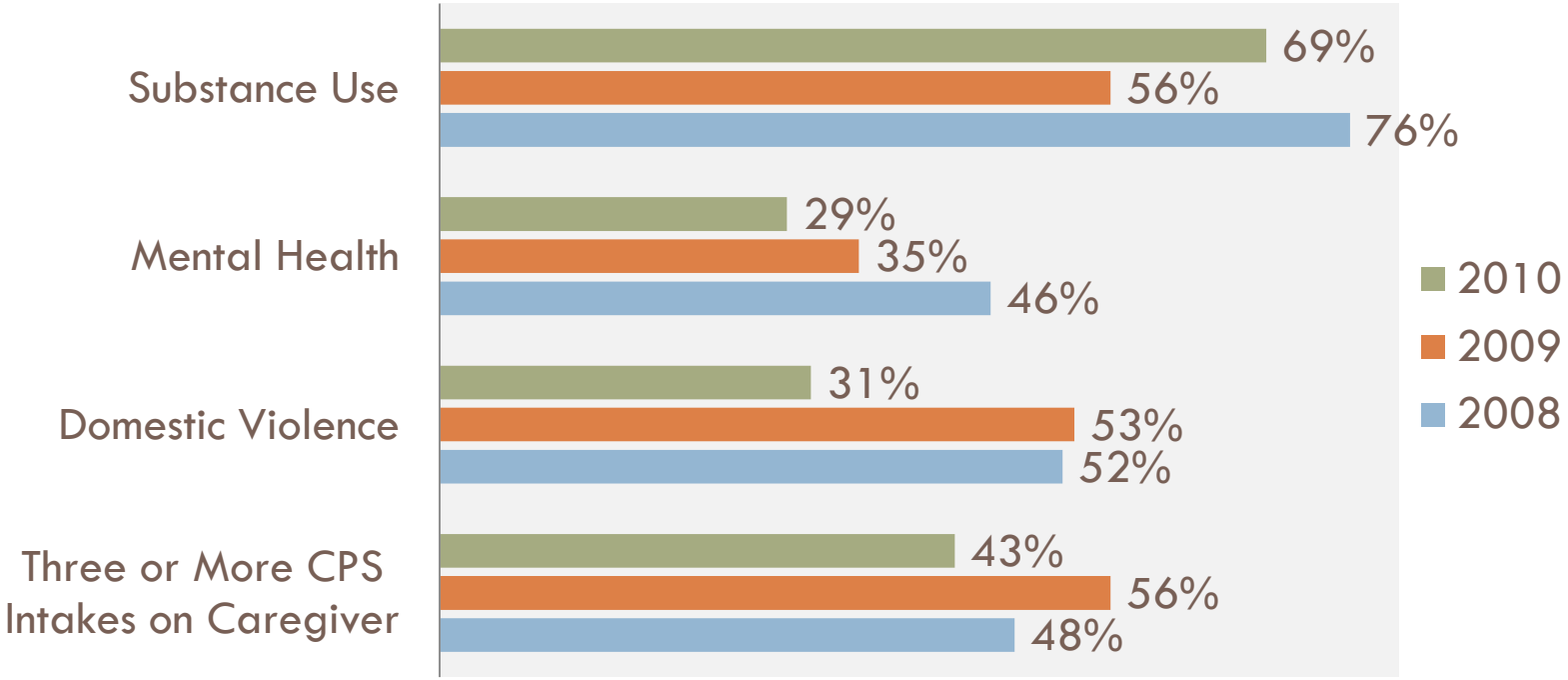
Percentage of Families with Identified Risk Factors
Infant Fatalities (under 1 year of age)



Risk Factors are identified in the case history and did not necessarily contribute to the cause of death.

Note: Prenatal drug use was documented in 54% infant fatalities

Child Fatalities

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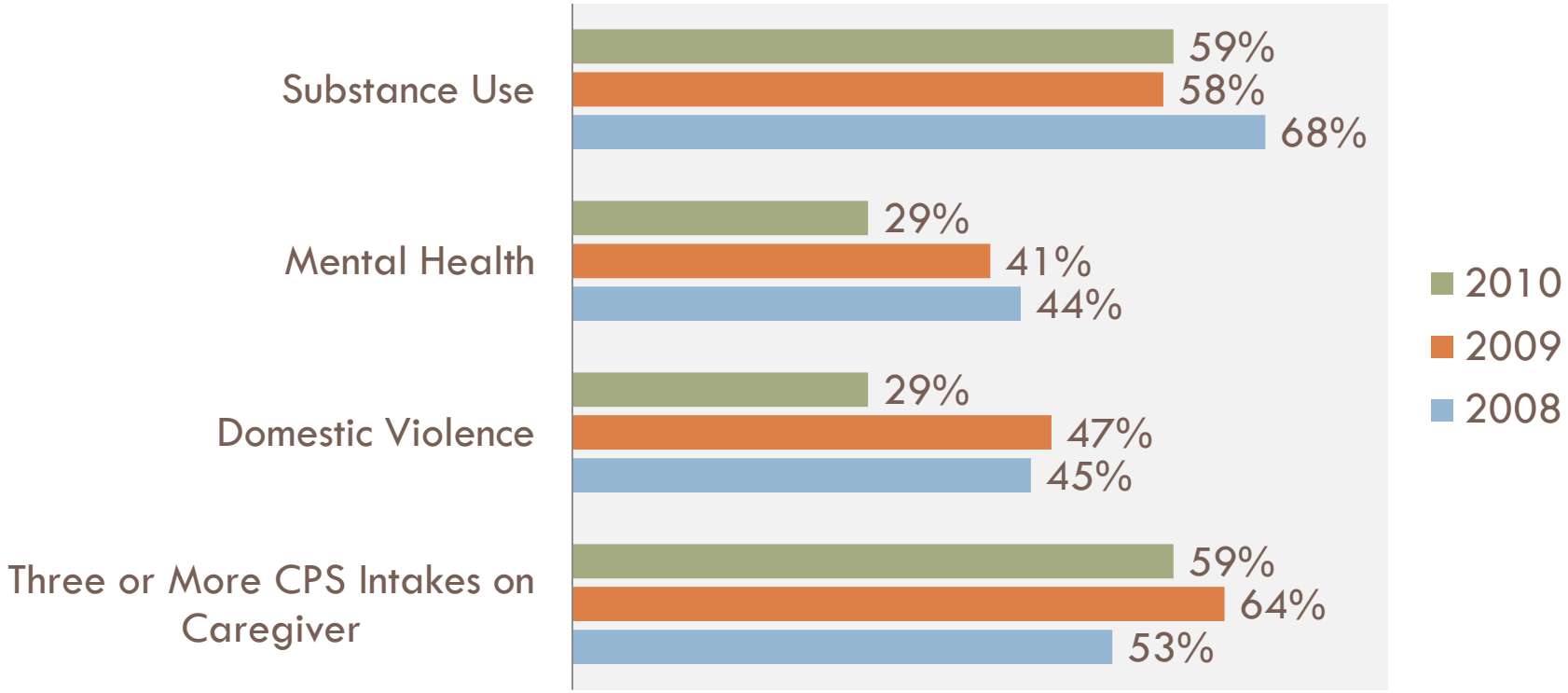
Percentage of Families with Identified Risk Factors
Total Child Fatalities



Child Fatalities

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- Sleep Environment: In 57% of the infant fatalities reviewed, sleep environment/co-sleeping was identified as the cause of death or a contributing risk factor.

- Infant Safe Sleep Workgroup

Implementation Status of Child Fatality Review Recommendations

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- Common Themes of Recommendations:
  - Provide training
  - Effective interventions with families
  - Intake screening decisions
  - Safety planning and risk assessment
  - Casework practice
  - Community and family education
  - Effective CPS investigations
  - Partnerships with community professionals
  - Child fatality investigations and reviews

Implementation Status of Child Fatality Review Recommendations

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- Changes to the Child Fatality Review Process
  - Scope or CA Child fatality reviews
  - Autopsy Reports and Supervising Agency Records
  - Public Information and Transparency

Child Near-Fatalities

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Data from 2009 through 2011 shows that:

- 46% of near fatalities reviewed resulted from clear physical abuse or neglect and that child abuse or neglect factors were documented as concerns in an additional seventeen percent of the cases reviewed.
- 55% percent were males and 45% were females.
- 51% percent involved children between the ages of birth to two years.

Recurrent Maltreatment

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In 2011, OFCO received 96 notifications of recurrent maltreatment from Children's Administration regarding 89 families

Recurrent Maltreatment

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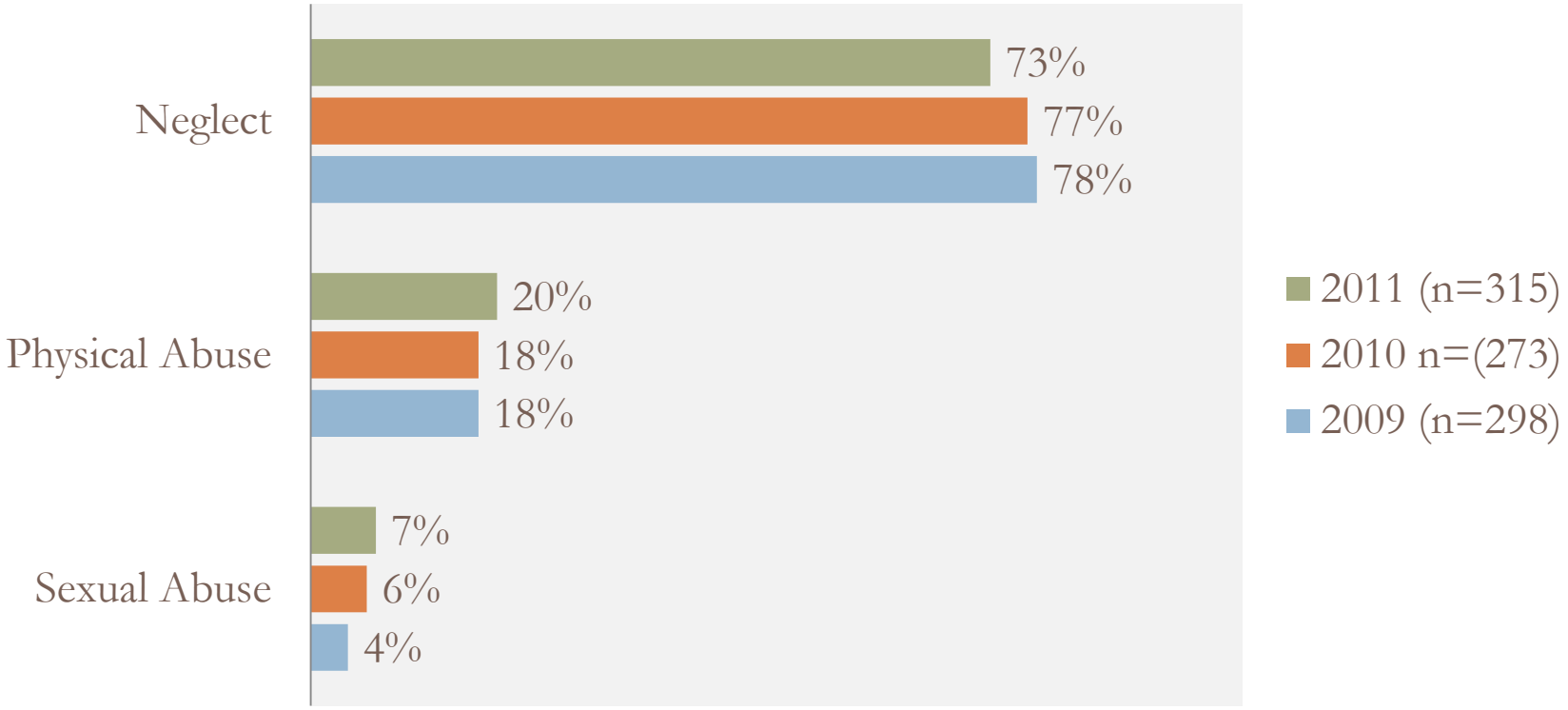
Recurrent maltreatment cases continue to primarily involve child neglect.

Percentage of Founded Allegations by Maltreatment Type



Recurrent Maltreatment

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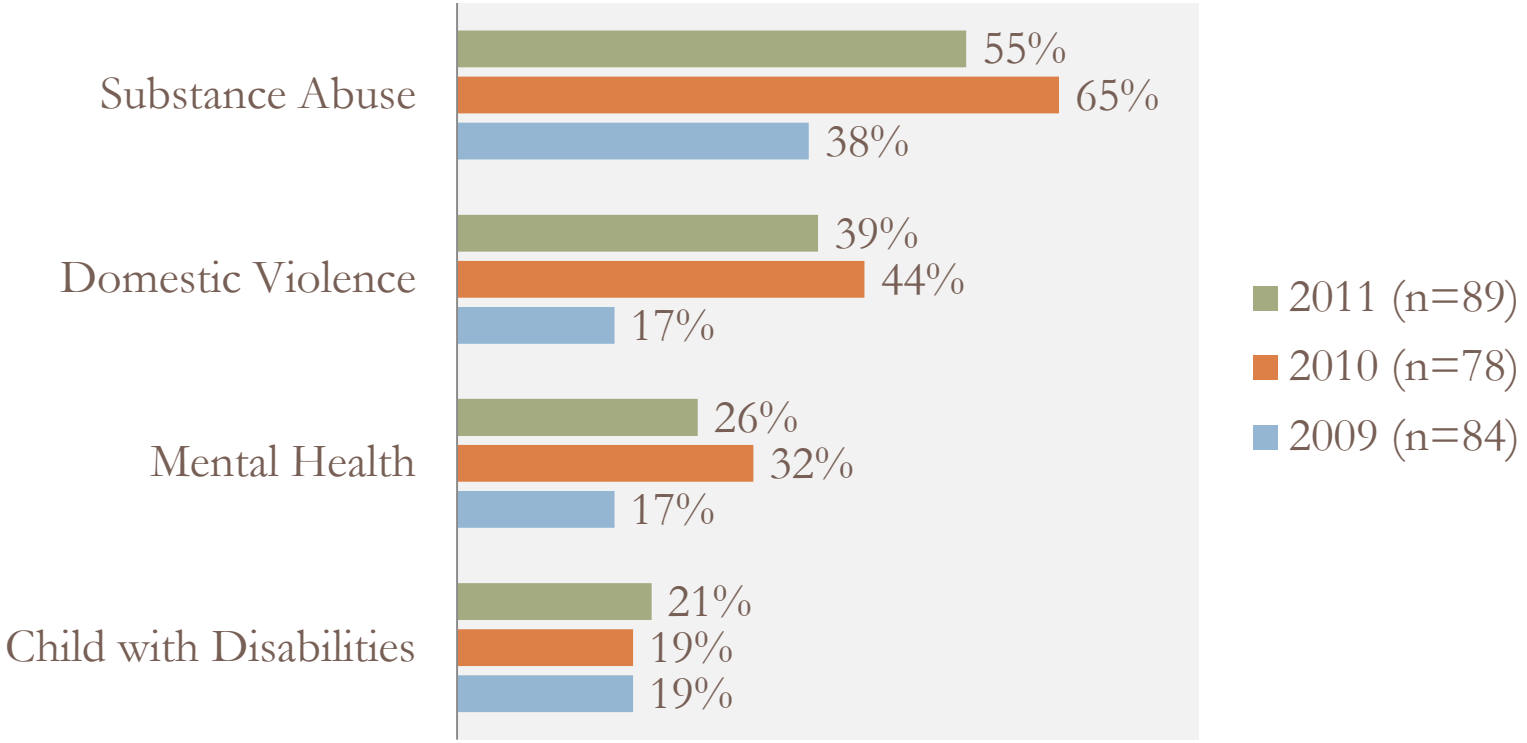
Common risk factors: mental health, substance abuse, and domestic violence.

Percentage of Families with Identified Risk Factors



Recurrent Maltreatment

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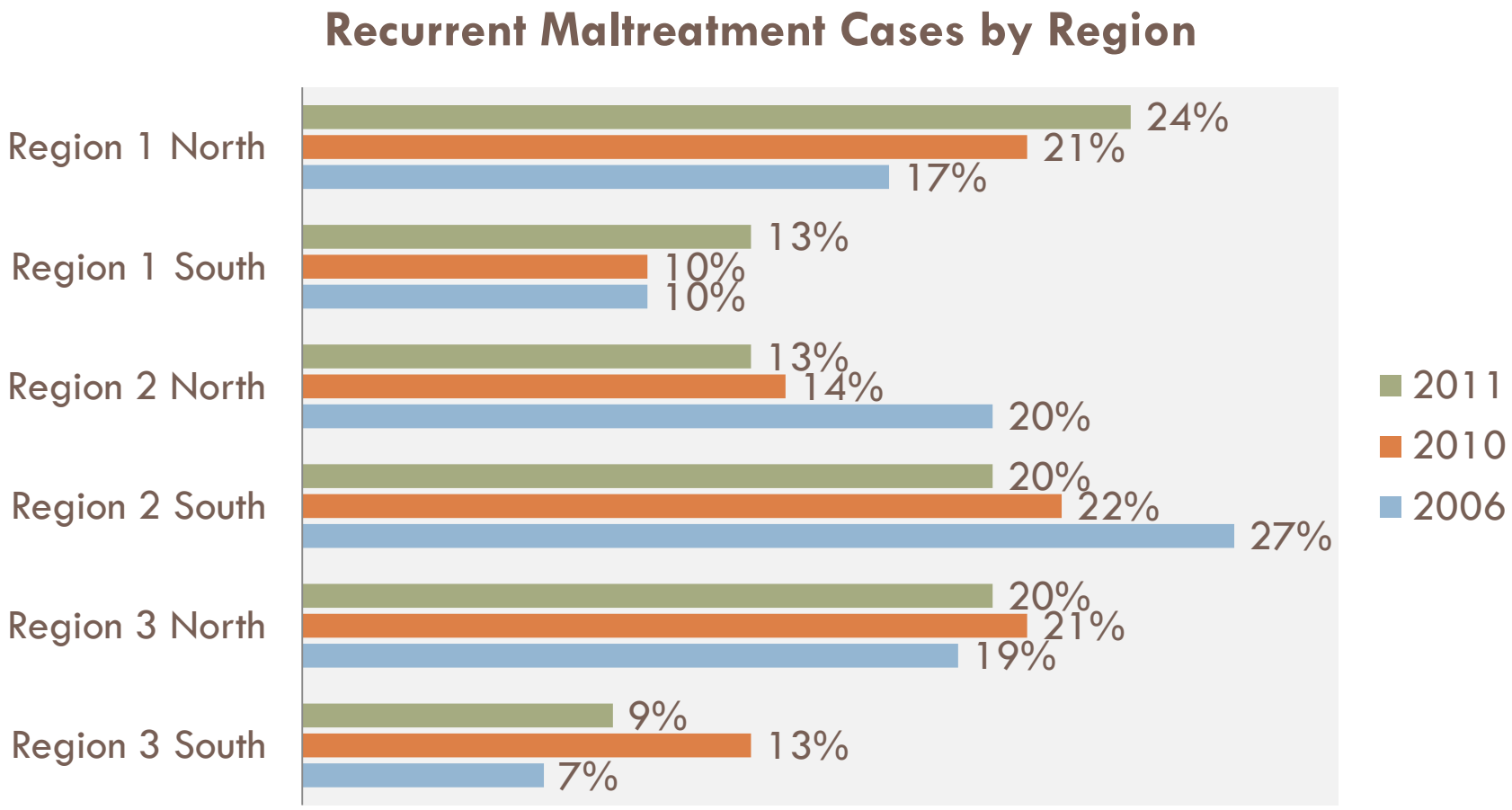

Recurrent Maltreatment

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OFCO Finding In 2010

In our review of cases with three founded reports of child abuse or neglect within one year, OFCO finds that Child Protective Services routinely fails to complete Investigative Assessments within the 45-day deadline required by policy.

Recommendation To DSHS/CA

Identify the common causes of delays in completing CPS investigations and take steps to ensure that Investigative Assessments are completed in a timely fashion.

Response From DSHS/CA

The Department is taking steps to obtain data on this practice issue to determine if it is a statewide trend. If this is a statewide trend, we will work with the regions to determine the cause for these delays and monitor staff compliance with policy.

OFCO Finding In 2011

Child Protective Services continues to routinely fail to complete Investigative Assessments within the 45-day deadline required by policy, thus potentially jeopardizing child safety.

Child Abuse and Neglect in Adoptive and Permanent Placements

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- OFCO reviewed 15 cases of severe abuse and neglect in adoptive or permanent placements.
- Common elements include:
  - Child locked in room
  - Withholding food from child
  - Exaggerating or misstating child's behaviors
  - Forcing child to remain outside
  - denying access to toilet facilities
  - Isolating child from the community

Child Abuse and Neglect in Adoptive and Permanent Placements

Questions raised include:

- Are neglect and abuse, including withholding food on the rise and are they more prevalent in adoptive homes?
- Does age, race, gender play a role in abuse of adopted children?
- Are changes needed to the adoption process involving foreign and/or cross-race adoptions, and the adoption of children from the foster care system?
- What are the lessons learned from the case situations you reviewed? What the implications/recommendations for day to day child welfare practice?
- Are incident rates of child abuse and neglect in adoptive homes commensurate with incident rates in biological parent homes?
- Do permanency goals and initiatives to increase adoptions have unintended consequences on child safety?
- Are child welfare agencies able to maintain adequate data regarding long term outcomes of children adopted from the foster care system?

Child Abuse and Neglect in Adoptive and Permanent Placements

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OFCO Recommendation:

Washington State in partnership with private child welfare agencies convene a work group of experts and leaders within the child welfare community to examine issues brought forward by OFCO.

2011 Legislative Activities

During the 2010 legislative session OFCO provided written or verbal testimony on the following bills:

- SB 5656: Creating a State Indian Child Welfare Act
- HB 1105: Addressing Child Fatality Reviews in Child Welfare Cases
- HB 1128: Providing for Extended Foster Care
- HB 1697: Providing for Unannounced Visits to Homes with Dependent Children
- HB 1774: Recognizing Adoptive Siblings and Adoptive Parents as Relatives