Office of the Family & Children's Ombudsman

An Independent Voice for Families and Children

16th Annual Children's Justice Conference

The Ombudsman's Unique Role in Child Protection and Welfare

Presented by

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April 21, 2008

Overview

- Origin of Office
- Statutory Authority
- Ombudsman's Role

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.

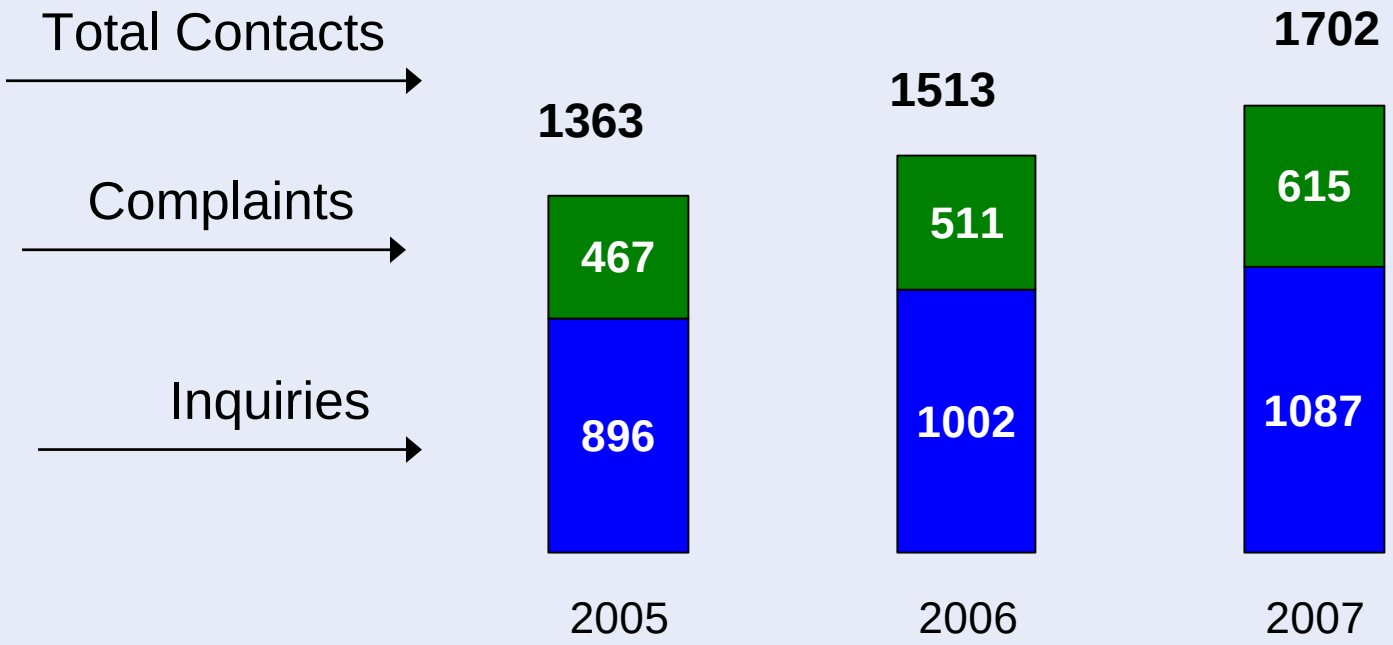
The Ombudsman's Role

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

Investigation of Complaints

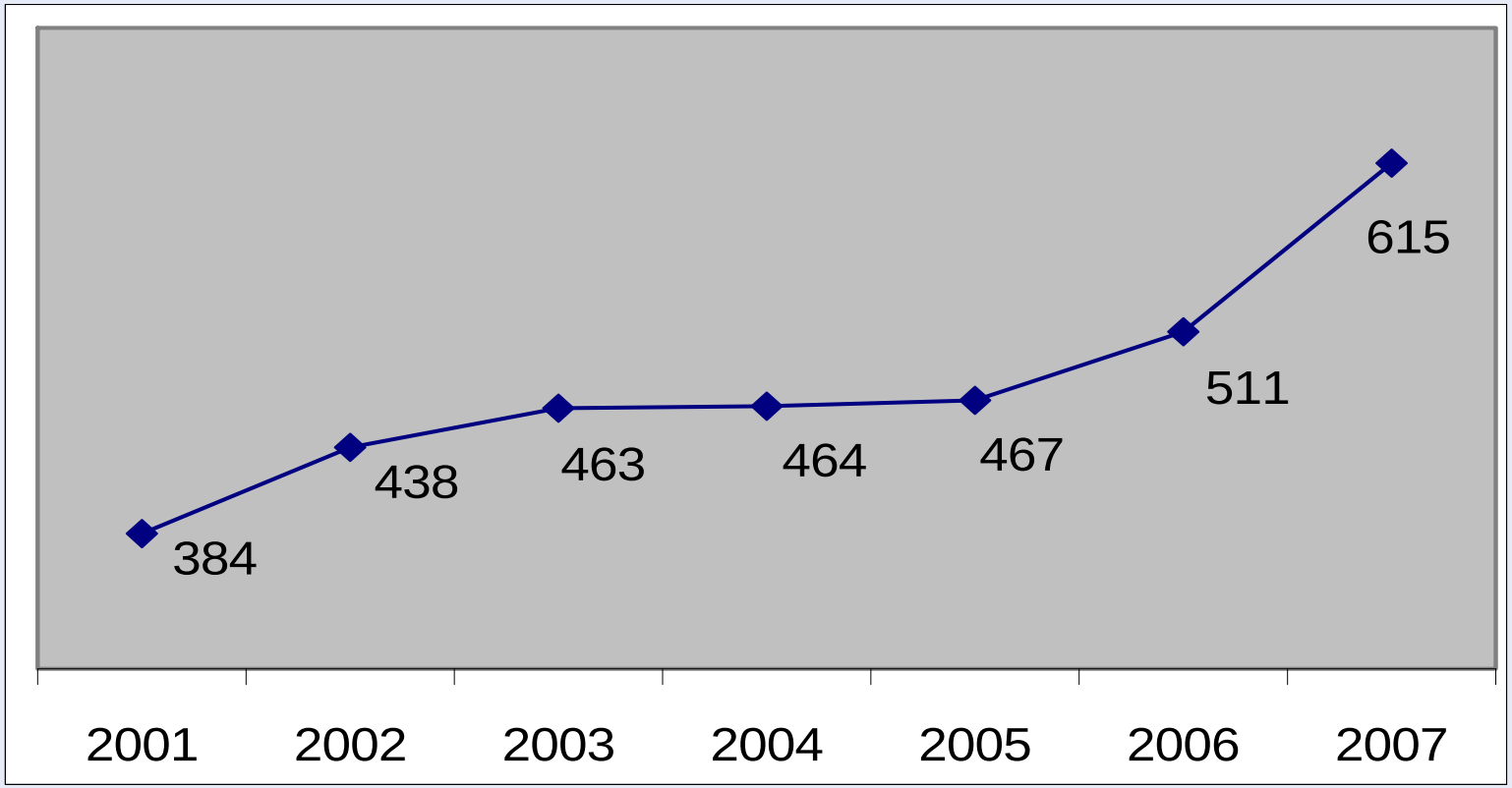
- **Investigate** complaints: determine whether a violation of law, policy, or procedure.
- **Monitor** procedures practiced by the agency.
- Periodically **review facilities** and procedures of state facilities and homes serving children.
- **Recommend changes** in law, policy, and procedure to address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

Inquiries and Complaints Received During Reporting Year



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

Total Complaints Received by Reporting Year



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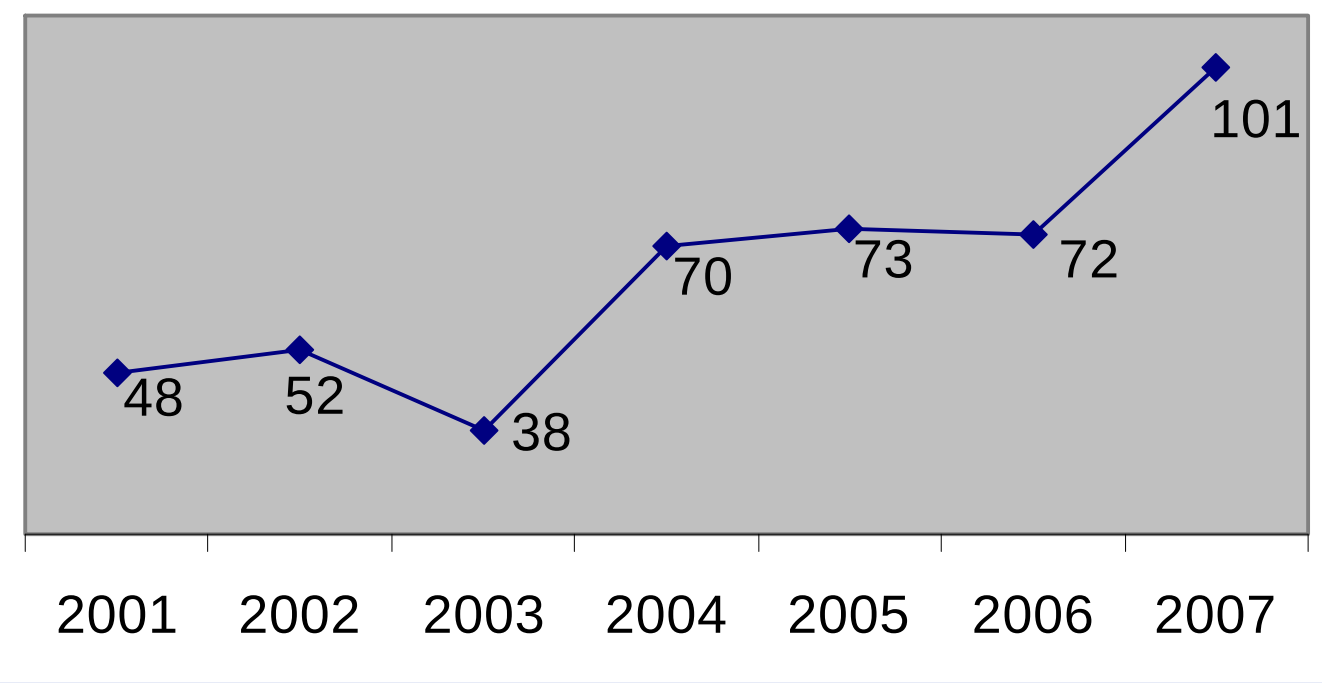
Total Emergent Complaints Received by Reporting Year



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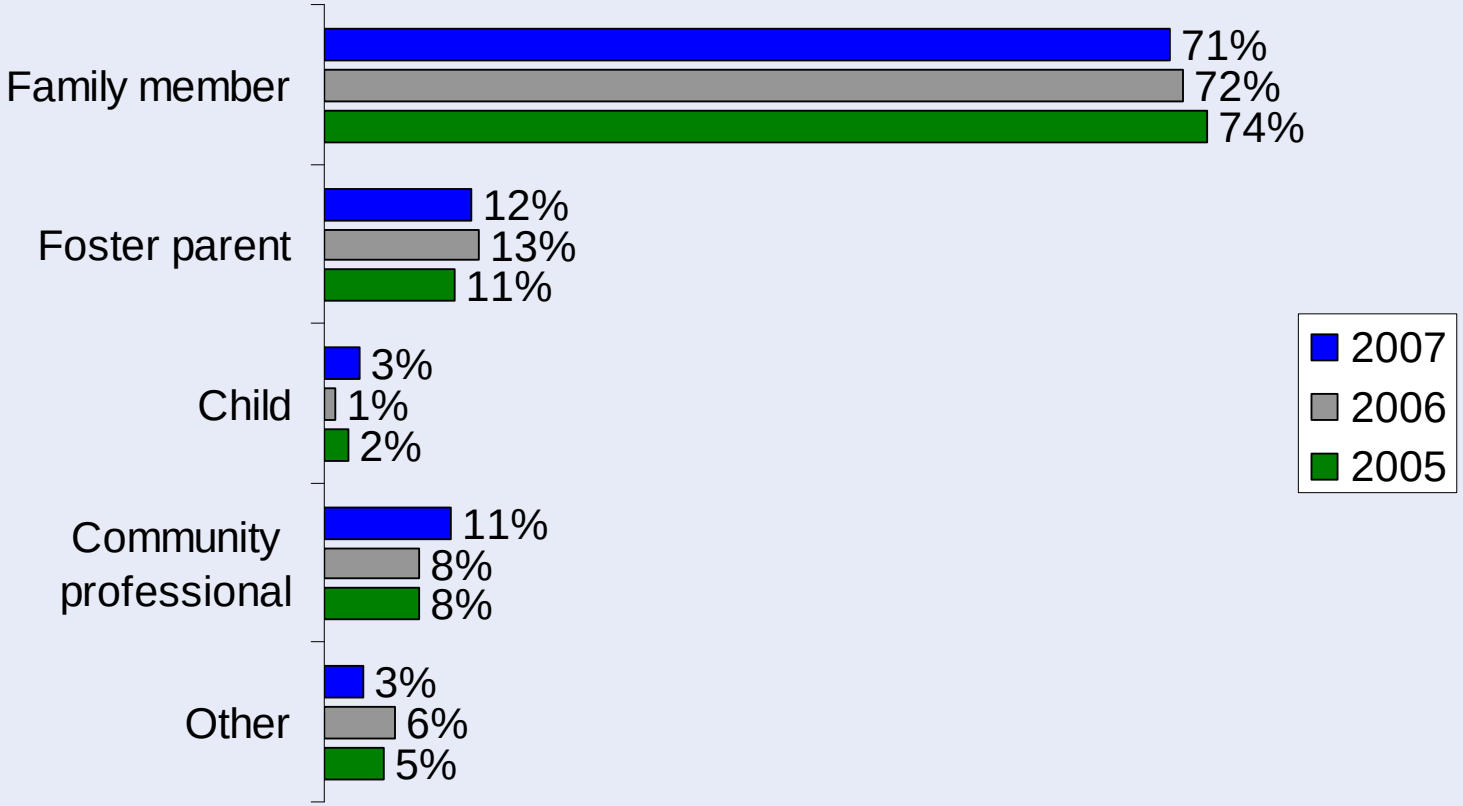
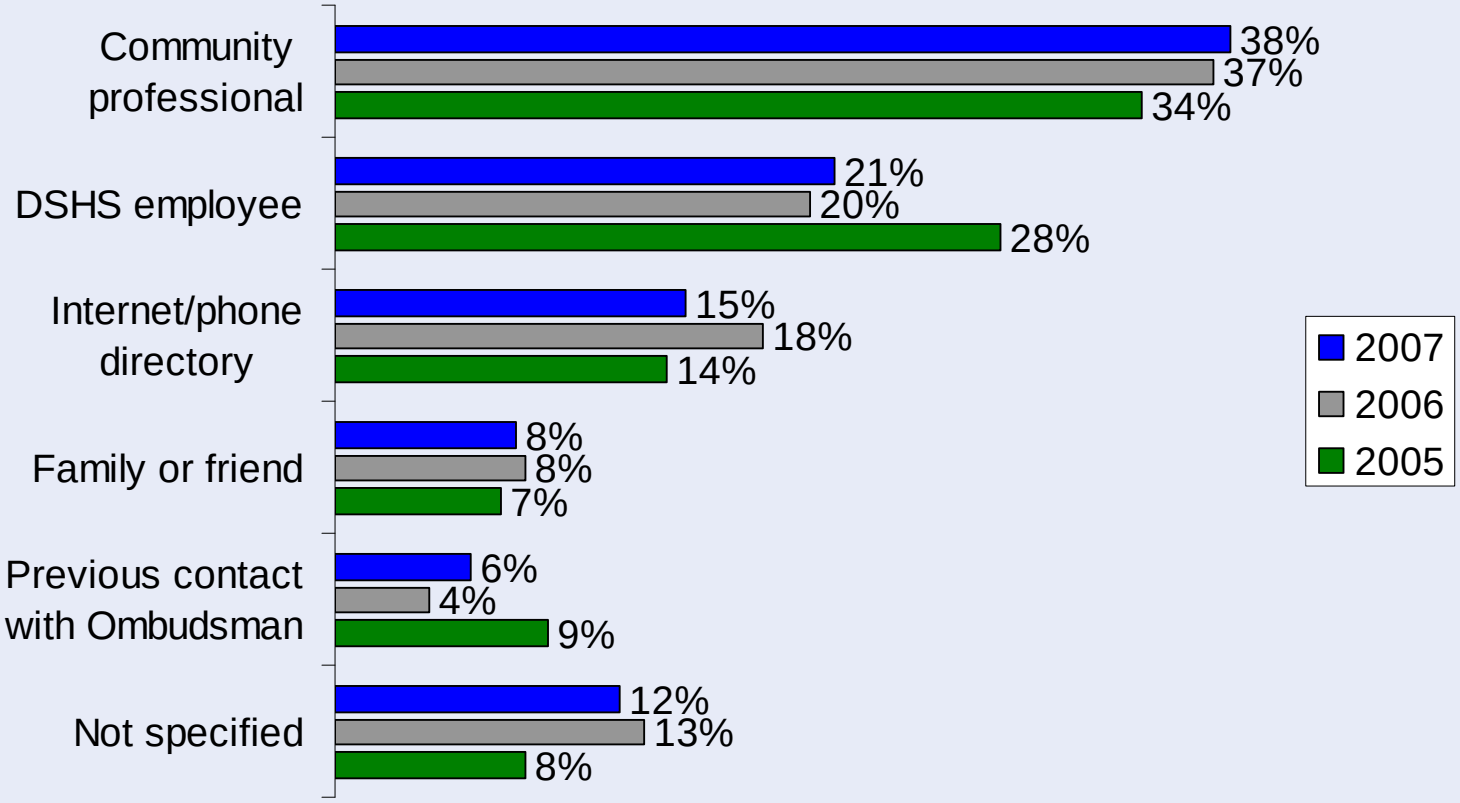
Persons Who Complained to the Ombudsman



How they Heard About the Ombudsman



Race of Complainant*

	OFCO 2006	OFCO 2007	WA State Census**
Caucasian	80.6%	80.2%	85.0%
African American	8.6%	11.5%	3.5%
American Indian/Alaska Native	9.0%	8.5%	1.7%
Hispanic	3.9%	2.8%	8.8%
Asian/Pacific Islander	1.4%	0.8%	6.4%
Other	1.8%	0.5%	--
Multi-Racial	3.7%	4.4%	3.0%
Declined to Answer	2.3%	2.9%	--

*Data adds up to over 100% because it allows people to self-identify with multiple races
**Taken from US Census http://quickfacts.census.gov/qfd/states/53000.html

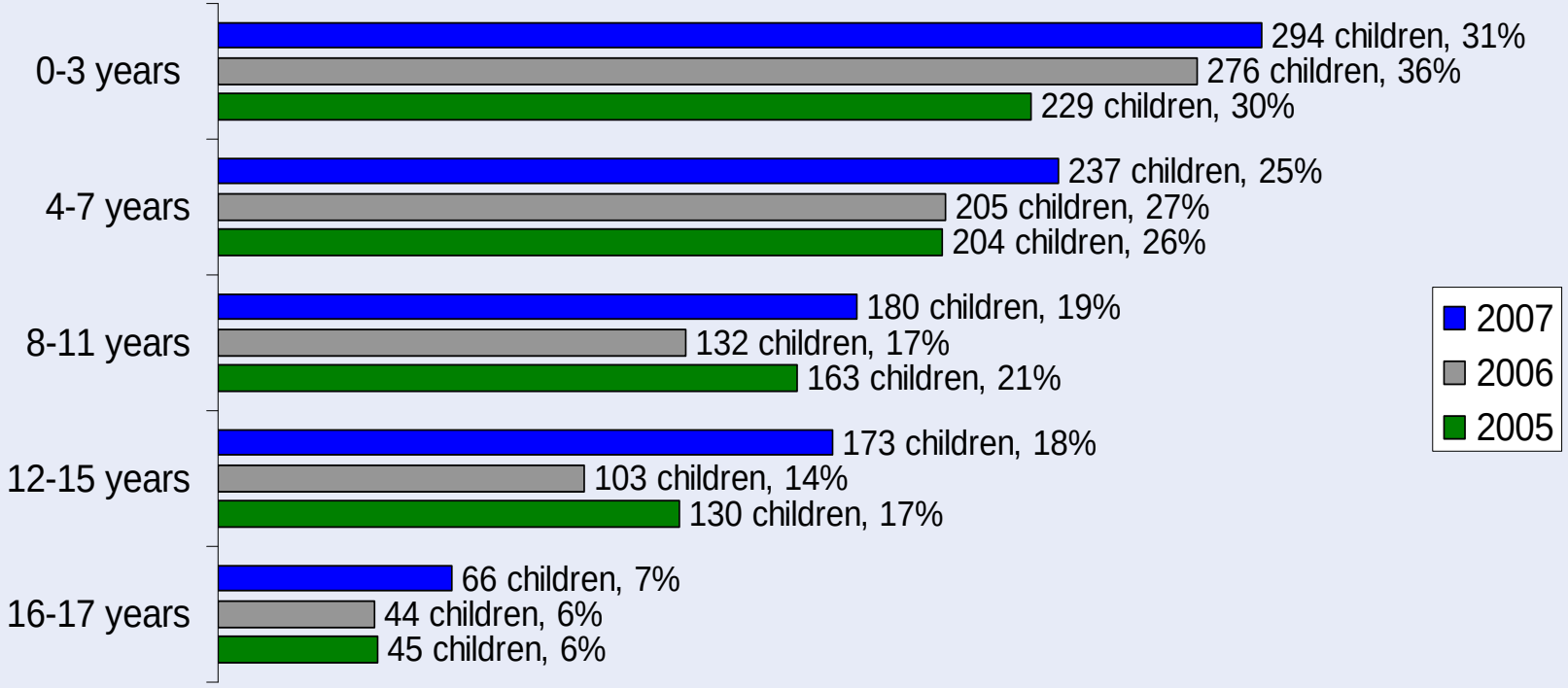
Race of Children*

	OFCO 2006	OFCO 2007	Children's Administration**
Caucasian	78.9%	76.8%	61.5%
African American	14.7%	20.0%	10.5%
American Indian/Alaska Native	11.4%	11.1%	11.9%
Hispanic	11.7%	8.7%	14.4%
Asian/Pacific Islander	2.2%	1.4%	1.2%
Other	1.7%	1.6%	3.5%
Multi-Racial	9.3%	11.4%	9.8%
Declined to Answer	--	0.5%	1.5%

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

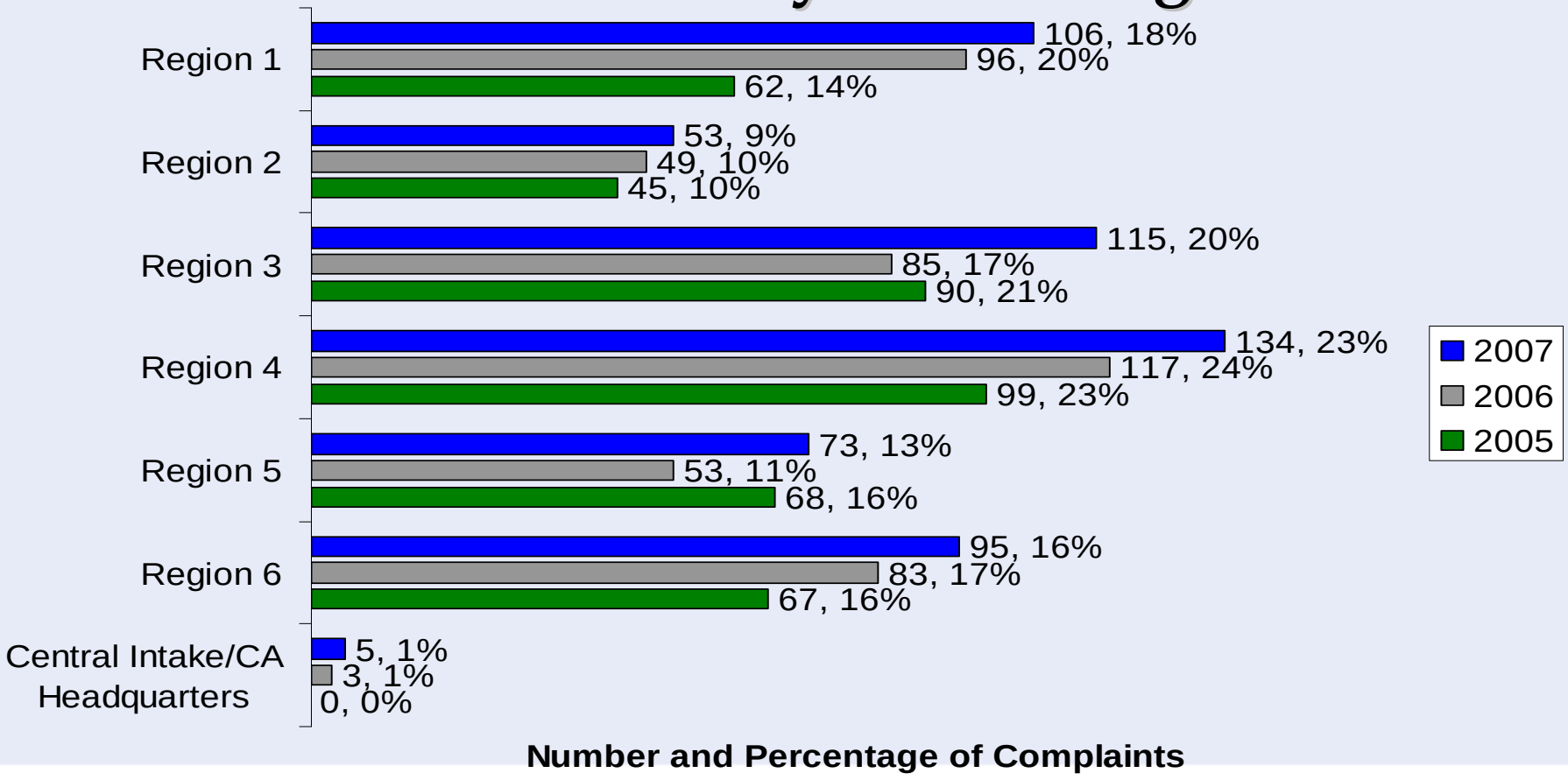
**Taken from Children's Administration Performance Report 2006 (http://www1.dshs.wa.gov/ca/pubs/2006perfrm.asp)

Ages of Children Identified in Complaints

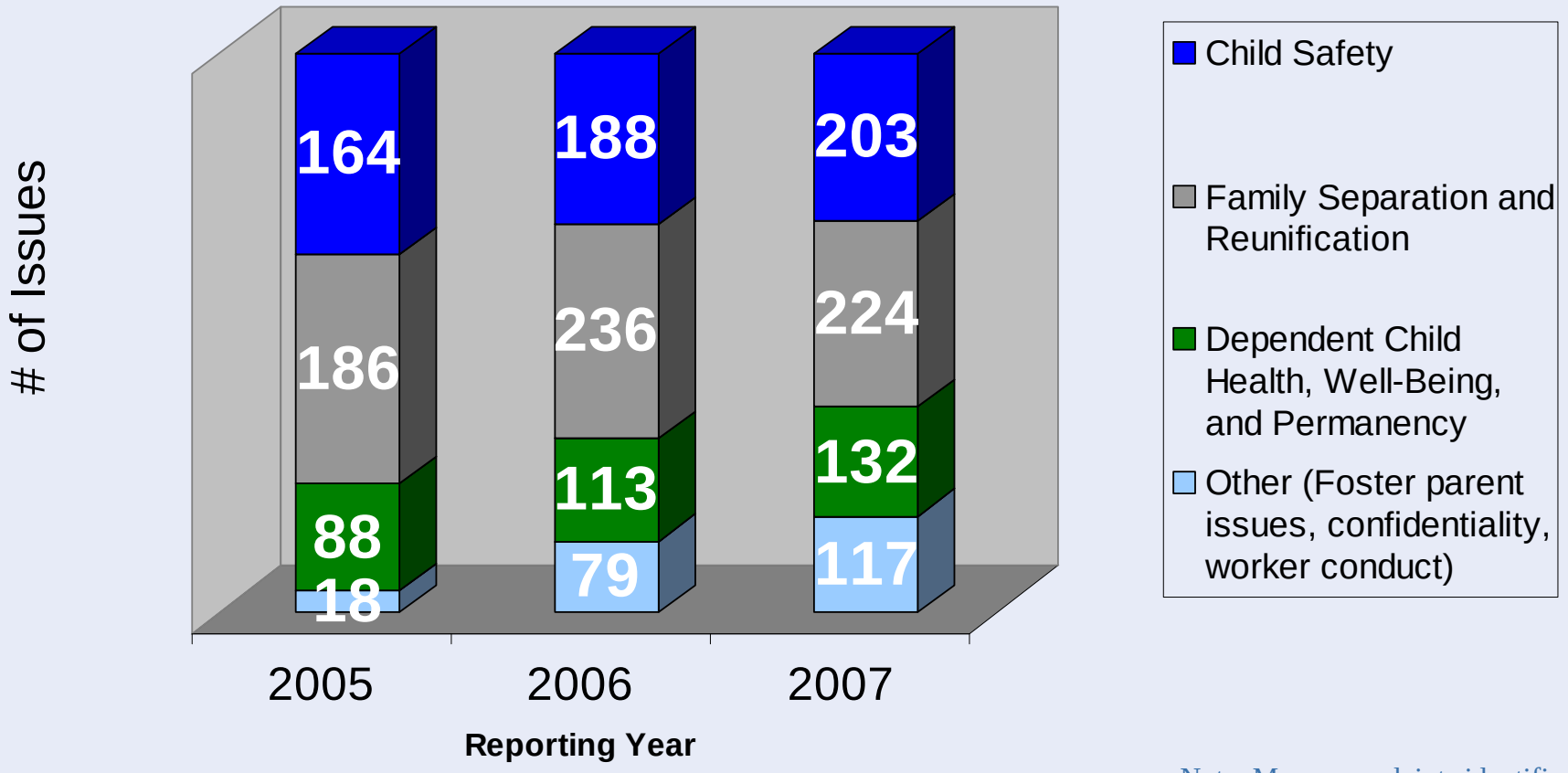


Note: Some individual children were counted more than once because they were identified in more than one complaint.

Complaints against the Children's Administration by DSHS Region

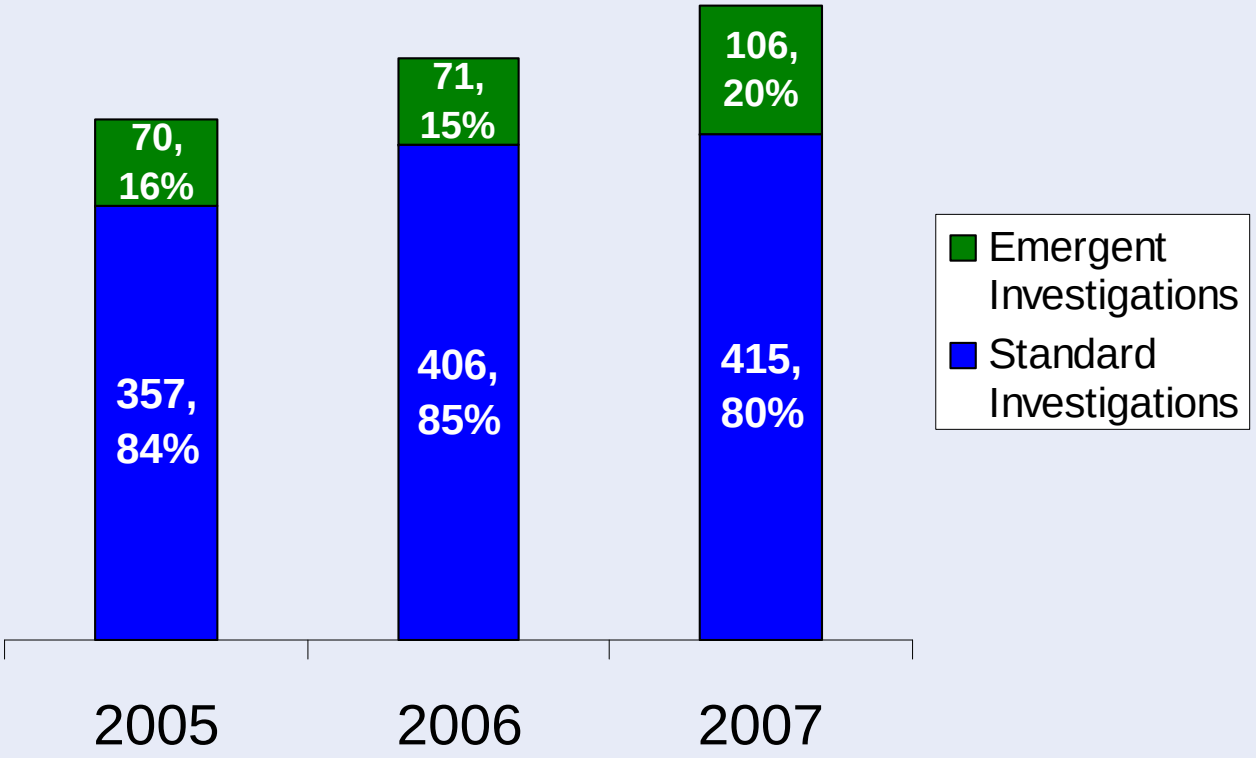


Complaint Issues



Note: Many complaints identified more than one issue.

Completed Investigations in Reporting Year



Ombudsman in Action

Inducing Corrective Action

When necessary, the Ombudsman induces DSHS or another agency to correct a mistake by sharing its investigation findings and analyses with supervisors and higher-level agency officials.

Finding: CPS returned two physically abused non-dependent children (an infant and toddler) to their parent without resolving the problems leading to their voluntary placement. CPS then failed to remove the children after the parent violated the safety agreement set up to prevent further abuse.

Ombudsman Action: Coordinated and facilitated sharing of information between two counties, CPS, CWS and the attorney general's office to ensure protective action

Outcome: CPS removed the children and filed a dependency petition

Ombudsman in Action

Facilitating Resolution

The Ombudsman frequently is able to resolve a concern before corrective action is necessary. *The office accomplishes this by ensuring that critical information is obtained and considered by the agency and facilitating communication among the people involved.*

Finding: CWS planned to move a 17-year-old dependent disabled youth who had aged out of the therapeutic placement the youth had been living in for two years. CWS had been unable to secure another appropriate long term placement before the youth's birthday, and planned to place the youth in interim care. The youth's providers believed that an interim placement would be disruptive and harmful to the youth's progress and well-being.

Ombudsman Action: Requested that DLR consider an administrative 30-day extension of the youth's current placement to allow CWS to secure an alternative long term placement for the youth.

Outcome: The extension was granted and an alternative placement found.

Assisting the Agency in Avoiding Errors and Conducting Better Practice

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

Finding: CWS failed to thoroughly investigate the cause of injuries to two dependent children occurring in their foster home. CWS had neither done a home visit, nor informed the foster home licensor about the incidents; furthermore, CWS had not contacted the children's medical providers to corroborate the foster parent's day care to verify injuries reported by the foster parent occurred there.

Ombudsman Action: Requested that CWS complete these tasks and if accidental injury was corroborated, that corrective action be taken with the foster parent to prevent similar injuries occurring in the future.

Outcome: CWS and OFCL complied with this request, ensuring a more thorough investigation and follow-up.

Ombudsman in Action

Preventing Future Mistakes

When corrective action is not possible, the Ombudsman ***brings the error to the attention of high-level agency officials, so they can take steps to prevent such mistakes from recurring*** *in the future.*

Finding: CPS failed to effectively communicate with law enforcement when placing a 3-year-old non-dependent child with a person identified as a relative by the parent. CPS did not realize law enforcement had taken the child into protective custody, making a voluntary placement agreement inappropriate. Furthermore, the caregiver chosen by the parent (who was later discovered to be unrelated to the child) was mistakenly cleared for placement by central intake despite having a history of 14 CPS referrals. Within 3 days of the placement, the caregiver violated the CPS safety plan by allowing the child to be taken out-of-state by a relative.

Ombudsman Action: Alerted CPS to history of CPS referrals and discussed management of this case with the supervisor.

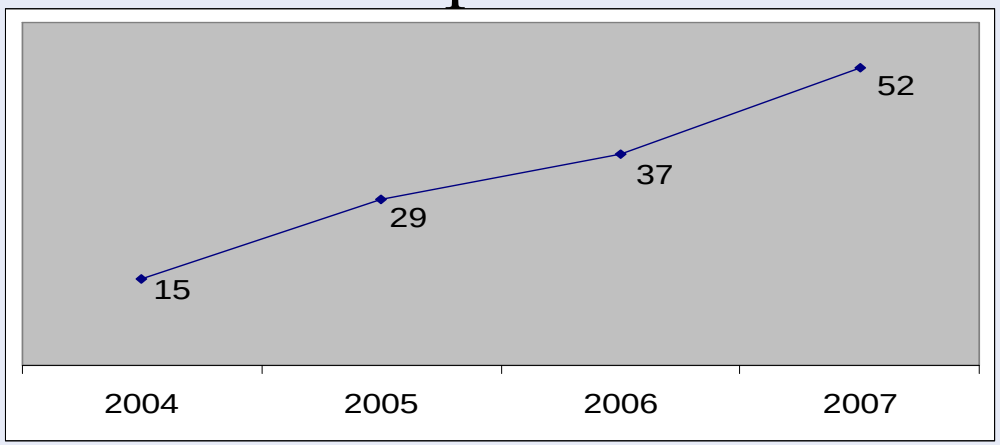
Outcome: CPS immediately obtained a court order for the child to be picked up out-of-state and placed in foster care in WA. The supervisor reported the inadequate background check of the caregiver to the area administrator, for follow up with Central Intake.

2006 Annual Report: Key Findings & Recommendations

- The need for better case practice in Native cases;
- A more effective response to children with special needs; and
- More manageable caseloads for DSHS workers

Indian Children and Families: Issues

- ICWA-related Complaints are on the Rise



- Indian Children are Disproportionately Represented in the Child Welfare System
- The Rate of Indian Child Fatalities is also Disproportionately High

Indian Children and Families: Recommendations

Recommendation 1: Increase Communication Among Stakeholders

Recommendation 2: Identify Gaps in Resources and Services

Recommendation 3: Avoid Long-Term Placement Disruption

Recommendation 4: Clarify Applicability of Permanency Timeframes

Recommendation 5: Implement a Weighted Caseload

Recommendation 6: Be an Active Player

Families in Crisis: Fractured System Fails Children with Special Needs

Recommendation 1: Establish a Protocol to Expedite Placement

Recommendation 2: Convene a Task Force to Develop a More Effective Response to Requests for Services from Adoptive Parents

Recommendation 3: Eliminate Waiting List for Children who qualify for Long-Term Inpatient Care in a CLIP Facility.

Establish Manageable Workloads

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.**

Impact of Annual Report

Media attention helps to elevate our concerns to the public, the agency, the Legislature, and the Governor.

- KXLY in Spokane aired a story on our 2006 Annual Report on 11/29/2007.
- King 5 in Seattle aired an investigative story on 11/29/2007 regarding failure of system to address special needs of foster children http://www.king5.com/localnews/investigators/stories/NW_112907INV_foster_care_follow_up_KS.50610365.html

Recommendations in annual report lead to legislative enactments

Highlights of 2008 Legislative Session

Passage of 2SSB 6206 requires:

- OFCO to issue an annual report to the legislature on the status of the Department's implementation of child fatality review recommendations.
- The Department to notify OFCO 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.
- OFCO to analyze a random sampling of referrals made by mandated reporters during 2006 and 2007 and report to the appropriate committees of the legislature.
- The Department to notify a child's guardian ad litem upon receiving a report of alleged abuse or neglect involving a child under the court's jurisdiction.

OFCO testified on a number of bills during the 2008 Legislative Session. OFCO's testimony can be viewed at http://www.governor.wa.gov/ofco

Two Highlights of 2007 Legislative Session

Enactment of:

- **SHB 1333 "Sirita's Law"** (effective 7/22/07) – Provides for greater scrutiny of adult caregivers in the home – **OFCO recommended heightened assessment of adult caregivers after reviewing fatality of Sirita and finding that the stepmother did not undergo assessment or evaluation prior to placement of Sirita.**

- **2SHB 1334 "Rafael Gomez Act"** (effective 7/22/07) – Requires the petitioner in a child welfare case to provide the court with relevant documentation to support recommendations and opinions.

What's Ahead for OFCO?

- OFCO received funding for 2 additional FTEs in 2008 to implement mandates of 2SSB 6206.
- Reporting on results of site visits to group homes/interviews of foster care youth.
- Reporting on results of reviewing referral screening decisions by DSHS.
- Ongoing review & reporting of child fatalities and identification of systemic flaws.
- Ongoing monitoring of Braam compliance.