The majority of complaints involved the Division of Children and Family Services.

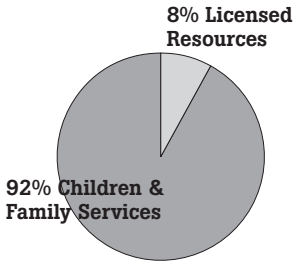
Ninety percent of all complaints involved the DSHS Children's Administration.[2] Ninety-two percent of those complaints involved the Division of Children and Family Services (DCFS), which includes Child Protective Services, Child Welfare and Adoption Services, and Family Reconciliation Services. The remaining eight 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.

Complaints against the Children's Administration by region.

	Children & Family Services	Licensed Resources
Region 1 Totals	**34**	**0**
Spokane	17	
Colville	7	
Wenatchee	4	
Moses Lake	4	
Newport	1	
Colfax	1	
Region 2 Totals	**28**	**6**
Yakima	14	2
Richland/Tri-Cities	7	2
Clarkston	2	
Ellensburg	2	
Toppenish	2	2
Walla Walla	1	
Region 3 Totals	**32**	**3**
Everett	11	3
Arlington/Smokey Point	5	
Monroe/Sky Valley	5	
Bellingham	4	
Alderwood/Lynwood	4	
Mount Vernon	3	

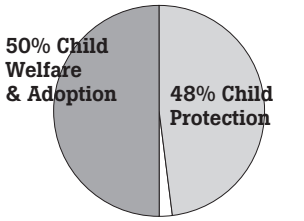
	Children & Family Services	Licensed Resources
Region 4 Totals	**62**	**8**
Seattle South	16	1
Kent/King South	16	1
Seattle Central	13	5
Seattle North	10	1
Bellevue/King Eastside	7	
Region 5 Totals	**36**	**4**
Tacoma	20	2
Bremerton/Kitsap	16	2
Region 6 Totals	**45**	**0**
Vancouver	6	
Centralia	5	
Kelso	5	
Port Townsend	5	
South Bend	5	
Aberdeen	4	
Shelton	4	
Lacey/Olympia	3	
Tumwater	3	
Port Angeles	3	
White Salmon	1	
Forks	1	

Complaints against DSHS Children's Administration



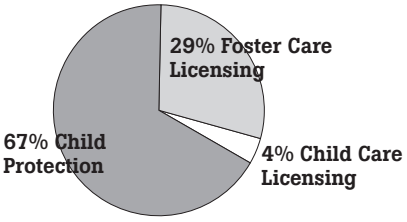
Total Complaints = 258

Children and Family Services



Total Complaints = 237

Licensed Resources



Total Complaints = 21

2. The remaining 10 percent involved: seven percent—Criminal Court, Dependency Court, Family Court, Regional Support Network, State-contracted Service Provider, State-licensed Child Placing Agency, and Washington State School for the Deaf; three percent—Other DSHS Divisions, including Community Services Division, Division of Child Support, and Division of Developmental Disabilities.

Safety of children was the number one complaint issue.

Safety of children was the issue most frequently identified in complaints to the Ombudsman. Of concern was the safety of children living in their parents' care, as well as the safety of children living in foster care, or in other substitute care. Half of the 456 children identified in complaints were age seven or younger.

Most frequently identified issues in complaints to the Ombudsman.

(*Number of complaints follows each issue.*[3])

Child Safety…121

Children in their Parents' Care

Failure to protect children from:
- Physical neglect by parent 24
- Physical abuse 23
- Sexual abuse 12
- Medical neglect by parent 9
- Emotional abuse by parent..... 9

Failure to protect dependent children in their parents' care 6

Failure to provide appropriate placement or services for children who may harm themselves or others 6

Children in Substitute Care

Failure to address safety concerns involving:
- Licensed foster home 11
- Relative's home 9
- Children being returned to parents' care 8

Failure to provide appropriate placement or services for dependent children who may harm themselves or others 4

Family Separation and Reunification…92

Unnecessary removal of children from parents..... 23

Failure to provide appropriate contact between children and parents.... 17

Failure to place children with relatives..... 15

Inappropriate removal of dependent children from parents' care..... 8

Inappropriate termination of parental rights..... 8

Failure to reunify families that have complied with court ordered services 7

Failure to provide access to family reunification services 7

Inappropriate permanent placement plan (guardianship or termination of parental rights) for children 7

Dependent Child Health, Well-being and Permanent Placement…48

Inappropriate removal of children living with relatives..... 19

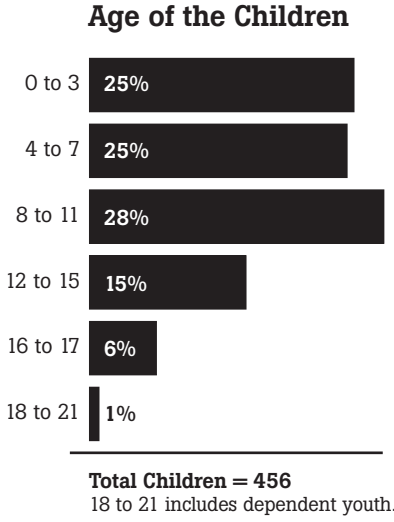
Inappropriate removal of children from a non–relative foster home.. 13

Failure to make mental health services available for children 8

Unreasonable delay or opposition to adoption by relatives 4

Unreasonable delay or opposition to adoption by foster parents..... 4

Half of the children identified in complaints were seven or younger.



3. Some complaints identified more than one issue.

The Office of the Family and Children's Ombudsman conducted 290 complaint investigations.[4]

Fifty-two percent were completed and resulted in findings. Thirty-one percent were closed prior to completion because the complaint was resolved or for another reason. Seventeen percent were still open at the end of the reporting period.

Completed investigations means sufficient information had been gathered to evaluate an agency's action or inaction and to make findings. Details of the findings and outcomes of the 150 investigations completed by the Ombudsman are listed in the tables on the next four pages.

Findings:

Did the alleged action or inaction occur?

138 investigations supported complaint allegations that the agency was acting or refusing to act in a particular way. Example: *Child Protective Services was refusing to investigate a child abuse report as alleged.* Twelve investigations did not support complaint allegations about the agency's conduct, or could not determine whether the alleged action or inaction occurred.

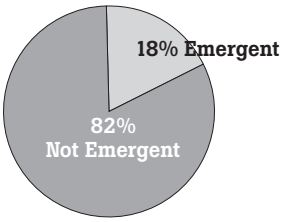
If so, was the action or inaction a violation of law, policy, procedure, or unreasonable exercise of authority?

127 investigations ended with no adverse findings. The agency's action or inaction was authorized by law, policy or procedure, and constituted a reasonable exercise of discretion.

11 investigations ended with adverse findings. The agency's conduct clearly violated a law, policy or procedure, or constituted an unreasonable exercise of discretion. In most cases, the agency acknowledged the violation and/or agreed to alter its course of action to address the Ombudsman's concern.

One out of six complaint investigations opened in the period met Ombudsman criteria for initiating an immediate investigation.

Emergent Investigations



Total Opened Complaint Investigations = 260

Emergent Criteria—If true, the alleged agency action or inaction would place the safety or well-being of a child or family at risk of serious harm.

4. Of these, 260 investigations were opened during the reporting year, and 30 were ongoing investigations from a previous period. For purposes of this report, investigations of complaints raising identical issues are counted only once.

Completed investigations.

No Adverse Findings. One-hundred twenty-seven investigations resulted in no adverse findings against the agency. This table identifies the agency actions and decisions that the Ombudsman investigated and determined were authorized and reasonable. These actions and decisions are categorized by issue area. Some complaint investigations addressed more than one action or decision.

Safety of Child in Parents' Care…28	**Safety of Child in Substitute Care…11**	**Family Separation and Reunification…88**
CPS decision not to take any protective action and/or close case after the investigation was complete..... 9	CPS decision to return a dependent child to the parents' care..... 3	CPS decision to seek court authorization to remove a child from home and/or file for dependency..... 26
CPS decision to screen out or not investigate report of alleged child mistreatment..... 6	DLR determination that abuse or neglect allegation against the foster parent was unfounded..... 3	CWS decision to recommend or support a permanent plan for guardianship and/or termination of parental rights..... 11
CPS decision not to seek removal of a child from parents' care..... 4	DLR decision not to seek removal of a dependent child from a foster home despite allegations that the home is unsafe 2	CWS decision not to return a dependent child to the parent's care..... 8
CPS decision not to remove a dependent child from parents' care..... 3	CWS decision to place a dependent child with a relative despite allegations the relative is unsafe..... 1	CWS decision not to place a child with a relative 8
CPS decision not to interview particular individuals during investigation ... 2	CWS decision not to place a dependent child in a residential facility..... 1	CWS removal of a dependent child from placement with a relative based on safety reasons..... 6
CPS decision to close a case after services were provided..... 1	CPS decision to place a youth with an unlicensed "responsible adult" 1	CWS removal of a dependent child from placement with a relative based on the child's long-term needs 5
CPS decision to seek dismissal of a child's in-home dependency 1		CWS decision to prohibit or suspend contact between a parent/relative and a child 5
CPS decision to seek voluntary placement agreement rather than dependency..... 1		CPS determination that allegation of parental abuse was founded or inconclusive 4
CPS decision to place a child with the non-custodial parent despite allegations the parent is unsafe..... 1		CWS decision regarding the parent's selection of service provider..... 3
		DLR determination that abuse allegation against a parent, who is also a licensed foster parent, was founded..... 2

Family Separation and Reunification *(continued)*

CWS decision to place a child in a foster home that is distant from the family 2

CPS decision to investigate abuse or neglect allegations against a parent..... 2

CWS decision not to seek early dismissal of in-home dependency..... 1

CWS failure to notify a non-custodial parent of custodial parent's voluntary placement of a child and to provide other confidential information 1

CWS removal of a child from foster adoption placement that was supported by the child's birth parent when the parent relinquished parental rights1

CWS failure to obtain an open adoption agreement permitting ongoing contact between a child and relatives..... 1

CWS decision not to obtain a psychologist's assessment of a dependent child to facilitate treatment of the child's parent..... 1

CPS support of a youth's court petition for substitute placement 1

Dependent Child Health, Well-being, and Permanent Placement…8

CWS decision not to remove a child from a relative despite allegations that the relative cannot meet the child's needs..... 2

CWS decision to change child's non-relative foster placement based on the child's long-term needs 2

CWS decision to change a child's non-relative foster placement based on concerns about the child's safety..... 1

CWS decision to place a child with relatives in another state..... 1

CWS decision not to place a child with a previous foster parent 1

CWS decision not to support adoption by a child's previous foster parent..... 1

Other Issues…10

Financial disputes..... 3

Disputes about the accuracy of DCFS case file information..... 2

DLR decision to require evaluation of a foster parent..... 2

DLR decision to seek revocation of a foster license 1

Continuance of a 72-hour shelter-care court hearing 1

CWS response to a contracted in-home service provider error..... 1

Terms and Acronyms

Dependent Child…A child for whom the State is acting as the legal parent.

CPS.....Child Protective Services

CWS .....Child Welfare Services

DCFS .....Division of Children and Family Services

DLR .....Division of Licensed Resources

Completed investigations.

Adverse Findings. Eleven investigations resulted in adverse findings against the agency. This table identifies the agency actions and decisions that the Ombudsman investigated and determined to be unauthorized or unreasonable. It also identifies the outcome of the case.

Current Actions and Decisions

1. Finding—CPS was unreasonably screening out report by relatives expressing concern about an unstable parent.

Outcome—At the Ombudsman's urging, CPS reconsidered the decision and conducted an investigation. The parent admitted ongoing drug use and agreed to give his relatives legal custody of the children.

2. Finding—CPS was unreasonably screening out a report by a mental health professional expressing concern about an unstable parent.

Outcome—At the Ombudsman's urging, CPS reconsidered the decision and conducted an investigation. In-home support services were provided. After receiving additional reports of concern from community professionals, the agency sought legal authority to remove the children from their parents' care.

3. Finding—CPS and the Attorney General's Office were unreasonably delaying the filing of a dependency petition on a 14 year-old mother and her infant, because of an inter-regional dispute regarding jurisdictional responsibility.

Outcome—At the Ombudsman's urging, a dependency petition was quickly filed on the mother and infant.

4. Finding—Family Reconciliation Services was unreasonably deciding to send home a youth upon release from a crisis residential center (CRC) without first obtaining a mental health evaluation, after the youth had made suicide threats and despite a CRC staff recommendation that the youth not be sent home.

Outcome—At the Ombudsman's urging, the youth was evaluated by a mental health professional who recommended in-patient treatment. The youth refused to enter treatment. He and his family were provided with in-home support services.

5. Finding—CWS had failed to conduct a search for relatives of a legally free child even though their interest and availability in caring for the child was documented in the case file. The agency placed the child with foster parents who now were seeking to adopt the child.

Outcome—DCSF acknowledged the error and agreed to consider the relatives as a potential permanent placement. However, the court ultimately approved adoption of the child by his foster parents.

6. Finding—CWS was requiring a relative foster parent to complete an intrusive parenting evaluation questionnaire. The agency was also relying on recommendations of a substandard parenting evaluation in determining a child's permanent placement.

Outcome—At the Ombudsman's urging, CWS agreed not to require the relative foster parent to complete the questionnaire, and agreed not to rely on the parenting evaluation recommendations. The child was eventually adopted by the relative foster parent.

Past Actions and Decisions

7. Finding—CPS had unreasonably screened out reports by mental health professionals in 1996, expressing concern about an unstable parent.

Outcome—CPS had appropriately investigated subsequent reports and eventually provided the family with intensive in-home services. The Ombudsman took no further action.

8. Finding—CWS had briefly left two children alone with their mother during a supervised visit which allowed the mother to flee with the children.

Outcome—By the time the Ombudsman received this complaint, the family had been located in another part of the state. DCFS acknowledged the error and indicated it had reviewed the incident with the CWS worker. The Ombudsman took no further action.

9. Finding—CWS (after consulting with the Attorney General's Office) had unreasonably decided not to issue a warrant for a 16 year-old dependent Washington State youth, who had run away to another state with her ten month-old infant, despite an earlier request by the other state's child welfare agency.

Outcome—By the time the Ombudsman received this complaint, CWS had issued a warrant, and the youth and her infant were eventually returned to Washington State. The Ombudsman took no further action.

10. Finding—CWS had unreasonably failed to provide support to a foster parent during the psychiatric crisis of a young child. The agency also had not provided timely access to appropriate psychiatric services.

Outcome—The child was ultimately moved from the foster home. The Ombudsman was informed that the CWS worker no longer worked in that office. The lack of support for foster parents and the difficulty in accessing children's mental health services are systemic problems that the Ombudsman has brought to the attention of state policy makers and agency officials.

11. Finding—CWS had unreasonably failed to notify a parent by certified mail about proceedings to terminate parental rights.

Outcome—The parent did not appear at the proceeding to contest the state's motion and her rights were terminated. The Ombudsman brought this matter to the agency's attention and CWS agreed to investigate it further.

The Ombudsman challenges an agency's reliance upon an evaluation by a contracted provider.

A community professional contacted the Ombudsman after DCFS abruptly removed a 5-year-old legally free child from her foster home. The child had been living in the home since infancy and the foster parents, who were distant relatives, were planning to adopt her. The child's sibling, who had previously lived in this home but had since been moved to a different foster home, had made allegations of sexual abuse by an adolescent boy in the foster home. Similar allegations of physical and sexual abuse by a wide range of people in her life had been unfounded in the past, and the professional believed that DCFS held a bias against the foster parents and was not considering information provided by other professionals who knew the family well.

About six weeks after removing the child, and after initial investigation of the allegations, the agency requested that the foster parents undergo a parenting evaluation to assess their suitability as a permanent placement for the child. The foster parents agreed to an evaluation by the provider who was already supervising visits between the foster parents and the child, at DCFS request. The evaluation was completed, and recommended that the child not be returned to the home until a number of different evaluations, including psychological evaluations, and treatment gains had been made by the foster parents. Upon review of the evaluation, the Ombudsman found significant problems, bringing into question its validity and that of the recommendations. The Ombudsman obtained a blind peer review of the evaluation, which strongly validated and underscored these concerns. At this point, the Ombudsman recommended that the agency disregard the findings and recommendations of this evaluator. The agency agreed, but decided to request a psychological evaluation of the foster parents. The Ombudsman concurred with this plan but recommended that the evaluator be mutually agreed upon by the foster parents and the agency. The psychological evaluation was expedited, and the evaluator recommended immediate return of the child to the foster home. Meanwhile, the investigation of the sibling's allegations was concluded and determined to be unfounded. The child was returned to the foster home and has since been adopted by the foster parents.

Investigations closed prior to completion.

Ninety–one complaints closed before the Ombudsman's investigation was complete.

Fifty–eight investigations were closed because the complaint was resolved during the investigation. In many cases, the Ombudsman's efforts to ensure that critical information was obtained and considered by the agency and to facilitate communication among the people involved resolved the problem. In other cases, the Ombudsman monitored the situation while the agency reached a decision. The table below describes how these complaints were resolved.

Summary of Closed Investigations

Resolved Complaints 64%

Other 36%

Total Closed Investigations = 91

Safety of Child in Parents' Care…18	**Safety of Child in Substitute Care…13**	**Family Separation and Reunification…9**
CPS obtained parental or court approval to place a child in substitute care 9	Dependent child received appropriate psychiatric assessment and/or residential treatment 4	Child placed with or allowed to remain in the care of an appropriate relative 5
CPS conducted investigation and offered appropriate services 3	Developmentally disabled child provided with appropriate institutional or group care placement 2	CWS agreed to consider a relative as a placement option and allow visitation 1
CPS removed a dependent child from a parent's care..... 2	Child removed from a foster home for safety reasons..... 2	CPS allowed a parent to take a dependent child to a preferred place of worship..... 1
CPS ensured that a parent obtained clinical assessments of a child 1	Dependency petition filed on a child placed by a parent with a relative..... 2	CPS confirmed that it did not screen in an inaccurate report that a developmentally disabled parent had abandoned a child..... 1
CPS notified a Tribe about a report involving a tribal family 1	Dependent child provided with appropriate therapeutic foster placement 1	CWS provided a parent with culturally appropriate reunification services..... 1
CPS and Prosecuting Attorney's office increased the rate of dependency filings 1	Child provided with appropriate placement upon release from a mental health facility..... 1	
Division of Developmental Disabilities provided appropriate in–home services to a developmentally disabled parent caring for a developmentally disabled child 1	CPS agreed not to allow a non–custodial parent to provide respite care for a dependent child 1	

The other 33 complaint investigations closed because nine complaints were withdrawn, while the complaint issue became moot in seven investigations. The remaining 17 investigations were closed because the complaint issues were determined to be outside of the Ombudsman's jurisdiction. These individuals were referred to another agency that could help with the following concerns:

Legal Proceedings—Actions by judges, commissioners, guardians ad litem, parenting investigators, and attorneys.

Support Enforcement—Actions by DSHS not affecting a family involved with the state due to child abuse or neglect issues.

Actions by child welfare agencies from another state.

Clinical Decisions—by mental health or medical professionals.

Educator and Service Provider Decisions—to report child abuse or neglect as required by State law (RCW 26.44).

Dependent Child Health, Well-being and Permanent Placement…4

DLR allowed a youth to stay in a current foster placement while making arrangements for a new placement 1

CWS returned a child to a previous foster home as requested by the child and recommended by a counselor 1

Developmentally disabled youth (age 18) allowed to stay in a current foster placement until age 21 1

CWS held prognostic staffing to assess the long-term needs of a youth 1

Other Issues…14

DCFS agreed to assign a new caseworker to a family/child 7

Financial dispute resolved 3

CPS agreed to change a neglect finding 1

DLR provided a foster parent with investigative finding 1

DLR assisted a parent with a CPS reporting issue 1

DCSF acknowledged a caseworker's performance issues and confirmed that the worker is no longer with the agency 1

Getting CPS to reconsider screening out a child abuse report for investigation

An aunt contacted the Ombudsman, requesting immediate action on her concern about the safety of her four nieces and nephews. The children's parents had a history of domestic violence and substance abuse, and according to the aunt, their father had physically abused them in the past and was mentally unstable. The children had been in their grandparents' care for the previous five years, until a couple of months prior, when the father arranged for the aunt to care for the children. Soon after placing the children with the aunt, the father was reported to have been driving a stolen vehicle, after vandalizing the mother's car. He was allegedly in possession of a loaded gun, threatening to commit suicide and "take his children with him." The aunt reported this information to CPS. Following this report, the father called the school to instruct the children to return to his home that day rather than go to their aunt's. CPS told the aunt that they would not investigate the situation.

The Ombudsman checked the department's automated database (CAMIS) and found a CPS history on the family dating back to 1993 with seven prior reports of chronic parental neglect and substance abuse. The children had previously been placed in state custody. The Ombudsman contacted CPS and found that the aunt's report had in fact been screened out without an investigation. The Ombudsman expressed concern about the situation in light of the family's CPS history, the father's current stability, and other risk factors. CPS decided to screen in the referral for investigation. During the investigation, the father admitted to CPS that he was using methamphetamine and agreed to seek treatment. A month later, the father agreed to give the aunt and another relative legal custody of the children.

The Ombudsman persuades CPS to remove children from a dangerous home environment

The Ombudsman was contacted by a school counselor requesting immediate action on his concerns about the safety of four children whom he believed were living in a dangerous home environment. School professionals as well as mental health providers working with this family were extremely concerned that CPS was not intervening aggressively enough to ensure the safety of the children. These professionals had made numerous reports to CPS alleging physical abuse, neglect, and emotional abuse of the children by their parents. The family had a history of moving from place to place, and had moved to Washington from Oregon two years previously. CPS received 18 reports on the family in those two years. The 11 year-old had been placed in foster care for about six weeks under a voluntary placement agreement between DCFS and the parents, following physical abuse of the child by her stepfather. The child was returned home on condition that the parents participate in various services.

At the time that the Ombudsman was contacted, the parents were failing to comply with services, and the children were exhibiting a great deal of fear and stress. The 11 year-old had told the CPS caseworker that there had been a lot of yelling in the home and that she was afraid of her stepfather. The children had head lice, one child was vomiting at school, and the younger children were wetting and soiling their pants. The in-home service provider was in disagreement with other professionals involved with the family, regarding the level of risk to the children and specifically, regarding whether the mother was actively using drugs.

When the Ombudsman contacted DCFS, the caseworker and supervisor stated that they'd been advised by the assistant attorney general to gather and document further information on the family as there was insufficient information supporting the need for substitute placement of the children. The Ombudsman raised concerns about the risk to the children's safety if they were left in the home while further documentation was obtained. DCFS agreed to increase the monitoring of the children in the home so that the DCFS worker and other professionals were visiting the home at frequent intervals, including on weekends. The Ombudsman then reviewed the DCFS case file. The Ombudsman learned that the family had a CPS history in Oregon, where the mother's parental rights to two older children had been terminated, and relinquished with regard to a third child. Three of the children had been placed in the state's custody there. The Ombudsman requested that CPS obtain the Oregon records as soon as possible and offered to assist in retrieving these. After completing this review, the Ombudsman strongly challenged the need to obtain further information. In response, and after learning that the mother had tested positive for methamphetamine and amphetamines, DCFS agreed without delay to seek court authorization to take the children into protective custody. The court approved the request, and the children were placed in foster care.

Fatality review.

Three year-old Zy'Nyia Nobles died at home on May 27, 2000. Zy'Nyia's brother saw their mother beating his sister. The mother was arrested and charged with homicide by abuse. The children had been dependent and living in foster care since February 1997. The Division of Children and Family Services (DCFS) returned them to their mother in February 2000, and the family remained under state supervision.

The Family and Children's Ombudsman reviewed case records to learn why the children had been returned to their mother, and to find out what services had been in place to support the family and monitor the children's safety.

Zy'Nyia's death was also reviewed by a Community Fatality Review Team convened by DCFS. The Team included a physician, attorney, mental health and substance abuse professionals, guardian ad litem, foster parent, legislators, and others. At the Team's first meeting on July 13, 2000, the Ombudsman presented its completed investigation summary and identified several performance and system issues.[1]

The Ombudsman asked the Community Fatality Team to consider these issues in a review of Zy'Nyia's death:

Performance Issues

Lack of Assessments—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.

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-ordered mental health counseling. Yet, the caseworker returned the children to their mother.

Family Support and Monitoring—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.

Child Safety Concerns—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.[2]

System Issues

Caseworker Bias—The Ombudsman asked the Team to consider how the system can better protect against caseworker bias. Bias occurs when a caseworker develops an initial belief about a person or event and then becomes resistant to altering that belief—even in the face of conflicting information.[3]

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.

In-home Service Providers—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.

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.

The Community Fatality Review Team released its report on November 29, 2000. The report addressed many of the issues pointed out in the Ombudsman review.[4]

1. Ombudsman July 2000 Review of Zy'Nyia Nobles Fatality, (edited to protect confidentiality): **www.governor.wa.gov/ofco**.
2. RCW 26.44.030 requires specified categories of professionals and service providers to report suspected child abuse and neglect.
3. Munro, E. (1996) Avoidable and Unavoidable Mistakes in Child Protection Work, British Journal of Social Work, 26, 793–808.
4. Zy'Nyia Nobles Fatality Review (edited to protect confidentiality): **www.wa.gov/dshs.**

Child safety

Recommendations Overview

In addition to investigating complaints, the Office of the Family and Children's Ombudsman is required by state law to develop recommendations for improving the child protection and child welfare system. The recommendations in this section are based on Ombudsman analysis of information derived from investigations, surveys and research. They are aimed at strengthening the state's protection of children.

State Law Issues

1. Modify the state law definition of neglect.
2. Require training for professionals and service providers that are mandated by state law to report child abuse and neglect.
3. Require DSHS to disseminate descriptive information about the Ombudsman.

System Resource Issues

1. Ensure that caseworkers have a reasonable workload.
2. Provide a guardian ad litem or volunteer court-appointed special advocate for every child that is the subject of a dependency proceeding.
3. Provide an adequate supply and range of placement options for children who cannot live safely at home.
4. Improve children's access to community mental health and residential treatment services.
5. Provide the Ombudsman with the capacity to monitor agency supervision of children's health and safety in residential settings.

DSHS Administration Issues

1. Implement key provisions of the *Kids Come First Action Agenda*.
2. Clarify and strengthen the role of supervisors.