TAKING ACTION ON BEHALF OF CHILDREN AND FAMILIES

The Ombudsman takes action when it has determined that intervention is necessary to avert or correct a harmful oversight or mistake by the Department of Social and Health Services (DSHS) or another agency.

If the Ombudsman concludes that DSHS or another agency is acting in a manner that is outside of the agency's authority or clearly unreasonable, and the act could result in foreseeable harm to a child or parent, the Ombudsman induces the agency to address the problem.

This section describes cases that were handled by the Ombudsman in the last two years. It illustrates how the office works to help DSHS avert and correct avoidable errors.

The Ombudsman's actions often consist of the following:

- Prompting DSHS to take a "closer look" at a concern by having the agency collect additional information so it can reasonably evaluate the situation.
- Facilitating information sharing among DSHS caseworkers, family members, and service professionals to ensure that the agency considers all of the pertinent information available to it before making a critical decision.
- Mediating professional disagreements among DSHS workers and between DSHS workers and other service providers to prevent the disagreement from delaying a critical DSHS decision and to ensure that the final decision is reasonably consistent with acceptable standards and practices.
- Sharing the Ombudsman's investigation findings and analysis with DSHS supervisors or higher-level agency officials to persuade them to correct a decision or course of action that the Ombudsman has determined is problematic.

The Ombudsman is often successful in resolving legitimate concerns by taking action.

The Ombudsman acts to:

- Prompt DSHS to take a "closer look."
- Facilitate information sharing to ensure all pertinent information is considered before critical decisions are made.
- Mediate professional disagreements to avoid delay.
- Share the Ombudsman's investigation findings and analysis with DSHS to correct a decision or course of action.

Through these actions, the Ombudsman is often successful in resolving legitimate concerns about the safety of a child or the well being of a parent or child.

Prompting DSHS to Take a Closer Look

In the course of a complaint investigation, the Ombudsman may identify a concern that has not been fully investigated or addressed by DSHS. When this occurs, the Ombudsman brings the concern to DSHS's attention so that it may receive further investigation and evaluation.

Child Protective Services Initiates Child-Safety Check

A public health nurse contacted the Ombudsman, expressing concern that DSHS Child Protective Services (CPS) was not taking sufficient steps to protect four children living at home, ranging in age from nine months to 11 years.

The nurse told the Ombudsman that the children's mother had been arrested and incarcerated on an alcohol-related offense, and that the children had been left in the care of three teenagers.

She expressed concern that the teens were not responsible caregivers, as they had reportedly been kicked out of their own homes and were not attending school.

The nurse described the children's home as filthy, and reported that the children had head lice and the 11-year old girl was sharing a bedroom with a 16-year old male.

She said that CPS had investigated her report, but was refusing to take protective action because the children did not appear to be at imminent risk. The Ombudsman initiated an emergent investigation.

During this process, the Ombudsman confirmed the nurse's account and found that both CPS and the police had investigated the situation several days earlier, but decided not to take protective action.

At that time, the mother had been out of the home for 48 hours. The Ombudsman contacted the CPS caseworker and her supervisor to discuss the report.

During the discussion, the Ombudsman suggested that CPS contact the police to request a child-safety check to determine whether the mother had returned home and to re-assess the children's situation.
The CPS caseworker agreed and went to the home the next day with a police officer.

They found that the mother had still not returned and there had not been any improvement in the children's circumstances.

The children were placed in protective custody, and CPS filed a dependency petition seeking legal custody.

Prompting DSHS to Take a Closer Look *(continued)*

The Ombudsman's ability to prompt DSHS to more closely scrutinize issues of concern has helped the agency avoid potentially harmful oversights and errors.

Child Welfare Services Initiates Child-Safety Check

An aunt filed a complaint with the Ombudsman alleging that DSHS Child Welfare Services (CWS) was refusing to reunite the aunt's three-year-old niece with her mother, despite the fact that the girl's six-year-old brother had been reunited with their mother several months earlier.

The aunt objected to the inconsistencies in CWS's case plans for each child and believed there was no good reason for the three-year-old girl not to be returned home, as her mother had complied with all court-ordered services, the girl was having unsupervised weekend overnight visits with her mother, and the six-year-old boy appeared to be doing well in his mother's care while under CWS supervision.

After investigating the aunt's complaint, the Ombudsman determined that CWS's refusal to reunite the three-year-old girl with her mother was authorized and reasonable.

The Ombudsman found that the child had recently returned from weekend visits home with bruises and injuries (including black eyes), and she reported seeing the mother's previous boyfriend at her mother's home and attributed the bruises to him.

The mother's previous boyfriend had a criminal conviction for manslaughter, as well as an untreated history of domestic violence against the mother, and there was a restraining order in place that prohibited contact between him and the children.

Based on these findings, the Ombudsman became concerned about whether CWS was providing adequate protection to the children.

Although the family was receiving family preservation services in the mother's home, providing some level of monitoring, the Ombudsman believed that the agency needed more detailed information about the children's situation, including whether the mother's previous boyfriend was in her home.

The Ombudsman asked CWS to request the police to conduct a child-safety check during the girl's next weekend visit home.

That weekend, the CWS caseworker and the police together made an unannounced visit to the mother's home and found the boyfriend there in violation of the restraining order and the mother's agreement with CWS. The children were returned to their previous foster homes.

Prompting DSHS to Take a Closer Look *(continued)*

Division of Licensed Resources Interviews Group Home Residents about Possible Abuse

A foster parent filed a complaint with the Ombudsman alleging that a six-year-old child had been sexually abused by another foster parent.

According to the foster parent, although the DSHS Division of Licensed Resources (DLR), Child Protective Services (CPS), had received a report that the foster child's foster father had victimized another child, CPS did not interview the child while she was living in the foster father's home to determine whether she may have been abused also.

The Ombudsman investigated and found that DLR/CPS had in fact failed to investigate whether this foster child had also been abused by the foster father, after another child reported being abused by him.

After the six-year-old child left the foster father and was living in a new foster home, she reported that her former foster father had sexually abused her. Her allegations were confirmed by a subsequent DLR/CPS investigation.

The Ombudsman concluded that DLR/CPS's failure to interview the child at the time of receiving the third-party abuse report was a violation of agency policy and procedure.

The Ombudsman found that the agency had actually identified a total of three children who had previously lived in that foster home (including this child), after receiving the report, and had unsuccessfully attempted to contact the other two children.

Instead of interviewing the six-year old, however, DLR/CPS contacted her new foster parent and inquired whether she had noticed any concerns related to the child's possible sexual abuse, and upon hearing no concerns, left it at that. Had the child not later disclosed the abuse, she may never have received the support and treatment she needed (the abuse was quite severe).

The Ombudsman verified that the child was now receiving treatment. In addition, the Ombudsman informed agency officials of DLR's failure to interview the children, so they could take appropriate corrective action, and documented the failure in the Ombudsman's database as a possible systemic problem.

The Ombudsman's investigation also found that the private placement agency that licensed the foster father failed to report to DLR that the foster father had been fired from his job with a children's group home for sexually harassing staff. The Ombudsman verified that DLR had taken appropriate corrective action with the licensing agency for failing to report this information.

In addition, the Ombudsman followed up with DLR/CPS to find out if children who were at the group home at the time the foster father was employed there, had been interviewed to ascertain whether any of them might have been victimized also.

The DLR/CPS supervisor acknowledged that these possible victims had not been interviewed, and agreed to generate a new report for investigation. The agency then interviewed all the young people they were able to locate.

Facilitating Communication and Mediating Professional Disagreements

In the course of investigating a complaint, the Ombudsman may find that the DSHS decision maker lacks pertinent information that is known to other agency workers, family members or local service professionals working with the family. Or the Ombudsman may find that professional disagreement among DSHS workers, or between DSHS and a local service professional, is preventing the agency from taking timely and effective action. *(continued on next page)*

CWS Learns that Mother Favors Grandmother's Visits with Children

A grandmother contacted the Ombudsman with her complaint that DSHS Child Welfare Services (CWS) was refusing to allow her to have contact with her three granddaughters, ages 6, 4 and 3, who were in state custody.

She told the Ombudsman she had called the CWS worker several times to request visits, leaving messages and not receiving any response.

She had not had any contact with the children for over four months. The children had lived with her on and off for long periods in the past, and she stated she and the children had a close relationship.

The Ombudsman informed the grandmother that CWS is under no legal obligation to provide visits between foster children and their grandparents; however, given the close contact the children previously had with their grandmother, the Ombudsman was uncertain whether the agency's actions were reasonable.

The Ombudsman's investigation found that CWS had not documented or returned the grandmother's calls, and also found that agency records indicated that the grandmother appeared to pose no safety risks to the children.

The CWS worker told the Ombudsman she had not discussed the grandmother's request with the children's mother, but believed the mother would not approve based on the mother's troubled relationship with the grandmother.

However, at the Ombudsman's suggestion, the CWS worker contacted the mother to tell her about the grandmother's request. The mother told the CWS worker that the children had in fact been asking about their grandmother and were missing her, and she would be in favor of having occasional supervised visits.

The agency facilitated arrangements for a brief visit with the grandmother as part of a pre-arranged family holiday party, which the children enjoyed.

CWS agreed to consider requests from the grandmother for future visits.

Facilitating Communication and Mediating Professional Disagreements *(continued)*

When this occurs, the Ombudsman acts to ensure that critical information is being shared appropriately and, when necessary, works to mediate professional disagreements. The Ombudsman's ability to impartially facilitate communication and mediate disagreements has enabled DSHS to avoid potentially harmful delays and mistakes.

CWS Abandons Plan to Change Child's Placement

A community service professional contacted the Ombudsman to express concerns about a plan by Child Welfare Services (CWS) to move a 2-year old special-needs Native American child from her placement with out-of-state relative caregivers to a non-relative foster care placement in Washington State.

CWS had placed the child with her out-of-state relatives shortly after she was born, based on allegations of prenatal drug exposure, and the mother's admitted history of drug abuse.

Soon after the child was born, the mother expressed interest in relinquishing her parental rights, and a relinquishment and order terminating parental rights was approved by the court. After the child became legally free, the relative caregivers filed for adoption.

Before the adoption could be finalized, however, the mother successfully petitioned the court to restore her parental rights. The mother also requested that, while she engaged in the process of regaining legal custody, the child be placed in her care, or alternatively that the child be placed in Washington State.

In order to meet its legal obligation to make "reasonable efforts" to reunite the child with her mother, CWS determined that the child must be returned to Washington State and be available to the mother, even if this required removing the child from the only home and caregivers she had known.

Accordingly, CWS developed a plan to return the child to Washington State for an extended visit. During the visit, the child would be placed with a non-relative foster parent, who would assess the extent of the child's special needs and her ability to adjust to a change in her placement. The visit would also provide an opportunity for contact between the mother and child.

The out-of-state relatives opposed the placement change, asserting that the child had been diagnosed with gross motor delay and behavioral problems, including disordered sleep, and sensory integration dysfunction, and that a sudden change in her environment would be traumatic and harmful.

Upon investigation, the Ombudsman found that the child's treatment providers had in fact made this diagnosis and were greatly concerned about the child's ability to tolerate any change in her placement.

The Ombudsman shared this information with the CWS. Because the agency did not possess any information contradicting these concerns, the Ombudsman suggested that CWS either seek a second evaluation of the child (while in her current placement) to verify her condition or pursue reunification in a manner that would avoid the concerns expressed by her treatment providers.

After further discussion with the Ombudsman and other service professionals involved in the case, CWS abandoned its plan to remove the child from her caregivers for an extended visit, and instead provided the mother with extended out-of-state visits, where the child and her relative caregivers reside.

The court decision restoring the mother's parental rights was later over turned, and the child's adoption with her relative caregivers has since been finalized.

Facilitating Communication and Mediating Professional Disagreements *(continued)*

The Ombudsman Takes Steps to Ensure that Disagreement Between DSHS Regions Does not Jeopardize Children's Safety

The uncle of three children, ages 4, 3 and 2, contacted the Ombudsman with concerns about the children's safety and well-being.

Three months earlier, the court had reunited the children with their parents, after the children had spent two years in foster care due to their parents' chronic substance abuse and consequent neglect of their basic needs. The youngest child was born testing positive for methamphetamine.

After the family was reunited, in DSHS Region "A", the parents moved to another area of the state, in DSHS Region "B," where Child Protective Services (CPS) began receiving reports that the parents had relapsed. When CPS contacted the parents to investigate, the parents moved back to Region A, temporarily leaving the children with a distant relative in still another part of the state, in DSHS Region "C".

At this point, the uncle contacted CPS in Region C to express grave concerns, explaining that the distant relative caring for the children had an extensive CPS history.

Region C CPS went to the relative's home and, finding no immediate safety concerns, closed the case. The uncle then contacted the Ombudsman. The Ombudsman immediately contacted Region C. Though aware of the relative's CPS history, Region C did not assess the current risk to the children to be high, and believed that the parents had a right to place their children with a relative.

The Region C supervisor told the Ombudsman that Region B had been consulted and did not have concerns about the children's current situation. This conflicted with information the Ombudsman found documented by Region B in CAMIS (CPS's automated case management system.)

The Ombudsman contacted CPS supervisors in Regions A and B to obtain their assessment. Both expressed extreme concern about the children's safety, based on the parents' and the current relative caregiver's history.

The Ombudsman was puzzled by Region C's non-emergent response, especially since Regions A and B indicated they would respond immediately if the children were residing in their catchment areas.

When the Ombudsman again contacted the Region C supervisor to share the concerns expressed by the other regions, the supervisor said she would request the family's file from Region A and conduct her own case review.

The Ombudsman believed this delay would create unnecessary risk of harm to the children, having determined there was sufficient information documented on CAMIS to warrant immediate protective action. The Ombudsman therefore began contacting higher-level DSHS officials in an effort to mediate the disagreement between the regions regarding the level of safety risk to the children.

At the same time, the Ombudsman was informed by the uncle that the parents had discovered that the extended family was trying to gain custody of the children through family court, and had abruptly taken the children from Region C to an undisclosed location in Region A.

The Ombudsman encouraged the uncle to report this development to CPS. The Ombudsman then contacted the CPS supervisor in Region A to make sure she was aware of the uncle's report. Region A assessed the uncle's report as warranting an emergent response, based on the parents' CPS and police history and their moving of the children from one region to another apparently to avoid CPS or other outside intervention. Region A made immediate efforts to locate the family.

Shortly afterward, the children's father was arrested when the police found a mobile methamphetamine lab in his car. The children were taken into protective custody and placed with their extended family.

Inducing DSHS to Correct Mistakes

Upon completing an investigation and analysis, the Ombudsman may determine that DSHS has acted in a manner that is outside of the agency's authority or clearly unreasonable, and that the act is harmful to a child or parent. When this occurs, the Ombudsman contacts high-level agency officials to share its findings and analysis and prompt them to review and correct the error.

CPS Returns Children to Mother's Care

A mother contacted the Ombudsman with concerns regarding a stalemate she had reached with Child Protective Services (CPS) regarding the voluntary placement of her children with their grandparents.

The mother had entered into a voluntary placement agreement (VPA) with the agency six months previously, whereby her two children, ages 13 and 11, would be cared for by their grandparents while she completed substance abuse treatment. Per law and policy, VPAs are valid for 90 days, and can be extended for another 90 days by agreement of both parties; the VPA in this case had therefore expired.

After successfully completing a three-month in-patient treatment program, the mother was asked by CPS to leave the children with their grandparents while she continued to attend out-patient treatment to maintain her sobriety. CPS wanted her to demonstrate two months of sobriety and continued treatment.

The mother had complied with this request, and now wanted her children returned. She told the Ombudsman that CPS was resisting this, and that the CPS caseworker was not informing her of her rights, given that no new agreement had been entered into. She was afraid of veiled threats she perceived that CPS would remove her children from her if she took them back home without their approval.

The Ombudsman's investigation of her case validated the information she provided. CPS told the Ombudsman that it had concerns about the children returning to live with their mother due to the chronic nature of her substance abuse history; however, the agency also acknowledged that it did not have a sufficient basis upon which to file a dependency petition on the children.

The Ombudsman determined that the agency was violating law and policy by delaying reunification of the children with their mother despite expiration of the VPA, by failing to inform the mother of her legal rights, and by not allowing her to address CPS's concerns through the legal process of a dependency hearing.

The Ombudsman contacted the CPS supervisor and shared these findings. The agency subsequently allowed the mother to take her children back into her care, and she agreed to enter into a voluntary service agreement with CPS, which required the mother to continue participation in outpatient treatment services for 90 days.

This agreement helped to allay the agency's concerns about the children's welfare. CPS continued to monitor the children's safety and the mother's progress, and closed the CPS case four months later.

Inducing DSHS to Correct Mistakes *(continued)*

The Ombudsman's ability to induce DSHS to correct errors has helped the agency to avoid or mitigate any harm to children and families resulting from its mistakes. It has also led to improvements in agency practices.

CPS Reverses Decision to Leave Children in Parents' Care

A program director for a preschool program contacted the Ombudsman, requesting an immediate investigation of her concerns about the safety of two siblings, ages two and three years. The three-year old had recently alleged incidents of serious physical abuse at home.

Child Protective Services (CPS) was already involved with the children's family due to a previous report alleging neglect/lack of supervision, and a more recent report alleging physical abuse of the three-year-old by the step-father and failure to protect by the mother.

At a Child Protection Team (CPT) staffing, several local service professionals involved with the family expressed concerns for the children's safety in this home, citing the children's young age, the step-father's history of violence, lack of impulse control, and anger issues, as well as the mother's and step-father's alleged prior methamphetamine use.

The CPT recommended that CPS file a dependency petition in court seeking to place the children in protective custody outside of their parents' home. However, CPS did not remove the children from the home, as recommended by the CPT.

Instead CPS entered into a voluntary service agreement with the parents, which required the parents to participate in services while the children remained in the home.

When the Ombudsman contacted CPS, the supervisor explained that the agency was satisfied that the children were not at imminent risk of harm.

However, a short time later, the CPS supervisor informed the Ombudsman that the mother and step-father had violated the terms of the service agreement and that CPS was now planning to file a dependency petition.

However, CPS was considering an *in-home* dependency, which would provide court authority and oversight for required services, but would allow the children to continue living with their parents.

The Ombudsman determined that the CPS supervisor was in violation of agency policy and procedure, as he had failed to seek review or approval from the DSHS area manager or regional administrator of his decision to disregard the CPT's recommendation to remove the children from their home.

Additionally, the Ombudsman determined that in light of the seriousness of the physical abuse described by the child and the presence of other risk factors , CPS's decision to leave the children in their home was not reasonable.

The Ombudsman contacted the DSHS area manager to express concern about the ongoing risk to the children if they remained in the home, and shared its conclusion that CPS was violating agency policy and procedure by failing to implement or formally reverse the CPT's recommendations. The area manager concurred with the Ombudsman's findings.

Without further delay, CPS obtained a court order to place the children in foster care and filed a dependency petition, in accordance with the CPT's recommendations.

Inducing DSHS to Correct Mistakes *(continued)*

CPS Reverses Finding of Parental Child Neglect

A parent contacted the Ombudsman after losing her job at a child care center, when the center learned that she had a finding of child neglect on her Child Protective Services (CPS) record.

This came as a rude shock to the parent, who stated she was unaware of the finding, although she was aware of the CPS investigation that had been conducted over three years ago.

The parent wished to appeal the findings, as she felt they were unreasonable. She had talked to several DSHS workers to explore what her options might be, as the time period in which a parent must appeal CPS findings once notified, was long gone. She was unable to obtain the answers she needed, or any suggestions for resolution of her situation.

The Ombudsman investigated her concerns and found that CPS had sent a certified findings notification letter to the parent, as required by law and policy. However, it seemed plausible that the parent might not have received the letter, given her situation at the time.

But more important, after reviewing the CPS investigation, the Ombudsman determined that the finding of neglect was clearly unreasonable, based upon the facts established during the investigation.

Furthermore, there was no prior CPS history on the family except for an "information only" report in 1991, which did not suggest any abuse or neglect on the part of the parent. For these reasons, the Ombudsman requested a review of the findings by the DSHS Area Administrator.

This review resulted in the administrator's decision to change the finding. The parent no longer has a founded record of child neglect, and can resume her work in the child care field.

After Acknowledging Error, DSHS Takes Positive Steps to Prevent Future Mistakes

An administrator for a county juvenile court and detention facility contacted the Ombudsman, complaining that CPS's Central Intake Unit had failed to respond appropriately to a youth in need of placement.

Despite several hours of effort, detention staff was unable to locate a parent or responsible adult for a 16 year-old youth who was to be released from detention.

The detention supervisor then contacted CPS Central Intake, as the facility could not hold the youth in a secure facility, nor could it simply release him without a parent or guardian. The CPS intake worker refused to respond and told the detention supervisor to call the police.

The Ombudsman's investigation confirmed the court administrator's account. The Ombudsman determined that CPS Central Intake had violated state law and agency policy by not investigating an allegation that no parent was available to care for a child. The Ombudsman then contacted DSHS officials in Olympia to share the office's findings and analysis.

The officials agreed that CPS Central Intake should have accepted this report, and a CPS worker should have been assigned to interview the youth and determine an appropriate CPS response.

The officials also contacted the administrator for the county juvenile court and detention facility and offered to meet to further discuss the issue and clarify CPS's role in cases in which a youth being released from detention does not have a parent or responsible adult to live with. The DSHS officials also agreed to clarify with CPS Central Intake staff that such reports should be accepted and assigned to a CPS investigator.

Inducing DSHS to Correct Mistakes *(continued)*

DSHS Uses Mishandled Case as a Teaching Tool

By way of a news report, the Ombudsman became aware of a family involved in a serious domestic violence incident involving the discharge of a firearm near the family's young children.

The Ombudsman initiated an investigation to determine whether Child Protective Services (CPS) was made aware of the incident by the police and had responded appropriately. The Ombudsman learned that following the domestic violence incident, the police placed the family's children into protective custody and then made a report to CPS.

After a preliminary assessment of the situation, CPS returned the children to the non-offending parent, after having establishing a safety plan with that parent. At the end of its investigation, CPS closed the case.

Through a review of CAMIS (DSHS's automated case-management system), the Ombudsman also learned that the family had been the subject of 16 CPS reports in the previous 21 months. These reports had all either been categorized by CPS as "information only" (because CPS determined that the allegations in the report did not meet the legal definition of child abuse or neglect) or assessed as being a low-risk, meaning that no CPS investigation was required.

Allegations screened out as "information only" included reports of a black eye observed on a three-year-old, choking and hitting an 8-year-old on the head, leaving a bruise, the parents not protecting the children from sibling abuse, domestic violence in the home, the mother hitting the children, and the mother having a CPS record in three other states.

Allegations assessed as low risk and referred for preventive services included reports of lack of supervision by the mother and the father's firing of weapons inside the home. Only the last report of domestic violence and the use of a firearm was assessed as warranting a full CPS investigation.

Upon reviewing CPS's assessment decisions, the Ombudsman became concerned about the agency's decision to release the children to the non-offending parent prior to the completion of the CPS investigation, and without a more structured and comprehensive safety plan for the family. These concerns were based upon:

- The agency's awareness that the parents had a CPS history in other states and had fled one state apparently to avoid removal of the children due to findings of physical abuse.
- The nature and extent of the parents' CPS history in this state in the past two years, including allegations of physical abuse by the non-offending parent.
- The level of violence the children witnessed in the latest domestic violence incident.
- Reported substance abuse by the offending parent.
- The young ages of the children, and the fact that at least three of them were identified as developmentally delayed, increasing their vulnerability.
- Ongoing concerns regarding the children's safety that had been reported by multiple local service professionals in contact with the family.

The offending parent had already been released from jail when the children were returned to the non-offending parent. The family immediately left the state.

Because of the concerns about the management of this case, the Ombudsman contacted DSHS Children's Administration (CA) headquarters with a request for the agency to conduct a full case review and address the practice concerns identified.

The Children's Administration agreed and assigned two senior staff to review the file and interview workers involved in the case. The review was broad in scope and specific in its identification of both strengths and problems in the management of the case.

The final report, which was shared with the Ombudsman, was thorough and informative, and presented several recommendations for practice changes based upon the six major findings of the review. The Ombudsman was informed that this review would be used by the DSHS Child Welfare Training Academy to educate caseworkers and strengthen caseworker practice.