EXECUTIVE SUMMARY

The Office of the Family and Children's Ombudsman was established by the Washington State Legislature in 1996[1]. The Ombudsman investigates complaints involving children and families receiving child protection and child welfare services, or any child reported to be at risk of abuse, neglect or other harm. In addition, the Legislature directed the Ombudsman to recommend system-wide improvements that benefit children and families.

The Ombudsman is required by law to submit an annual report to the Governor and the members of the Legislative Children's Oversight Committee. The report is to include an analysis of the Ombudsman's work and recommendations for improving the child protection and welfare system.

The Ombudsman's Role:

- **Listen** to Families and Citizens
- **Respond** to Complaints
- **Act** on Behalf of Children and Families
- **Improve** the System

This report provides an account of the Ombudsman's activities through August 31, 2003. It also describes cases handled by the Ombudsman that illustrate how the office works to help the Department of Social and Health Services (DSHS) avert and correct avoidable errors. In addition, the report sets forth the Ombudsman's recommendations for system-wide improvements.

The Role of the Ombudsman

The Ombudsman operates as an independent agency under the Office of the Governor. Acting as an impartial fact finder, the Ombudsman provides families and citizens an avenue through which they can obtain an independent and impartial review of the decisions made by DSHS and other state agencies.

The Ombudsman performs its duties by focusing its resources – five full-time staff and a biennial budget of nearly one million dollars – on complaint investigations, complaint intervention and resolution, and system investigations and improvements.

Inquiries and Complaints

A fundamental aspect of the Ombudsman's work is to respond to the needs of citizens by listening to their concerns, educating them about the child welfare process and referring them to appropriate resources to assist them with their particular issue.

By responding effectively to citizens' questions and concerns, the Ombudsman determines if their concern falls within the scope of the Ombudsman to investigate, or if there is another resource available to better assist them.

[1] RCW 43.06A

Between September 1, 2002 and August 31, 2003, the Ombudsman received over 1400 inquiries from families and citizens who needed information. During this period, the Ombudsman also received 463 complaints - an all-time high and a 17 percent increase from 2000-01. The steep upward trend of complaints filed with the Ombudsman in recent years shows no signs of slowing.

Most complaints to the Ombudsman were filed by parents and other family members. Complaints most frequently identified DSHS' allegedly inadequate response to a report of child abuse or neglect as the issue of concern. A majority (58 percent) of individuals filing complaints with the Ombudsman indicated that they were referred to the office by someone else. Over half of these individuals reported that they were referred by a community professional, local service provider or DSHS worker.

Complaint Investigation and Ombudsman In Action

The Ombudsman spends more time investigating and evaluating complaints than on any other activity. Impartial investigation and analysis enable the office to respond effectively when action is necessary to facilitate resolution of a concern or induce corrective action by the agency.

Between September 1, 2002 and August 31, 2003, the Ombudsman completed 460 complaint investigations – an increase of nearly 13 percent from the previous year. The Ombudsman resolved 31 percent of complaints during this period that were the subject of an emergent investigation. Emergent investigations most often involved concerns about a child's safety or well-being. Nearly one-quarter of emergent investigations were closed after direct intervention by the Ombudsman to induce the agency to correct an unauthorized or unreasonable course of action.

During the same period, the Ombudsman facilitated resolution of nearly 25 percent of complaints that were the subject of a standard investigation. Almost two-thirds of standard investigations were closed after the office determined that further action was not warranted.

Fatality Review

The Ombudsman receives notification from DSHS' Division of Children and Family Services (DCFS) on every fatality known to DCFS. This information sharing is a critical step in the Ombudsman's review of cases in which child abuse or neglect was identified as a factor in the child's death.

Two-year-old Rafael Gomez died on September 10, 2003, six months after the DCFS returned him to the care of his parents. The Ombudsman reviewed DCFS case records to learn more about DCFS' activities in Rafael's case, including the agency's efforts to return the child to his parents despite the serious injuries he sustained previously while in their care.

The Ombudsman found that caseworker bias was a key contributing factor to DCFS' flawed decision to advocate for Rafael's return home. Despite a series of significant injuries incurred by Rafael at home and the presence of other red flags indicating that he was at risk of physical abuse, the DCFS worker maintained his erroneous perception that the child's parents posed no safety risk to the child. The Ombudsman presented its completed investigation summary, which identified caseworker bias and several other issues of concern, to the Community Fatality Review Team convened by the DSHS

Children's Administration (CA). The Ombudsman asked the Review Team to consider the Ombudsman's findings as part of its comprehensive review of Rafael's death.

Child Protection Teams

Child Protection Teams, or CPTs, are made up of community professionals with a wide range of expertise whose role is to assess child protection and welfare cases and advise DCFS on risky and/or complex decisions. Because CPTs represent such a vital component of the system's cross-check on caseworker bias, and due to recurring concerns expressed in the past two community child fatality review reports and in complaints to the Ombudsman, the office initiated an independent review of CPT practices. The death of Rafael Gomez was the second child fatality in three years to raise serious concerns about DCFS' use of Child Protection Teams.

There continues to be disagreement within DCFS as to the fundamental purpose and value of CPTs and virtually no uniformity in CPT practices among DCFS regions, or even among local offices within a region. The Ombudsman found that, despite recent efforts by DSHS to implement CPT improvements, there has been little overall positive change in their structure and use.

Based on these findings, the Ombudsman recommends that Children's Administration leadership work closely with DCFS staff and stakeholders to develop a collective understanding of the purpose and value of CPTs. The leadership should also communicate – and regularly reiterate – its expectations regarding the agency's use of CPTs. In addition, Children's Administration should fully endorse and support the development and implementation of a uniform statewide CPT system by addressing key issues. These issues include: clarifying policy and practice guidelines; establishing a system of accountability; providing training to DCFS staff and CPT members; and clarifying and supporting the role of CPT coordinators.

Issues and Recommendations

After complaint investigations, the Ombudsman spends most time on identifying and investigating system-wide problems. The Ombudsman has identified and investigated four systemic issues that are the subject of findings and recommendations in this report. These issues are discussed in greater detail in the section titled *Issues and Recommendations*. They include:

1. **Evidence-based Assessment and Treatment.** In reviewing child fatality reports and complaints in 2003, the Ombudsman identified a major deficit in the consistency and quality of assessments and services typically used in the child welfare system. Fortunately, assessment tools and treatment services exist whose validity and effectiveness are supported by scientific evidence. An independent state entity should convene a multi-disciplinary Evidence-Based Services Summit to examine a broad range of evidence-based assessment and service models[2] for children and families in the child welfare system and make recommendations to DSHS.

[2] Evidence-based assessments and treatment refers to tools and methodologies whose validity and effectiveness are supported by scientific evidence.

2. **Protecting Adolescents.** The Ombudsman found that in some cases, CPS screens out reports of child maltreatment involving adolescents without an investigation. CPS characterizes such reports as a "family in conflict" and refers them to a DCFS unit called Family Reconciliation Services. This practice appears to be based on the assumption that the adolescent's age alone enables the youth to protect him or herself from abuse or neglect. However, not all adolescents are, in fact, capable of protecting themselves from parental maltreatment, and CPS' failure to respond means that legitimate reports of child maltreatment are not being addressed. The Ombudsman recommends that state law be amended to clarify that DSHS may not refuse to provide adolescents with child protective services based solely on their age.

3. **Children with Disabilities.** The Ombudsman found that DSHS is not able to meet the needs of families requesting an out-of-home placement for children with developmental disabilities, or physical or mental handicaps. DSHS acknowledges that the Voluntary Placement program, which was created to serve this population, has no funding to serve additional children. The Ombudsman recommends that the state provide an adequate supply and range of residential placement options for children with developmental disabilities or other serious handicaps.

4. **Relative and Kinship Care.** The Ombudsman found that DCFS often has difficulty in timely identifying and assessing the suitability of relatives who are willing to care for a child in state custody. The Ombudsman recommends that, as part of its current improvement activities, Children's Administration develop:

    1) a statewide protocol for identifying relative/kinship placement resources, and

    2) an objective assessment process for evaluating the suitability of relative/kinship caregivers.

    CA should also promote family involvement in the agency's case planning process. In addition, the Ombudsman recommends that CA develop criteria to assist workers in assessing and prioritizing their responsibilities and competing policy goals when making critical placement decisions.

Terms and Acronyms:

Dependent Child.....A child for whom the state is acting as the legal parent.
CA.....Children's Administration
CPS .....Child Protective Services
CPT .....Child Protection Team
DSHS.....Department of Social and Health Services
DCFS .....Division of Children and Family Services
CWS .....Child Welfare Services