IMPROVING THE SYSTEM

The Legislature charged the Ombudsman with facilitating improvements to the child protection and child welfare system. After complaint investigations, the activity the Ombudsman spends the most time on is identifying and investigating system-wide problems. The Ombudsman's findings and system-improvement recommendations are published in public reports to agency officials and state policymakers.

To avoid duplicating other system-improvement efforts and target its limited resources to the issues of most importance to parents and children, the Ombudsman has developed specific criteria for selecting systemic issues for investigation. The Ombudsman employs these criteria when determining what kind of investigations to undertake.

The Ombudsman gives priority to systemic issues that impact a child or family's

- **Safety;**
- **Well-being; or**
- **Permanence.**

The Ombudsman criteria give priority to systemic issues that appear to have a significant impact on the safety, well-being or permanence of children and/or their families, and have been:

- Identified as a pattern or trend in complaints filed with the Ombudsman, and have not been adequately addressed by another agency;
- Identified as a concern, but have not been adequately investigated or addressed by another agency, and the Ombudsman's unique features (independence, neutrality, access to confidential information, cross-system perspective) would make it effective in evaluating the issue and/or;
- Assessed as being "invisible" because they are unlikely to be raised in complaints or concerns brought to the Ombudsman's attention (e.g., inadequate child fatality reviews).

This section summarizes the systemic investigations conducted by the Ombudsman since the office became operational in 1997. It describes the Ombudsman's findings and recommendations and how they were used by agency officials and state policymakers to improve the child protection and child welfare system.

Promoting Access to DSHS's Complaint Resolution Process and the Ombudsman

In 1997, the Ombudsman determined that the DSHS Children's Administration was not complying with state law requirements directing it to inform clients about the agency's complaint resolution process and how to access it. The Ombudsman found that DSHS caseworkers did not receive training on the agency's complaint resolution process and rarely informed clients about their rights or the procedures for pursuing a complaint against the agency, including their right to contact the Ombudsman.

The Ombudsman recommended that DSHS:

1) Provide clients (including young people age 12 and older) with concise written information outlining their rights and the procedures for filing a complaint under the agency's complaint resolution process, and their right to contact the Ombudsman, and;

2) Train workers on their duty to inform clients about the agency's complaint resolution process.

In response, DSHS:

1) Developed a new complaint brochure and "Clients Rights" poster that describes the agency's complaint process and how to contact the Ombudsman;
2) Developed an informational brochure for foster youth age 12 and older that includes information on their rights as a foster child and how to contact the Ombudsman and;
3) Incorporated information on the agency's complaint process, including the role of the Ombudsman, into the Child Welfare Academy's basic training curriculum.

Since these steps were implemented in 1999, the number of individuals filing complaints who said they were referred to the Ombudsman by a DSHS worker has increased by 20 percent.

Tightening School District Compliance with Mandatory Reporting Law

In 1998, the Ombudsman surveyed 130 school districts on their policies and procedures for reporting suspected child abuse and neglect. State law requires professional school personnel who have reasonable cause to believe that a child has suffered abuse or neglect to report the incident, or cause a report to be made, to the police or Child Protective Services (CPS). Failure to make a mandated report is a criminal offense.

The Ombudsman's survey was prompted by the confusion it encountered among teachers and other professional school personnel about their legal duty to report suspected child abuse and neglect. Many school personnel told the Ombudsman that school district policy required them to report abuse and neglect concerns to the principal, and not to the police or CPS. In addition, in the course of several complaint investigations, the Ombudsman had noted instances where a teacher's reasonable concern about a child's possible abuse had not been reported to the police or CPS.

The Ombudsman found that the policies of 47 of the 130 school districts surveyed did, in fact, require school personnel to report their concerns to the principal or other school official, who was then authorized to decide whether a report should be made to the police or CPS. The Ombudsman concluded that the policies not only were inconsistent with state law, but they also subjected school personnel to potential criminal liability if a mandated report was not made.

The Ombudsman recommended that 1) local school districts review their reporting policies to ensure that they are in compliance with the state's mandatory reporting law, and 2) school districts adopt the model reporting policy and procedure developed by the Washington State School Directors Association (WSSDA). In response, the WSSDA published the Ombudsman's findings in the WSSDA *Policy News* for school board members and advised that school districts modify problematic policies. The WSSDA also provided school districts with the model reporting policy recommended by the Ombudsman for adoption.

Improving CPS Child Sexual Abuse Interviews and Investigations

In December 1998, the Ombudsman completed its review of the involvement of DSHS case workers in the 1994-95 Wenatchee child sexual abuse investigations.

The Ombudsman's review was prompted by concerns that alleged child sexual abuse perpetrators and victims had been improperly questioned in joint interviews with Child Protective Services (CPS) and the police. The techniques allegedly employed by CPS and the police in eliciting statements from suspects and alleged child victims had become the focus of intense and enduring controversy.

The Ombudsman's review was the first full-scale independent review of the Wenatchee investigations by a government agency. It was undertaken to determine whether new or stronger safeguards were needed to protect children who are the subject of CPS investigative interviews and to ensure that possible child victims are provided with appropriate mental health services.

The Ombudsman's 6-month investigation encompassed the review of thousands of pages of documents and scores of interviews. In its final report, the Ombudsman noted that the sexual abuse allegations made by children had progressed over time from allegations commonly made in sexual abuse cases (e.g., abuse of a child by a single family member or friend) to allegations that are uncommon in sexual abuse cases (e.g., organized and systemic abuse of many children by community members).

Because the CPS interviews were not well enough documented, the Ombudsman could not determine whether the uncommon allegations occurred, as some of the children alleged, or something went wrong during the investigative process, resulting in factual distortions. The report described documented and alleged events that illustrate investigative errors that experts agree can increase the possibility of factual distortion.

The Ombudsman made three major recommendations for improving CPS child sexual abuse investigations. They were incorporated into state law by the 1999 Washington Legislature.

Interview Documentation. The Ombudsman recommended that CPS caseworkers be required to document child interviews in a verbatim or near-verbatim manner that captures which questions are asked, in what order, and the exact answers given to the questions. The Legislature placed this requirement in state law and also directed the Children's Administration to establish three pilot sites that rely on different methods and techniques for conducting and preserving the interviews of child sexual abuse victims. An independent evaluation of the three sites concluded that audio-taping was the most practical interview documentation method. DSHS plans to begin audio-taping child interviews this year.

Specialized Sexual Abuse Investigator Training. The Ombudsman recommended that DSHS be required to provide CPS caseworkers with specialized training in interviewing techniques. The Legislature extended the Ombudsman's recommendation to require that all persons responsible for investigating child sexual abuse allegations, including the police, prosecutors and CPS workers, receive ongoing specialized investigative training, including training on child interviewing techniques. State law now requires child sexual abuse investigators to receive specialized training.

Protocols for Child Sexual Abuse Investigations. The Ombudsman recommended that local jurisdictions be required to establish collaborative cross-discipline protocols to coordinate and guide the activities of law enforcement and other professionals involved in criminal child abuse investigations. The Legislature placed this requirement in state law and directed that each county have its protocol in place by July 1, 2000 and that each protocol must be consistent with state guidelines.

The Ombudsman found that approximately one third of Washington children involved in child abuse and neglect proceedings did not have a guardian ad litem.

Increasing Guardian ad Litem (GAL) Representation

In 1999, the Ombudsman issued a report on the lack of guardian ad litem representation for children in child abuse and neglect court proceedings.

The Ombudsman's report was prompted by the significant number of complaints received by the office in which the affected child was reported as having no one to represent his or her best interests in court.

The federal Child Abuse Prevention and Treatment Act (CAPTA) requires states that receive CAPTA grants to certify that the state has in effect, and is enforcing, a state law providing the appointment of a GAL to represent the child's best interest in judicial proceedings involving issues of child abuse or neglect.

The Ombudsman found that Washington State was receiving about $1.25 million per biennium in CAPTA grants and had made the required certification.

However, in a state-wide study, the Ombudsman found that approximately one-third of Washington children involved in child abuse and neglect proceedings did not have a GAL to represent them in court.

Over one-half of the children involved in proceedings in King, Snohomish and Spokane counties did not have a GAL during the time period under study. The Ombudsman also found that children in three counties were being served by GALs with individual caseloads ranging from 90 to 400 children.

Based on these findings, the Ombudsman recommended that the number of GALs be increased to a level that is sufficient to ensure appointment for all children who are involved in a child abuse and neglect proceeding.

The Ombudsman also recommended that state law be amended to clarify that a GAL shall be appointed to represent the best interest of every child involved in a child abuse and neglect court proceeding.

In response, the 1999 Legislature appropriated $1 million for the FY 1999-2001 biennium for additional volunteer court-appointed special advocate (CASA)/GAL representation.

This appropriation was the state's first major expenditure for volunteer CASAs/GALs for children, which it has continued to maintain.

The Ombudsman found that Washington is one of only five states in which the statutory definition of child neglect specifies that the risk of harm to a child must be imminent.

Highlighting Chronic Child Neglect

In 2000, the Ombudsman issued a report recommending that the Legislature modify the state law definition of child neglect. The recommendation was based on earlier Ombudsman reports, which identified DSHS's failure to timely intervene in chronic child neglect cases as a major concern.

While reviewing case files in the course of investigating complaints on other issues, the Ombudsman found that Child Protective Services (CPS) often screened out reports of child neglect without an investigation.

The problem was illustrated by the tragic death of a 7-year-old boy in a lake while he was playing unsupervised with his brother and several other children. The boy and his brother had been the subject of 19 reports to CPS, many from local service professionals expressing concern about the boys' speech delays, the mother's mental instability, and her persistent failure to provide the boys with appropriate care and supervision. CPS screened out 14 of the 19 reports without an investigation.

According to CPS, reports of child neglect were often screened out because the specific parental act or omission alleged in the report did not meet the state law definition of neglect, i.e., did not constitute a "clear and present" danger. Thus CPS often did not investigate a neglect report despite being aware of a documented pattern of neglectful conduct indicating that a child could be at risk.

In addition, the Ombudsman learned that CPS workers were being advised by assistant attorneys general that clear evidence of a neglectful act resulting in imminent danger was required to justify the filing of a petition in court to compel parental participation in services or remove the child. Consequently, CPS workers felt that until they had such evidence, they had no option but to pursue less aggressive interventions.

Further, the Ombudsman found that Washington is one of only five states in which the statutory definition of child neglect specifies that the risk of harm to a child must be imminent.

Based on these findings, the Ombudsman recommended that the statutory definition of child neglect be modified to clarify that neglect may result from an act or omission, *or pattern of conduct*, that constitutes a *substantial* danger to the child's health, welfare or safety. The Ombudsman also recommended that courts be allowed to consider the cumulative harm suffered by a child in determining whether a child shall be deemed a dependent of the state.

(Continued on next page)

In response, the House of Representatives established an interim Child Neglect Workgroup to study the issue further and develop policy and practice recommendations. The Workgroup was comprised of legislators, agency officials, child and family advocates, local service professionals, guardians ad litem, attorneys, and judges.

The Workgroup made several recommendations, including one to modify the definition of child neglect. Prominent newspapers, including the *Tacoma News Tribune* and the *Seattle Post-Intelligencer*, editorialized in favor of the change, citing the Ombudsman's report. Subsequently, the House approved legislation modifying the definition of child neglect. When the Senate failed to approve the legislation, House legislators indicated they would continue to push for its passage.

In addition, DSHS implemented changes in the agency's practices as part of its *Kids Come First Action Agenda.* The agency implemented a new risk assessment tool to identify serious risk for child abuse and neglect in families, adopted new practices to assist families on public assistance with chronic neglect issues, and established criteria for an automatic review of chronic neglect cases when a certain number of reports have been received by CPS. Further, the Office of the Attorney General provided assistant attorneys general in the Juvenile Practice Section with intensive training on chronic child neglect issues.

Addressing Biased Decision-making

In 2000, the Ombudsman reviewed the confidential DSHS case records of three-year-old Zy'Nyia Nobles and her family. Zy'Nyia died at home the previous month. Her mother was subsequently convicted of homicide by abuse. Zy'Nyia and her older brother were dependent and had been living in foster care since February 1997. DSHS Child Welfare Services (CWS) returned the children to their mother in February 2000, and the family remained under CWS supervision.

The Ombudsman conducted the case review to learn why the children had been returned to their mother and to determine 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 DSHS. The Team included community professionals, legislators and others.

At the Team's first meeting, the Ombudsman presented its completed investigation summary and identified several issues of concern. The Ombudsman asked the Community Fatality Review Team to consider the identified issues during its review of Zy'Nyia's death.

An issue of major concern identified by the Ombudsman was that of "decision maker bias." Decision maker bias occurs when a case worker develops an initial belief about a person or event and then becomes resistant to altering that belief, even in the face of conflicting information.

The Ombudsman found that the CWS case worker who made the decision to return the children to their mother appeared to have developed a strong bias in favor of the mother. At critical times, the worker appeared to assume the role of the mother's advocate.

This was demonstrated by the worker's decision to return the children to the mother's care without first addressing documented concerns about her mental health and parenting capacity or her repeated failure to comply with court-ordered services. It was also demonstrated by the inaccurate and incomplete information presented by the worker to the Child Protection Team (CPT) and the court.

The information presented by the worker tended to omit and minimize troubling concerns about the mother's mental health and parenting capacity. This undermined the CPT and court's oversight function. The Ombudsman highlighted this dynamic in its investigation summary and asked the Fatality Review Team to consider how the system can better protect against case worker bias.

When the Community Fatality Review Team issued its report, case worker bias was the central feature. The Fatality Review Team made several recommendations aimed at strengthening objectivity in case work decision making and improving the use and effectiveness of CPTs. Several of the Team's recommendations were subsequently included in the DSHS *Kids Come First Action Agenda.*

The Agenda provided new statewide training designed to strengthen "objective decision making" by case workers and supervisors. It also included new requirements for documenting decisions, which were intended to promote and support objective decision-making.

In addition, the Agenda included a provision to improve the use of CPTs by training case workers and CPT members on the use of CPTs, clarifying expectations, providing new tools to enhance CPT effectiveness, and tracking CPT performance.

Discovering What Young People Say is Working Best in Foster Care

In 2000, the Ombudsman initiated an innovative project aimed at learning what is working best in the foster care system. The state's foster care problems are well known. In contrast, the system's strengths have received little attention or study.

The project was greatly influenced by a system-change approach called Appreciative Inquiry. This approach is based on the premise that positive systemic change can be achieved by identifying what works and focusing energy on doing more of it. It was also based on the belief that young people in foster care have the most to teach adults about what in the system is working well and matters most to them.

The Ombudsman interviewed 32 young people, ages 11 to 17 years old, residing in licensed family foster homes. The young people were asked several open-ended questions about their most positive experiences in foster care. (See side bar.) They were also asked for their ideas on how to make their experiences in foster care the best they could be.

After synthesizing all of the stories and ideas elicited through the interviews, the Ombudsman identified three prominent themes that reflected the participants' collective perspective on what is working well and matters most to them.

The Ombudsman asked foster youth these questions:

1. During your time in foster care, you have probably had some tougher times and some better times. For now, I'd like you to remember one of the really good times you've had. It might be a particularly good day or week, or any time when things were going really well for you. Of it might have been a great talk you had with someone; or any time you remember being really special – a time when you felt really good and happy.

2. Think about a time while you've been in foster care when you felt really taken care by an adult. This could have been a time when someone was really kind or caring, or a time when someone listened to you or helped you get what you wanted.

3. Think about a time while you've been in foster care when you felt really taken care of by an adult, who seemed to just understand what you wanted or needed without you even asking.

4. This next question is an important question for most people and you may need a moment to think about it. It can be a great feeling to be accepted, included in things. Think of a time during your foster care experience when you felt a part of things. This could be a person who made you feel accepted or a part of a group where you felt included.

5. Now I would like you to think for a moment about your own strengths and gifts. Specifically, I'd like you to remember a time that you went after something you wanted. It might have been something big or something quite small. Anyway, there was something that you realized was important to you, and you said to yourself, "Go for it," and as a result, you made something good happen for yourself.

Feeling like a regular part of the family.

"When I got here it felt … like a normal family. There were four kids and two adults. I feel very accepted and included now in my foster home. I am treated like a member of the family. They don't treat me different.

For example, if I do something special, like I was in a play last summer, they didn't all show up to come and see me in the play. Whoever could make it came to see me, and I liked it that way because that's the way it would be for any other family member."

"Holidays, Christmas, birthdays – my foster family always includes me. ***Even if I'm in a bad mood I get included.*** *I am included and part of everything. When we have a family picnic, I don't know everyone, but everyone acknowledges that I'm part of the whole scheme. All the relatives just accept me as family."*

Feeling cared about.

"I grew up taking care of myself. ***The most I've ever felt taken care of by an adult is here****. Just little things make a difference, like [my foster mom] noticed my new pants and asked if I wanted to get my pants hemmed."*

"My foster mother had six foster kids in her home. She would buy us all our own toiletries, shampoo and deodorant and things, and she would put our name on the things so it was just for us.

It's the only foster home I've been in where we didn't have to share things like that…"

"My foster mother walked me to my class the first day of school and introduced me to my teacher. She talked to him for awhile and made it easier than I thought it would be. New schools are always hard. I was worried, but things turned out OK."

"I wanted to be in football, and my [foster] dad helped me so I could do it. He said anything I needed, he would help me with it. I knew I would have to practice a lot. I told myself to just do my best and try to get it. I had a lot of help. My PE teacher let me run laps during PE, so I could catch up on my speed. My coach let me stay after practice, and he helped me with my passing, blocking and my speed. My [foster] dad picks me up because I miss the bus since I stay so late after school. He picks me up, and he helps coach me, and just helps me."

Feeling like my opinions matter.

"[My guardian] really helped me to get off my meds. I was on a bunch of different meds since I was about four years old, for ADD, ADHD, and the meds had lots of side effects. Like I would get migraines and an upset stomach.

I had been asking for years to go off the meds, and no one listened to me. They would just change my prescription. But the side effects never went away. At first, [my guardian] told me I had to take meds, but then ***he supported me*** *and told the case worker and everyone else to take me off my meds, which they did. It was kind of cool that he stood up for me. I've been off my meds now for six or seven months."*

"My foster parents have a second house in Ocean Shores, and they thought about moving there. [My foster mom] asked me if it was okay with me if we moved and, if it was, she told me to give her five reasons why it would be good to move. Before, my mom moved all the time, and I never had any input. I had to change schools every year. [My foster mom] wanted everyone on board if we decided to move."

The appreciative interviews were a powerfully rewarding experience for the Ombudsman interviewers.

The interviewers came out of the process with a renewed sense of the individuality, vulnerability, resilience and awareness of the young people in foster care.

In addition, the interviewers were moved by the ***utter simplicity of their best experiences and wishes*** and by the unexpected commonalities and coherence in what young people said matters most to them.

The Ombudsman recommended that the DSHS Children's Administration convene a large cross-section of key participants in the foster care system, including young people, in an "Appreciative Summit." The purpose of the summit would be to engage participants in a mutual discovery of what's working best in the foster care system and to design specific ways to replicate and amplify these successes throughout the system.

DSHS did not convene a summit, as the Ombudsman recommended. However, since publishing its report on the project, the Ombudsman has been contacted by DSHS, along with several child welfare advocates across the country, who wanted to learn more about this positive approach to large-scale change and discuss other potential applications in the child welfare system. In addition, DSHS expressed interest in using the Ombudsman report as a component of its foster parent recruitment and training efforts.

Strengthening Student Safety at the Washington School for the Deaf

In 2001, the Ombudsman completed an investigation of student-on-student sexual abuse at the residential Washington School for the Deaf (WSD). The Ombudsman's review was prompted by student safety concerns raised by WSD parents at a special legislative hearing.

The purpose of the Ombudsman's review was to develop an accurate understanding of the nature and extent of sex-related incidents that had been reported to school authorities and to identify systemic or practice issues regarding the response to these incidents by WSD, Child Protective Services (CPS) and law enforcement.

The Ombudsman's investigation encompassed documented reports of sex-related incidents involving WSD students during the 1995-96 through 2000-01 school years. Ombudsman investigators reviewed written incidents reports and tracked the responses of WSD, CPS, and the police.

The Ombudsman's final report noted that WSD's incident documentation and record-keeping system was inadequate to allow Ombudsman investigators to reliably identify every report of alleged student-on-student misconduct at WSD.

However, working with the records available to it, the Ombudsman counted 121 reports of serious incidents of student sexual misconduct during the six-year period under review. Further, the Ombudsman determined that 11 "repeat perpetrators" were responsible for 62 percent of the reports.

All of the repeat perpetrators had severe behavioral and/or mental health issues. Despite their serious and chronic behaviors WSD continued to enroll and serve these students.

Because the school lacked the resources necessary to meet the needs of these students, their sexual aggression continued and led to the ongoing victimization of other students. The Ombudsman found that WSD's responses appeared to result in a culture that tolerated sexual aggression and victimization.

Finally, the Ombudsman determined that Child Protective Services (CPS) was unable to facilitate necessary safety improvement at WSD in part because it lacked formal authority to compel the school to address identified safety deficiencies and concerns. The Ombudsman made several recommendations for strengthening student safety at WSD.

One of these called for the WSD to obtain expert consultation on sexual aggression and victimization issues to assist the school in identifying sexually aggressive students, improving staff awareness and understanding of sexual aggression and victimization, and developing a protocol for assessing and addressing the needs of student victims.

The school implemented this recommendation in the process of implementing Governor Gary Locke's safety directive (The Governor's directive included a provision directing the school not to admit sexually aggressive students.)

The Ombudsman also recommended a change in state law to formalize and strengthen CPS's oversight role at WSD. The 2002 Washington Legislature responded by providing CPS with statutory authority to investigate and follow up on safety-related deficiencies and concerns at WSD.

Supporting Relative Placements for Children

In 2002, the Ombudsman participated in a work group established by the Legislature to develop policy options for strengthening and supporting relative and kinship placements for children under the state's care.

The Kinship Care Workgroup was convened by DSHS and met over a period of several months. The Workgroup examined a variety of barriers faced by relative and kinship caregivers, including caregivers' financial needs, legal issues, and ability to access social services.

The Ombudsman provided the Kinship Care Workgroup with the perspectives and needs of relative and kinship caregivers who had contacted the office with an inquiry or complaint. The Ombudsman identified common issues and concerns, as well as its own observations about the barriers that appeared to prevent or undermine children's placement with relatives.

The Ombudsman encouraged the Kinship Care Workgroup to address several key issues:

1) Ensuring that DSHS case workers conduct timely and thorough relative searches when placing children outside of their home;
2) Providing relative caregivers with access to the court system to provide information on the child's well being;
3) Improving inter-state communication between agencies when dependent children are placed in a relative's home outside of the child's home state and;
4) Establishing safeguards to ensure that neither child safety nor family preservation is jeopardized in efforts to promote relative placements.

The Kinship Workgroup's final report included several recommendations, including:

1) Development of a standardized, statewide protocol for DSHS case workers to identify possible relative and kinship placements;
2) Establishment of a program to assist relative and kinship caregivers with understanding and navigating the service system for children in out-of-home care; and
3) Implementation of a "Kinship Caregiver's Authorization Affidavit" that would allow caregivers to access appropriate medical and education services.

The Workgroup's recommendations were incorporated into legislative proposals and presented to the 2003 Legislature for consideration.

Strengthening Family Reunification Efforts

The Ombudsman is currently participating on the Dependency and Termination Equal Justice Project.

The 2001 Legislature directed the Washington State Office of Public Defense to initiate the Project in response to troubling statistics indicating that Washington State's family reunification rate is over 30 percent lower than in 1997.

The Project's purpose is to enhance family reunification and permanency for children in state care by designing a statewide program to improve the representation of parents in dependency and termination of parental rights proceedings.

A major portion of the Project's work is being carried out by three subcommittees. Each subcommittee is concentrating on an area that greatly affects the reunification process.

The Legal Representation subcommittee is reviewing the impact of continuances in dependency and termination proceedings, and the correlation between reductions in continuances and achieving earlier permanent plans for children in state care.

The Expert Services subcommittee is examining the provision of expert services, as well as the effectiveness of drug courts, in dependency and termination proceedings.

Under the current system, the majority of expert witnesses in dependency and termination proceedings are obtained through state-contracted providers, and parents rarely have the ability to seek their own expert assessment.

The Ombudsman is participating on the Access to Services subcommittee. State and federal law provide that parents are entitled to receive remedial services, such as drug treatment and parenting classes, to assist them in reuniting with their children.

These laws also require that either family reunification or an alternative permanent placement plan for the child must be established within specific timelines.

This subcommittee is examining parents' ability to access effective remedial services in a timely manner, while also maintaining regular parent-child visitation. As a subcommittee participant, the Ombudsman is highlighting legitimate concerns brought to its attention by parents.

These include DSHS's inability or failure to implement appropriate remedial services in a timely manner and the agency's sometimes unrealistic case plans that fail to prioritize services or allow a reasonable time period for completion.

The Ombudsman is also highlighting the inconsistent efforts by the agency to facilitate meaningful visitation between parents and their children in state care.

The Equal Justice Project will culminate in a published report with its findings and recommendations to judicial leaders and state policy makers.