OMBUDSMAN IN ACTION

The Ombudsman takes action on a complaint when it has determined that action is necessary to avert or correct a harmful oversight or avoidable 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 intervenes by persuading the agency to correct the problem. The office induces corrective action by sharing its investigation findings and analyses with supervisors and higher-level agency officials.

Frequently, a concern is resolved before corrective action is necessary. In these cases, the Ombudsman actively facilitates resolution by ensuring that critical information is obtained and considered by the agency and facilitating communication among the people involved.

On occasion, an agency error is brought to the Ombudsman's attention after the fact, and corrective action is not possible. When this occurs, the Ombudsman brings the error to the attention of high-level agency officials, so they can take steps to prevent such incidents from recurring in the future.

The Ombudsman is often successful in resolving legitimate concerns.

The Ombudsman facilitates resolution by:

- Prompting DSHS to take a "closer look."
- Facilitating information sharing to ensure all pertinent information is considered before critical decisions are made.
- Mediating professional disagreements to avoid delay of critical decisions.

The following sections provide brief descriptions of complaints in which the Ombudsman induced corrective action, facilitated resolution, or prevented future mistakes in the last reporting period. It illustrates how the office works to help DSHS avert and correct avoidable errors.

Inducing Corrective Action

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

Finding: A Child Protective Services (CPS) worker entered into an agreed order of dependency with a mother that allowed liberal unsupervised visits between the mother and her child. The worker did this even though his supervisor had directed him to place restrictions on the mother's contact with the child due to safety concerns. As a result, the child was exposed to unauthorized contact with her dangerous father, and was driven in a vehicle by her mother while the mother's license was suspended.

Outcome: After the Ombudsman intervened, CPS took corrective action by setting a court hearing to address this issue, and the court amended the agreed order to require only supervised visits.

Finding: A CPS supervisor unreasonably changed a screening decision on a report alleging chronic neglect of a developmentally disabled youth, resulting in no investigation.

Outcome: The Ombudsman intervened and requested a review by the area manager, who agreed that the screening decision should not have been changed, and the report was assigned for a high standard investigation.

Finding: CPS did not investigate within the required timelines a report of child abuse that it had determined to be "emergent."

Outcome: The Ombudsman intervened with the CPS supervisor. As a result, the report was investigated two days later. The child disclosed recent physical abuse, and she was placed into protective custody.

Finding: CPS failed to provide services in a timely manner to protect young children, and preserve a family after the parent was expelled from an in-patient drug treatment program. CPS had an open case with this family at the time the parent was expelled from treatment, due to physical abuse and neglect allegations.

Outcome: The Ombudsman intervened and contacted the area manager, expressing concerns regarding services for this family. CPS established a safety plan and provided comprehensive services including family preservation services, mental health services, and outpatient drug treatment. The agency also convened a Child Protection Team (CPT), a group of knowledgeable professionals, to review the case and provide additional recommendations.

Finding: CPS failed to conduct an adequate investigation into allegations of sexual abuse of a child by a stepfather who had a prior conviction of a child sex offense. Specifically, CPS unreasonably relied upon the assessment of a mental health provider who was not a certified sex-offender treatment provider; had not reviewed records regarding the step-father's previous crimes against children; and had not established a safety plan to protect the children residing in the home.

Outcome: The Ombudsman intervened and contacted the area manager to express concerns regarding CPS' investigation. CPS then agreed to obtain an evaluation of the step-father by a certified sex offender treatment provider, review criminal court records, and establish a safety plan to limit contact between the step-father and children in the home.

Finding: CPS unreasonably screened out a report of sexual abuse of a child, after deciding that the report did not meet the criteria for investigation.

Outcome: After the Ombudsman intervened with the area manager, CPS reconsidered the screening decision, accepted the report for investigation and forwarded the report to law enforcement.

Finding: Child Welfare Services (CWS) failed to provide a dependent youth with an appropriate placement. Specifically, on numerous occasions, the youth's placement at a secure Crisis Residential Center (CRC) exceeded the five-day maximum set forth in law.

Outcome: After the Ombudsman intervened, CWS placed the youth in a therapeutic foster home.

Finding: CWS inappropriately used a substance abuse detoxification/ assessment center serving both adults and youths, as a short-term placement for dependent youths who were homeless or disenfranchised, but were not necessarily in need of detoxification or assessment for substance abuse treatment. While this center reportedly provided a high level of supervision, it did not separate the juvenile population from the adults.

Inducing Corrective Action *(continued)*

Outcome: After the Ombudsman intervened, the area manager acknowledged that the detoxification assessment center had been used inappropriately for short-term placement for youth, and issued a directive that this practice cease.

Finding: CWS failed to comply with Inter-state Child Placement Compact (ICPC) requirements prior to placing dependent children with an out-of-state relative. The purpose of the requirements is to ensure that the placements of children who are placed out of state are safe and appropriate.

Outcome: The Ombudsman intervened by notifying the area manager, who then initiated the ICPC process.

Finding: CPS failed to follow the recommendation of the Child Protection Team (CPT) to remove children from their parent's care based on allegations of physical abuse, nor did the agency obtain required approval from the regional administrator to disregard this recommendation.

Outcome: The Ombudsman intervened, notifying the area manager of its concerns that the recommendations of the CPT had been ignored. The area manager acknowledged that the decision to override the CPT recommendation should have been approved by the regional administrator. CPS subsequently placed the children in protective custody and filed a dependency petition.

Finding: CPS failed to appropriately assign a report of child neglect by a day care provider. The report had been assigned to the Office of Foster Care Licensing as a licensing complaint, and not referred to CPS as a child safety concern. As a result, CPS did not investigate the report.

Outcome: After the Ombudsman intervened, CPS corrected its error and conducted an investigation, including interviews with all children involved, their parents, and their day care providers.

Finding: Due to a dispute over jurisdiction between two DSHS regions, CPS failed to assign an emergent referral for investigation of allegations of child neglect.

Outcome: The Ombudsman intervened and contacted the area managers involved urging the agency to take appropriate action in response to this report. The case was then assigned within two days and the children were ultimately placed with a suitable relative.

Finding: CPS failed to investigate allegations of child abuse and neglect in a timely manner. Specifically, the worker did not conduct parent and child interviews within required timelines.

Outcome: The Ombudsman intervened by contacting the CPS supervisor with concerns. A CPS worker went to the home and interviewed the mother the next day. The mother admitted illegal drug use. CPS provided chemical dependency assessment and treatment services to the mother and established a safety plan that included both scheduled and unannounced home visits.

Finding: CPS Central Intake failed to send a report requiring an emergent response to the local investigative CPS unit within 24 hours. This prevented the local unit from responding within 24 hours, as required by law and policy.

Outcome: After the Ombudsman brought the omission to the agency's attention, CPS Central Intake sent the report to the local CPS unit for immediate investigation.

Finding: CWS failed to adequately address mental health issues regarding a grandparent, prior to placing a dependent child with him. The grandparent had failed to maintain placement of the grandchild in the past. Furthermore, the grandparent had a history of abuse and neglect as a parent.

Outcome: By the time the Ombudsman received this complaint, the child had already been placed with the grandparent. The Ombudsman intervened by contacting the CWS supervisor to request that these concerns be thoroughly investigated as part of the adoption home study. Prior to completion of the home study, the child was removed following the grandparent's mental health crisis.

Facilitating Resolution

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

Finding: CWS failed to conduct a home visit or criminal background check before placing two foster children with relatives in a distant region of the state.

Outcome: At the Ombudsman 's urging, the worker conducted an assessment of the home, which uncovered the relatives' criminal history. This information, in addition to subsequent CPS reports alleging abuse and neglect of the children in the home, led CWS to determine that the placement was, in fact, unsuitable and the children were ultimately moved to another placement.

Finding: CWS failed to conduct any health and safety visits for over nine months, regarding a dependent child placed in a relative's care.

Outcome: After the Ombudsman flagged the omission, the case was reassigned to a new caseworker who, upon investigation, found multiple safety concerns. The child was subsequently removed from the relative's home due to reports of domestic violence, and the child was placed in foster care.

Finding: CPS failed to monitor a six-month Voluntary Service Agreement (VSA) with a parent that established a safety plan for the protection of a child from a registered sex offender.

Outcome: The omission was addressed when, at the Ombudsman's urging, the CPS worker conducted a home visit and interviewed the child. The parent signed a new safety plan, and the CPS case was ultimately successfully closed.

Finding: CPS failed to immediately notify a father when his two children were placed in protective custody and a dependency petition filed.

Outcome: At the Ombudsman's urging, CPS called the father, and faxed notice of the dependency proceeding to the father's attorney.

Finding: CWS failed to notify a father when a dependency guardianship of his child was vacated, even though he was paying child support and could have been located. As a result, the father was not being considered as a placement resource for the child.

Outcome: The father learned from relatives that the guardianship had been vacated, and he contacted the department. At the Ombudsman's urging, CWS agreed to conduct a home study and, if appropriate, consider the father as a placement resource.

Finding: CWS failed to follow the recommendation of a Child Protection Team (CPT) to remove a child from a foster home. Two years after the recommendation, the agency neither had taken steps to address the CPT's safety concerns nor to override the CPT recommendation.

Outcome: While this complaint was under investigation by the Ombudsman, CWS convened a new CPT to assess the child's safety and well-being.

Finding: CPS failed to complete an investigation into multiple allegations of child abuse and neglect in a timely manner. The CPS case remained open but inactive for several months after law enforcement and CPS completed their joint investigation of sexual abuse allegations.

Outcome: The CPS case was reassigned due to the urging of the Ombudsman, and the new caseworker entered into a voluntary service agreement with the family, which provided intensive family preservation services.

Finding: CPS failed to investigate a report alleging physical abuse and neglect of a child in a timely manner.

Outcome: At the Ombudsman's urging, CPS investigated the referral and entered into a safety plan/service contract with the parent.

Finding: CPS unreasonably decided to close a case because the mother refused to accept services, even though allegations of physical abuse of a child were founded.

Outcome: The situation was resolved when, at the Ombudsman's urging, CPS agreed to staff the case with a CPT. The parent agreed to the services and evaluations recommended by the CPT.

Facilitating Resolution *(continued)*

Finding: CPS failed to intervene in a timely manner to protect two children from chronic maltreatment by their parent. Over a period of almost four years, CPS received 25 reports, documenting physical neglect, emotional abuse, and physical abuse of the children, directly related to the parent's mental disabilities. Although CPS provided services, the parent's participation was marginal, no progress was identified, and the level of risk to the children was not reduced.

Outcome: While the situation was resolved, during the course of the Ombudsman's investigation, CPS received a new report of abuse and placed the children in protective custody with their relatives.

Finding: CWS failed to establish permanency in a timely manner for a 10-year-old legally free child placed with relatives out-of-state. The child had been placed with her relatives for over two-and-a-half years and the adoption had not been finalized due to ICPC compliance issues with both the sending and the receiving state.

Outcome: With the Ombudsman's assistance in facilitating communication, the ICPC delays were addressed, and the adoption was finalized.

Finding: CWS failed to provide appropriate out-of-home care as recommended by the treatment providers for an adolescent child with significant mental health and behavioral problems, after a Voluntary Placement Agreement (VPA) expired. The youth's reunification with his family failed after 17 days, and he was again placed voluntarily with another family. The youth had been the subject of a VPA for over one year, and had been in at least 13 different placements.

Outcome: At the Ombudsman's urging, CPS filed a dependency petition and found a therapeutic placement for this child.

Preventing Future Mistakes

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

Finding: The Ombudsman found that CPS unreasonably declined to investigate numerous referrals over a two-year period reporting chronic child maltreatment that included physical abuse, neglect, and exposure to domestic violence. The children were ultimately taken into protective custody by law enforcement, which finally resulted in CPS involvement.

Outcome: The Ombudsman requested a full review of the case by Children's Administration (CA), and the final CA report, with several recommendations for changes in CPS practice, is being used by the DSHS Child Welfare Training Academy.

Finding: A state-contracted therapist for a child failed to report that the child had been hit with a belt by his relative foster parent. CPS later determined that the act constituted physical abuse, and the child was moved to the care of another relative.

Outcome: The Ombudsman brought the therapist's omission to the attention of the area manager, who then reviewed the relevant laws and policies governing mandated reporters with the therapist.

Finding: CPS failed to conduct a timely investigation into allegations of physical abuse and neglect of a child by her parents. Specifically, the child was not seen by a CPS worker until three weeks after the report was made. Although bruises on the child had been reported, by the time the child was seen no bruises were observed. This resulted in an inconclusive finding. The investigation itself was not completed until six months later, well outside of the 90-day timeline for completion of CPS investigations.

Outcome: By the time the Ombudsman received this complaint, CPS had completed its investigation. The Ombudsman brought concerns regarding the delay in seeing the child and completing the investigation to the attention of CA officials. A subsequent CPS referral alleging medical neglect of the child was investigated in a timely manner.

Finding: CPS failed to take appropriate steps to protect young children, after an infant in the home suffered serious head injuries as a result of physical abuse. The parents initially did not identify the perpetrator, and after he confessed, the parents refused to cooperate with law enforcement's efforts to locate the perpetrator, did not obtain a restraining order against him, and refused services offered by CPS.

Outcome: By the time the Ombudsman received this complaint, the perpetrator had been arrested. However, the Ombudsman concluded that based on the severity of the child's injury, and questions as to the parents' willingness and ability to protect, it was clearly unreasonable for CPS to have allowed the children to remain in the home. The Ombudsman requested an internal review of the case by CA headquarters. The review concluded that the uninjured children should have been removed from the home during the CPS investigation, due to the high risk factors posed by the children's age, the fact that the identity of the perpetrator remained unclear for some time, and the family's failure to cooperate with CPS.

Finding: CWS failed to do a relative search until a dependent infant had been in a non-relative foster home for seven months. CWS also failed to conduct required 90-day health and safety visits to the child, for over five months, and failed to provide the foster parents with five days' notice of the child being moved.

Outcome: By the time the Ombudsman received this complaint, the child had been removed from foster care and placed with a relative.

Preventing Future Mistakes *(continued)*

Ombudsman brought these findings to the attention of Children's Administration headquarters.

Finding: CPS unreasonably screened out a referral from a youth detention facility reporting that a youth was in need of placement as no parent could be located, and the youth was due for immediate release.

Outcome: CPS Central Intake Unit acknowledged to the Ombudsman that this referral should have been accepted, and stated it would take corrective action with supervisors and workers regarding proper response to these types of referrals.

Finding: CPS Central Intake Unit failed to answer incoming calls in a timely manner. Specifically, a medical professional attempting to report suspected child abuse/neglect was kept on hold for 27 minutes.

Outcome: By the time this complaint was received by the Ombudsman, the medical professional had succeeded in reporting safety concerns to CPS. The Ombudsman notified Children's Administration headquarters of systemic concerns regarding Central Intake, which were ultimately addressed by returning CPS Intake daytime to local CPS offices.

The Ombudsman is Often Successful at Resolving Legitimate Concerns

The Ombudsman actively facilitates resolution by ensuring that important information is obtained and considered and by mediating professional disagreements so that critical decisions can be made.

The Ombudsman assists a relative caregiver maintain guardianship of a child

A grandparent contacted the Ombudsman with concerns about DCFS' decision to remove her 16-year-old granddaughter from her care. The youth had been in her care since she was five years old, and a dependency guardianship was established eight years ago. The youth was recently removed from her care due to findings of medical neglect. The grandparent believed the allegations had not been investigated adequately and that the agency's findings were unreasonable.

The Ombudsman determined that DCFS' decision was primarily based on concerns of a treating emergency room physician, alleging that the grandparent failed to administer the youth's seizure medication as prescribed. The Ombudsman questioned whether DCFS had considered a letter of support from the youth's primary care physician, as well as other letters from the school, the church, extended family and friends all supporting the grandparent's ability to care for this youth. At the Ombudsman's urging, the caseworker interviewed the physician and requested a copy of his letter. The caseworker further found that the youth, though placed with another relative, still very much wanted to live with her grandparent. After interviewing the primary physician and reviewing all available information, the new caseworker agreed to return the youth to her grandparent's care and withdrew the motion to terminate the guardianship.

The Ombudsman assists CWS in gathering complete information to ensure suitable permanent placement

A foster parent contacted the Ombudsman with concerns about DCFS' plan to place her 11-year-old foster child with his half-sibling, who was in the care of the sibling's parent. Safety concerns centered on allegations that the parent's spouse had a criminal record; the sibling had behavior problems; and the parent would not be able to provide the 11 year old child with appropriate attention and supervision due to the number of children in the home. The Ombudsman found other issues not raised by the complainant. Although parental rights to the child had been terminated for the past four years, a permanent placement had not yet been identified. He had been in approximately 18 different placements, including a failed relative placement, a failed reunification, and a failed pre-adoptive placement. While reviewing DCFS records, the Ombudsman discovered CPS history listed under a different spelling of the parent's last name, which had previously not been considered by DCFS staff. These records included a CPS finding of physical abuse of a child by the parent, and a referral alleging sexual assault of two adolescent youths. The Ombudsman also found that the parent's spouse had an extensive CPS history regarding her own children, as well as a criminal history.

After consideration of the records that the Ombudsman brought to the agency's attention, the sibling's parent did not pass an adoption home study. Because there had been significant delays in achieving permanency for this child, the DCFS Area Manager directed that all work on the case be expedited. A suitable adoptive family who had known the child was explored, and the child was placed in this home five months after the case came to the Ombudsman's attention.