Office of the Family and Children's Ombuds

An Independent Voice for Families and Children

2015 Annual Report

Patrick Dowd, *Director*

ofco.wa.gov

STATE OF WASHINGTON
OFFICE OF THE FAMILY AND CHILDREN'S OMBUDS
6840 FORT DENT WAY, SUITE 125
TUKWILA, WA 98188
(206) 439-3870 • (800) 571-7321 • FAX (206) 439-3877

January 2016

To the Residents of Washington State:

I am pleased to submit the 2015 Annual Report of the Office of the Family and Children's Ombuds. This report provides an account of OFCO's activities from September 1, 2014 to August 31, 2015. OFCO thanks the parents, youth, relatives, foster parents, professionals and others who brought their concerns to our attention. We take their trust in our office most seriously.

During this reporting period, OFCO conducted 681 complaint investigations regarding 1,065 children and 636 families. Seventeen complaints were handled as an "emergent investigation" as the allegations involved either a child's immediate safety or an urgent situation requiring timely intervention. As in past years, the separation and reunification of families and the safety of children living at home or in substitute care were by far the most frequently identified issues in complaints. In addition to complaint investigations, OFCO monitors practices and procedures within the child welfare system and makes recommendations to better serve children and families. Systemic issues and recommendations discussed in this report include the shortage of placement resources for children in state care. As a result, in some counties children are temporarily placed in motels because an appropriate placement is not immediately available. Additionally, therapeutic placements and services are often lacking for adolescents with mental health and behavior rehabilitation needs that are beyond the parents' ability to safely address in the home. The shortage of licensed placements for children increases the pressure on all phases of our child welfare system - the case workers seeking appropriate placement for a child; the foster parents who are asked to take additional children; the courts that must review and approve case plans for services, placement and permanency; and, most importantly, the children who experience placement disruptions, separation from siblings, and turmoil in their lives.

Past Annual Reports included a review of child fatalities, child near fatalities and the implementation status of recommendations from child fatality reviews. This year OFCO will produce a separate report covering all issues it reviewed related to child fatalities and near fatalities.

On behalf of all of us at the Office of the Family and Children's Ombuds, I want to thank you for your interest in our work. I am grateful for the leadership and dedication of those working to improve the welfare of children and families and I am grateful for the opportunity to serve the residents of Washington State.

Sincerely,

Patrick Dowd, JD
Director Ombuds

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The OFFICE OF THE FAMILY AND CHILDREN'S OMBUDS (OFCO) was established by the 1996 Legislature to ensure that government agencies respond appropriately to children in need of state protection, children residing in state care, and children and families under state supervision due to allegations or findings of child abuse or neglect. The office also promotes public awareness about the child protection and welfare system, and recommends and facilitates broad-based systemic improvements.

This report provides an account of OFCO's complaint investigation activities from September 1, 2014, through August 31, 2015. This report also provides recommendations to improve the quality of state services for children and families.

CORE DUTIES

The following duties and responsibilities of the Ombuds are set forth in state laws:[1]

Respond to Inquiries:
Provide information on the rights and responsibilities of individuals receiving family and children's services, and on the procedures for accessing these services.

Complaint Investigation and Intervention:
Investigate, upon the Ombuds' own initiative or receipt of a complaint, an administrative act alleged to be contrary to law, rule, or policy, imposed without an adequate statement of reason, or based on irrelevant, immaterial, or erroneous grounds. The Ombuds also has the discretion to decline to investigate any complaint.

System Oversight and Improvement:

- Monitor the procedures as established, implemented, and practiced by the Department of Social and Health Services (DSHS) to carry out its responsibilities in delivering family and children's services to preserve families when appropriate and ensure children's health and safety;
- Review periodically the facilities and procedures of state institutions serving children, and state-licensed facilities or residences;
- Review child fatalities and near fatalities when the injury or death is suspected to be caused by child abuse or neglect and the family was involved with the department during the previous 12 months;
- Recommend changes in law, policy and practice to improve state services for families and children; and
- Review notifications from DSHS regarding a third founded report of child abuse or neglect, within a twelve month period, involving the same child or family.

[1] RCW 43.06A and RCW 26.44.030.

Annual Reports:

- Submit an annual report to the Legislative Children's Oversight committee and to the governor analyzing the work of the office including recommendations; and
- Issue an annual report to the legislature on the implementation status of child fatality review recommendations.

INQUIRIES AND COMPLAINT INVESTIGATIONS

Between September 1, 2014 and August 31, 2015, OFCO completed 678 complaint investigations regarding 1,065 children and 636 families. As in previous years, issues involving the separation and reunification of families were by far the most frequently identified complaint issues. The safety of children living at home or in substitute care, and complaints about agency conduct comprised the next-highest categories of issues identified in complaints.

OMBUDS IN ACTION

OFCO takes action when necessary to avert or correct a harmful action or oversight, or an avoidable mistake by Children's Administration (CA). Forty-two complaints prompted intervention by OFCO in 2015. OFCO provided substantial assistance to resolve either the complaint issue or a concern identified by OFCO in the course of its investigation, in an additional 32 complaints.

In 2015, OFCO made 33 formal adverse findings against CA. OFCO provides CA with written notice of adverse findings resulting from a complaint investigation. CA is invited to respond to the finding, and may present additional information and request a revision of the finding. This process provides transparency for OFCO's work as well as accountability for DSHS.[2]

WORKING TO MAKE A DIFFERENCE

Shortage of Foster and Other Residential Care Placements

Washington State has experienced a significant decline in the number of licensed foster homes, yet the number of children requiring out-of-home care has not decreased. As a result of limited placement resources, children in state care have been temporarily housed in motels, waiting for an appropriate placement to be found. This report describes 120 "placement exceptions" involving 72 children. OFCO found that this is primarily a regional problem, occurring most frequently in Snohomish and King Counties. Seventy percent of the children placed temporarily in motels are between the ages of 12 and 17 years. Many of these children also have mental health and behavioral rehabilitation needs.

Limited placement resources also impact the department's ability to provide out-of-home care for a child who has not suffered abuse or neglect, but whose behavior or special needs overwhelm the parent's ability to care for the child. These types of cases sometimes involve multiple systems, such as mental health, child welfare, and juvenile justice. This report describes some of the barriers encountered by families in obtaining out-of-home placement and treatment for children with special behavior and mental health needs.

[2] An inter-agency agreement between OFCO and CA was established in November 2009.

Several steps are needed to address this problem. At a minimum the state must: develop a range of licensed placement options sufficient to meet the varied needs of children entering state care; establish effective protocols between state agencies to provide services and placement in a timely manner; and coordinate efforts with private agencies, such as hospitals and community mental health providers serving these children and families.

Family Assessment Response

Family Assessment Response (FAR) provides an alternative to the traditional Child Protective Services (CPS) investigation for allegations of abuse or neglect rated as low to moderate risk. FAR has been incrementally implemented across the state since January 1, 2014. Between September 1, 2014 and August 31, 2015, OFCO received 23 complaints involving families engaged in the FAR pathway. The most common concerns raised in these complaints involved the screening of reports to CPS (i.e. to FAR versus for a CPS investigation), the authority of FAR workers to interview children, and the unavailability of FAR services in some parts of the State.

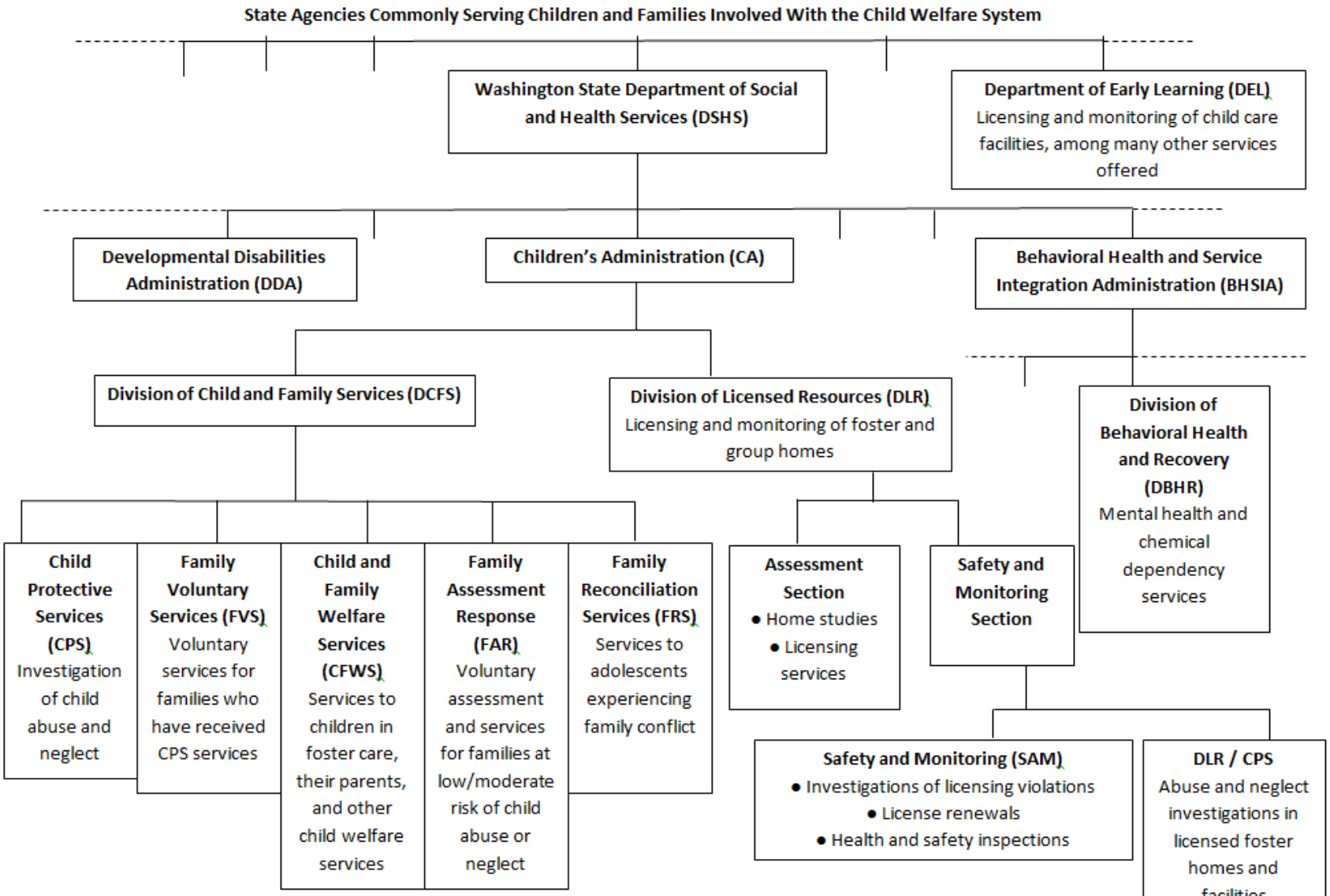
Child Welfare Legislation

As part of the Ombuds' duty to recommend system improvements, OFCO reviews and analyzes proposed legislation and testifies before the Legislature on pending bills. This section highlights those bills in the 2015 legislative session, including bills to better educate parents about the dependency process, evaluate what factors contributed to child fatalities and near fatalities to improve the health and safety of children, increase and improve services targeting youth homelessness, and extended foster care for youth after age 18.

TERMS AND ACRONYMS

AAG	Assistant Attorney General
AIRS	Administrative Incident Reporting System
ARY	At Risk Youth
BHSIA*	Behavioral Health and Service Integration Administration
BRS	Behavioral Rehabilitation Services (a program within CA for children with special needs)
CA*	Children's Administration
CASA	Court Appointed Special Advocate
CHINS	Child in Need of Services
CPS*	Child Protective Services
CPT	Child Protection Team
CRC	Crisis Residential Center
CFWS or CWS*	Child and Family Welfare Services or Child Welfare Services
DBHR*	Division of Behavioral Health and Recovery
DCFS*	Division of Child and Family Services
DDA*	Developmental Disabilities Administration
DEL*	Department of Early Learning
Dependent Child	A child for whom the state is acting as the legal parent
DLR*	Division of Licensed Resources
DSHS*	Department of Social and Health Services
FamLink	Statewide Automated Child Welfare Information System (CA's electronic record-keeping system)
FAR*	Family Assessment Response
FRS*	Family Reconciliation Services
FVS*	Family Voluntary Services
FTDM	Family Team Decision Meeting
GAL	Guardian ad Litem
HOPE Center	Residential facilities where youth may stay for up to 30 days while being evaluated for appropriate placement
ICPC	Interstate Compact for the Placement of Children
ICWA	Indian Child Welfare Act
Legally Free Child	A child whose parents' parental rights have been terminated
OFCO	Office of the Family and Children's Ombuds
SDM	Structured Decision Making (framework for CA casework practice)
VGAL	Volunteer Guardian ad Litem
VSA	Voluntary Service Agreement

*An organizational chart for these state departments and divisions is shown on the following page.



Please note, this is not an exhaustive list of state agencies that serve children and families, nor is it a complete organizational structure chart of DSHS. Rather, it is intended to be used to provide context for some of the agencies and divisions discussed in OFCO's Annual Report.

I. THE ROLE OF OFCO

"I've dealt with a lot of government agencies and rarely have I found that [the agencies] are as efficient as you have been. I appreciate the calls back even if you can't share [confidential] information with me. It's good to know you are monitoring a situation that has concerning issues."

~ Complainant and concerned relative

THE ROLE OF OFCO

The Washington State Legislature created the Office of the Family and Children's Ombuds[3] (OFCO) in 1996 in response to two high profile incidents that indicated a need for oversight of the child welfare system.[4] OFCO provides citizens an avenue to obtain an independent and impartial review of Department of Social and Health Services (DSHS) decisions. OFCO is also empowered to intervene to induce DSHS to change problematic decisions that are in violation of the law or that have placed a child or family at risk of harm, and to recommend system-wide improvements to the Legislature and the Governor.

- **Independence.** One of OFCO's most important features is independence. OFCO's ability to review and analyze complaints in an independent manner allows the office to maintain its reputation for integrity and objectivity. Although OFCO is organizationally located within the Office of the Governor, it conducts its operations independently of the Governor's Office in Olympia. OFCO is a separate agency from DSHS.

- **Impartiality.** The Ombuds acts as a *neutral investigator* and not as an advocate for individuals who file complaints, or for the government agencies investigated. This neutrality reinforces OFCO's credibility.

- **Confidentiality.** OFCO must maintain the confidentiality of complainants and information obtained during investigations. This protection makes citizens, including DSHS professionals, more likely to contact OFCO and speak candidly about their concerns.

- **Credible review process.** OFCO has a credible review process that promotes respect and confidence in OFCO's oversight of DSHS. Ombuds are qualified to analyze issues and conduct investigations into matters of child welfare law, administration, policy, and practice. OFCO's staff has a wealth of collective experience and expertise in child welfare law, social work, mediation, and clinical practice and is trained in the United States Ombudsman Association Governmental Ombudsman Standards. OFCO and DSHS operate under an inter-agency agreement that guides communication between the two agencies and promotes accountability.[5]

AUTHORITY

Under chapter RCW 43.06A, the Legislature enhanced OFCO's investigative powers by providing it with broad access to confidential DSHS records and the agency's computerized case-management system. It also authorizes OFCO to receive confidential information from other agencies and service providers,

[3] State law requires that all statutes must be written in gender-neutral terms unless a specification of gender is intended. Pursuant to Chapter 23 Laws of 2013, the term "ombudsman" was replaced by "ombuds". http://apps.leg.wa.gov/documents/billdocs/2013-14/Pdf/Bills/Session%20Laws/Senate/5077-S.SL.pdf

[4] The death of three year old Lauria Grace, who was killed by her mother while under the supervision of the Department of Social and Health Services (DSHS), and the discovery of years of sexual abuse between youths at the DSHS-licensed OK Boys Ranch. The establishment of the office also coincided with growing concerns about DSHS' role and practices in the Wenatchee child sexual abuse investigations.

[5] The inter-agency agreement is available online at http://ofco.wa.gov/documents/interagency_ofco_dshs.pdf

including mental health professionals, guardians ad litem, and assistant attorneys general.[6] OFCO operates under a shield law which protects the confidentiality of OFCO's investigative records and the identities of individuals who contact the office. This encourages individuals to come forward with information and concerns without fear of possible retaliation. Additional duties have been assigned to OFCO by the Legislature over the years regarding the reporting and review of child fatalities, near fatalities, and cases of children experiencing recurrent maltreatment.[7]

OFCO derives influence from its close proximity to the Governor and the Legislature. The Director is appointed by and reports directly to the Governor. The appointment is subject to confirmation by the Washington State Senate. The Director-Ombuds serves a three-year term and continues to serve in this role until a successor is appointed. OFCO's budget, general operations, and system improvement recommendations are reviewed by the Legislative Children's Oversight Committee.

WORK ACTIVITIES

OFCO performs its statutory duties through its work in four areas, currently conducted by *6.8 full time employees*:

- **Listening to Families and Citizens.** Individuals who contact OFCO with an inquiry or complaint often feel that DSHS or another agency is not listening to their concerns. By listening carefully, the Ombuds can effectively assess and respond to individual concerns as well as identify recurring problems faced by families and children throughout the system.

- **Responding to Complaints.** The Ombuds impartially investigates and analyzes complaints against DSHS and other agencies. OFCO spends more time on this activity than any other. This enables OFCO to intervene on citizens' behalf when necessary, and accurately identify problematic policy and practice issues that warrant further examination. Impartial investigations also enable OFCO to support actions of the agency when it is unfairly criticized for properly carrying out its duties.

- **Taking Action on Behalf of Children and Families.** The Ombuds intervenes when necessary to avert or correct a harmful oversight or mistake by DSHS or another agency. Typical interventions include: prompting the agency to take a "closer look" at a concern, facilitating information sharing, mediating professional disagreements, and sharing OFCO's investigative findings and analyses with the agency to correct a problematic decision. These interventions are often successful in resolving legitimate concerns.

- **Improving the System.** Through complaint investigations and reviews of critical incidents (including child fatalities, near fatalities, and cases of children experiencing recurrent maltreatment), OFCO works to identify and investigate system-wide problems, and publishes its findings and recommendations in public reports to the Governor and the Legislature. This is an effective tool for educating state policymakers and agency officials about the need to create, change or set aside, laws, policies or agency practices so that children are better protected and cared for and families are better served by the child welfare system.

[6] See also RCW 13.50.100(6).
[7] See RCW 74.13.640(1) (b); 74.13.640(2); and 26.44.030(15).

II. LISTENING TO FAMILIES AND CITIZENS

- Inquiries and Complaints
- Complaint Profiles
- Complaint Issues

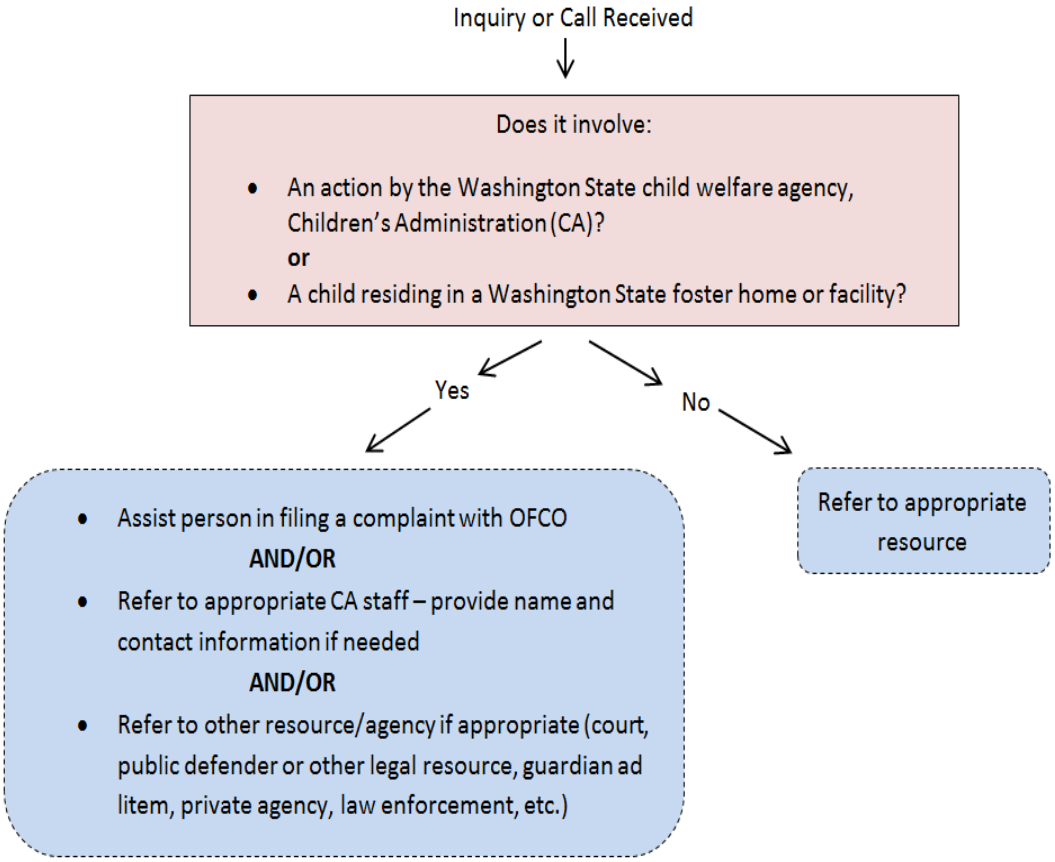
"I can't thank you enough. This is huge for me. I finally feel heard."

~ Incarcerated father of dependent child, upon OFCO intervening to begin communication with DCFS about services for family reunification

INQUIRIES AND COMPLAINTS

The Ombuds listens to people who contact the office with questions or concerns about services provided through the child welfare system. Callers may include family members of children receiving such services, professionals working with families and children, or concerned citizens. By listening carefully, the Ombuds identifies what the caller needs and responds effectively. Callers may simply need information about Children's Administration's (CA) process and/or services, or they may want to know how to file a complaint if their concern falls under OFCO's jurisdiction. While OFCO's online complaint submission process (launched April 2014) has greatly expedited filing a complaint, OFCO still provides live telephonic assistance to complainants who want help with the process. For example, they may want verification about whether OFCO can investigate their concern, or guidance in framing or identifying their complaint issue. Callers whom OFCO cannot help directly are referred to the right place for information or support. OFCO makes every effort to have each incoming call answered by a live person rather than a voicemail or menu of options. We frequently hear from callers that this individualized service is highly valued.

Figure 1: **What Happens When a Person Contacts OFCO?**



COMPLAINT PROFILES

COMPLAINTS RECEIVED

This section describes complaints filed during OFCO's 2015 reporting year — September 1, 2014 to August 31, 2015. **OFCO received 694 complaints in 2015**. As shown in Figure 2, complaints filed with OFCO decreased steadily between 2009 and 2013, but increased sharply to 713 in 2014. The number of complaints received in 2015 dropped slightly, while still remaining higher than most years before 2013. This increase is largely attributable to the launch of OFCO's online complaint submission process in April 2014, which greatly simplified and expedited the complaint filing process. Figure 3 shows that nearly 80 percent of complaints are now submitted electronically.

Figure 2: **Complaints Received**[8]

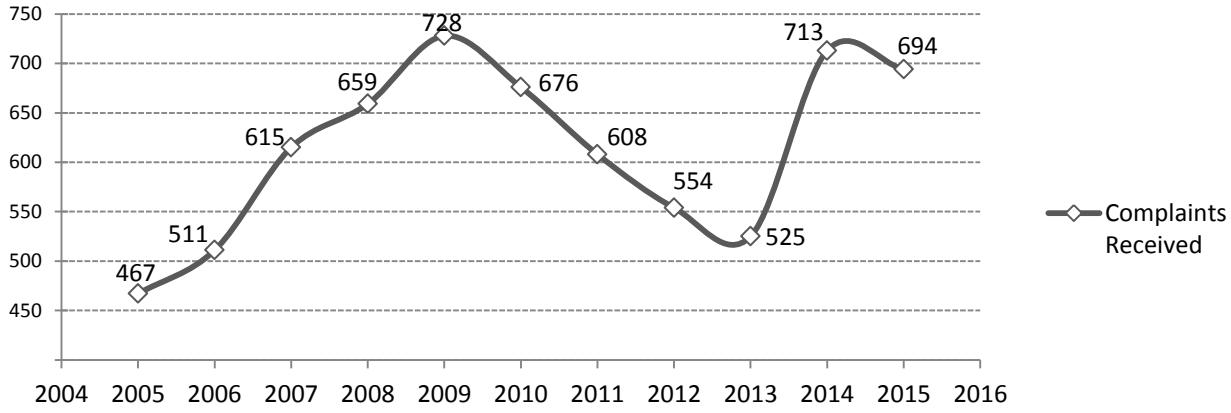
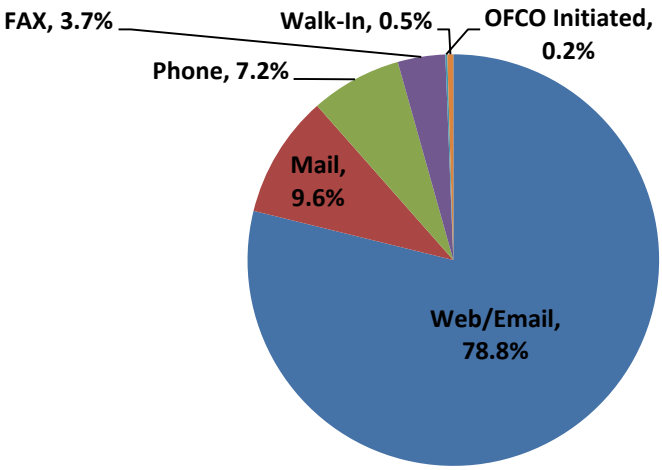


Figure 3: **How Complaints Were Received, 2015**

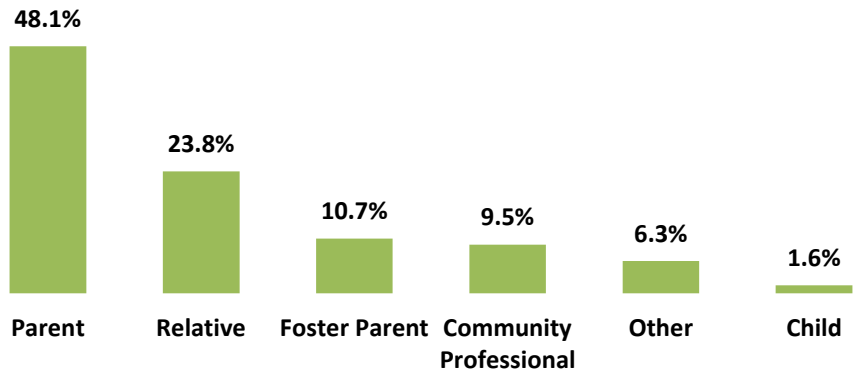


[8] The number of complaints directed at each DSHS region and office is provided in Appendix A

PERSONS WHO COMPLAINED

Parents, grandparents, and other relatives of the child whose family is involved with CA have historically filed around three-quarters of complaints investigated by OFCO, and 2015 was no exception. As in previous years, few children contacted OFCO on their own behalf.

Figure 4: **Complainant Relationship to Children, 2015**



OFCO's complaint form asks complainants to identify their race and ethnicity for the purposes of ensuring that the office is hearing from all Washington citizens.

Table 1: **Complainant Race and Ethnicity, 2015**

	OFCO Complainants 2015	WA State Population*
Caucasian	70.5%	78.5%
African American	7.3%	3.6%
American Indian or Alaska Native	5.0%	1.4%
Asian or Pacific Islander	1.6%	7.3%
Other	0.3%	3.9%
Multiracial	4.5%	4.8%
Declined to Answer	10.8%	-
Latino / Hispanic	6.9%	11.5%
Non-Hispanic	93.1%	88.5%

**U.S. Census Bureau, 2009-2013 American Community Survey 5-Year Estimates*

CHILDREN IDENTIFIED IN COMPLAINTS

Nearly 40 percent of the 1,065 children identified in complaints were four years of age or younger. Another 31 percent were between ages five and nine. OFCO receives fewer complaints involving older children, with the number of complaints decreasing as the child's age increases. This closely mirrors the ages of children in out of home care through the Division of Child and Family Services (DCFS).[9]

Figure 5: **Age of Children in Complaints, 2015**

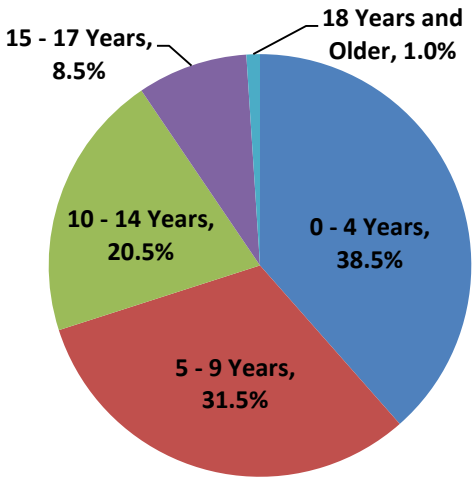


Table 2 shows the race and ethnicity (as reported by the complainant) of the children identified in complaints, compared with children in placement through CA and the general state population.

Table 2: **Race and Ethnicity of Children Identified in Complaints, 2015**

	OFCO Children 2015	Children in Out of Home Care*	WA State Children**
Caucasian	68.9%	66.9%	71.0%
African American	7.6%	9.0%	4.1%
American Indian or Alaska Native	5.9%	6.2%	1.6%
Asian or Pacific Islander	1.7%	1.5%	7.4%
Other	0.7%	0.1%	6.1%
Multiracial	13.3%	15.2%	9.8%
Declined to Answer	1.9%	-	-
Latino / Hispanic	16.8%	18.5%	19.4%
Non-Hispanic	83.2%	81.5%	80.6%

**Data reported by Partners for Our Children (partnersforourchildren.org, 2015)*

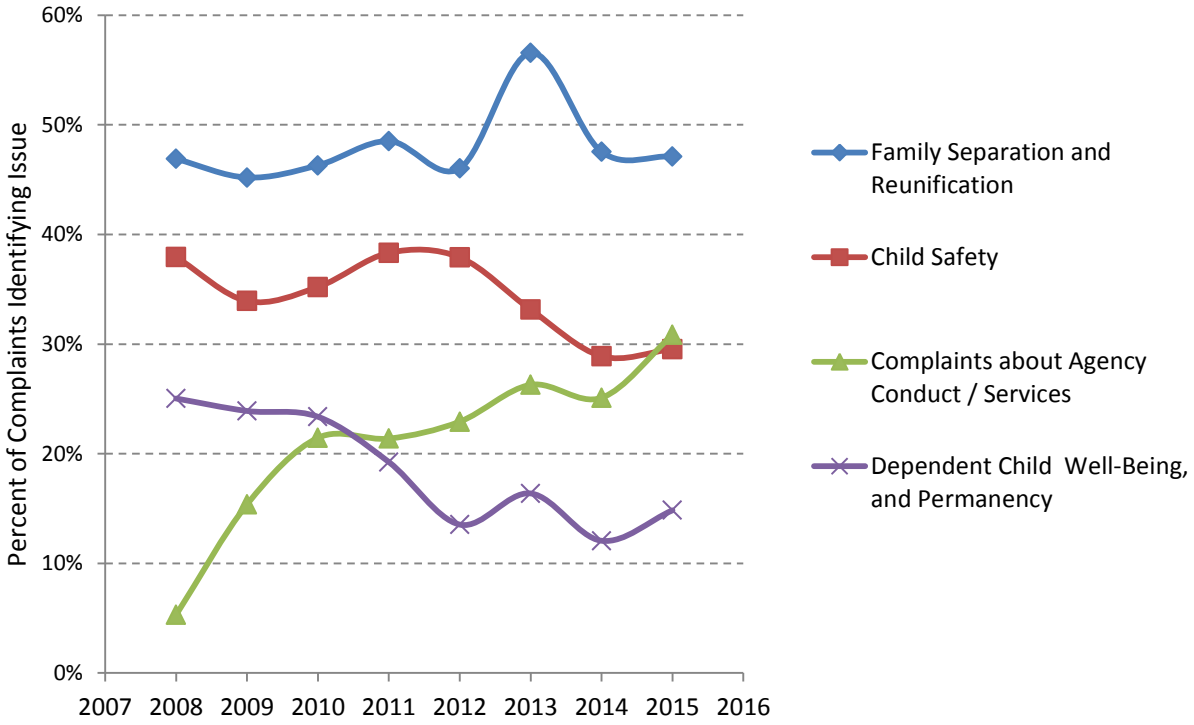
***U.S. Census Bureau, 2009-2013 American Community Survey 5-Year Estimates*

[9] For more information on the ages of children in out of home care, see Appendix B.

COMPLAINT ISSUES

Concerns identified in complaints to OFCO, while varying somewhat year-to-year, have remained largely consistent over time, as displayed in Figure 6.

Figure 6: **Categories of Issues Identified by Complainants**



As in previous years, issues involving the **separation and reunification of families** (raised 327 times in complaints) were the most frequently identified. This category of complaints incorporates a broad spectrum of issues affecting family stability. Specific concerns include:

- removal of children from parents (raised in 89 complaints) or relatives (22 complaints);
- failure to place children with relatives (51) or siblings (5);
- failure to ensure appropriate visitation or contact between children and their parents, siblings, or relatives (56); and
- delays in (or failures to) reunify a family (73); and
- termination of parental rights (5).

In previous years, issues involving **child safety** were the next-most identified concern in complaints. In 2015 however, the number of complaints involving child safety -- while still representing a large amount of complaints (205) -- was slightly eclipsed by complaints about the **conduct of DCFS staff, and/or agency services** (raised 213 times). This increase probably reflects OFCO's stronger efforts to track

these types of complaints, rather than an actual increase in their number. Complaints about agency conduct or services incorporate a broad category including:

- concerns about unprofessional conduct by agency staff (90 complaints) such as harassment, retaliation, discrimination, bias, breaches of confidentiality, or a conflict of interest;
- communication failures (43);
- inaccurate agency records (13);
- an unwarranted or unreasonable Child Protective Services (CPS) investigation (43); and
- an unreasonable finding of abuse or neglect by CPS (23);

Nearly half of the **205 child safety** complaints focused on concerns that the agency was failing to protect children from abuse or neglect while in their parents' care (100 complaints). Another 20 percent concerned safety risks to dependent children in foster or relative care (54). Thirty-one complainants were concerned about addressing the safety of children being returned to their parents' care.

Complaints involving **the well-being and permanency of children in foster or other out-of-home care** increased this year (103 complaints), although this category of complaints continues to be identified at much lower rates than in the late 2000s. This category includes inappropriate placement changes for dependent children, as well as placement instability like multiple or abrupt moves (raised in 41 complaints, higher than in the last four years). Seventeen complaints raised concerns about a child's permanency plan, including delays in permanency. The agency's failure to provide adequate services to a dependent child was a concern in 32 complaints this year – also higher than in the last four years.

Table 3 shows the number of times specific issues within these categories were identified in complaints.

Table 3: **Issues Identified by Complainants**

	2015	2014	2013	2012
Child Safety	**205**	**206**	**174**	**210**
Failure to protect children from parental abuse or neglect	100	122	91	118
Abuse	53	62	45	68
Neglect	44	56	43	49
Failure to address safety concerns involving children in foster care or other non-institutional care	54	41	44	51
Failure to address safety concerns involving child being returned to parental care	31	29	18	27
Child with no parent willing/capable of providing care	11	2	6	7
Child safety during visits with parents	5	10	10	5
Failure by agency to conduct 30 day health and safety visits with child	3	2	1	1
Safety of children in institutions/facilities (non-childcare)	1	0	3	2
Safety of children in childcare facilities (DEL)	1	0	0	1

	2015	2014	2013	2012
Dependent Child Well-Being and Permanency	**103**	**86**	**86**	**75**
Unnecessary/inappropriate change of child's placement, inadequate transition to new placement	39	19	25	28
Failure to provide child with adequate medical, mental health, educational or other services	32	28	21	15
Inappropriate permanency plan/other permanency issues	14	12	16	11
ICPC issues (placement of children out-of-state)	5	5	6	2
Failure to provide appropriate adoption support services/ other adoption issues	5	11	11	15
Unreasonable delay in achieving permanency	3	5	0	3
Placement instability/multiple moves in foster care	2	3	1	3
Extended foster care; independent living service issues	2	1	1	1
Inadequate services to dependent/non-dependent children in institutions and facilities	0	2	5	0

	2015	2014	2013	2012
Family Separation and Reunification	**327**	**339**	**297**	**255**
Unnecessary removal of child from parental care	89	80	49	36
Failure to reunite family	73	83	33	67
Failure to place child with relative	51	71	73	61
Failure to provide appropriate contact between child and parent/other family members (excluding siblings)	49	52	39	37
Other inappropriate placement of child	23	20	23	20
Unnecessary removal of child from relative placement	22	11	15	16
Failure to provide sibling visits and contact	7	4	0	4
Failure to place child with siblings	5	3	7	4
Inappropriate termination of parental rights	5	11	8	7
Concerns regarding voluntary placement and/or service agreements	0	4	1	2

	2015	2014	2013	2012
Complaints About Agency Conduct	**214**	**179**	**138**	**127**
Unprofessional conduct, harassment, retaliation, conflict of interest or bias/discrimination by agency staff	71	29	23	4
Unwarranted/unreasonable CPS investigation	43	38	24	19
Communication failures	43	44	43	43
Unreasonable CPS findings	23	28	21	28
Breach of confidentiality by agency	19	21	14	15
Inaccurate agency records	13	9	7	15
Heavy-handedness, unreasonable demands on family by agency staff	0	3	3	1
Poor case management, high caseworker turnover, other poor service	1	2	1	2
Lack of coordination between DSHS Divisions	1	2	2	0

	2015	2014	2013	2012
Other Complaint Issues	**112**	**102**	**59**	**51**
Violation of parent's rights	23	15	6	9
Failure to provide parent with services/other parent issues	47	35	15	12
Children's legal issues	5	11	12	4
Lack of support/services to foster parent/other foster parent issues	7	15	8	11
Foster parent retaliation	1	1	1	2
Foster care licensing	13	8	4	9
Lack of support/services and other issues related to relative/suitable other/fictive kin caregiver	15	9	5	4
Retaliation against relative caregiver	0	0	3	0
Violations of the Indian Child Welfare Act (ICWA)	1	8	5	0

III. TAKING ACTION ON BEHALF OF VULNERABLE CHILDREN AND FAMILIES

INVESTIGATING COMPLAINTS

- Investigation Outcomes
- OFCO in Action
- Adverse Findings in Investigations

"You and Families United were the only people willing to talk to me."

~ Father who was subject of CPS investigation, after complaint was resolved

"Thank you for bringing this to my attention. I'm glad we were able to follow up on this."

~ DCFS supervisor, after OFCO alerted her to the placement of a child with a parent who had concerning criminal history

INVESTIGATING COMPLAINTS

OFCO's goal in a complaint investigation is to determine whether DSHS Children's Administration (CA) or another state agency violated law, policy or procedure, or unreasonably exercised its authority. OFCO then assesses whether the agency should be induced to change its decision or course of action.

OFCO acts as an impartial fact finder and not as an advocate. Once OFCO establishes that an alleged agency action (or inaction) is within OFCO's jurisdiction, and that the allegations appear to be true, the Ombuds analyzes whether the issues raised in the complaint meet at least one of two objective criteria:

1. The action violates law, policy or procedure, or is clearly unreasonable under the circumstances.
2. The action was harmful to a child's safety, well-being, or right to a permanent family; *or* harmful to the preservation or well-being of a family.

Through impartial investigation and analysis, OFCO determines an appropriate response, such as:

- Where OFCO finds that the agency is properly carrying out its duties, the Ombuds explains to the complainant why the complaint allegation does not meet the above criteria, and helps complainants better understand the role and responsibilities of child welfare agencies.
- Where OFCO makes an adverse finding regarding either the complaint issue or another problematic issue identified during the course of the investigation, the Ombuds may work to change a decision or course of action by CA or another agency.
- In some instances, even though OFCO has concluded that the agency is acting within its discretion, the complaint still identifies legitimate concerns. In these cases the Ombuds provides assistance to help resolve the concerns.

OFCO conducted **681 complaint investigations** in 2015.[10] These investigations involved **1,065 children and more than 636 families**. As in previous years, the majority of investigations were **standard non-emergent investigations** (94.3 percent). Only about one out of every 17 investigations (5.7 percent) met OFCO's criteria for initiating an **emergent investigation,** i.e. when the allegations in the complaint involve either a child's immediate safety or an urgent situation where timely intervention by OFCO could significantly alleviate a child or family's distress. Once a complaint is determined to be emergent, OFCO begins the investigation immediately. As shown in Figure 7, OFCO received fewer emergent complaints in 2015 compared to past years.

Over the years, OFCO consistently intervenes in emergent complaints at a higher rate than non-emergent complaints. In 2015 **OFCO intervened or provided timely assistance to resolve concerns in 20.5 percent of emergent complaints**, compared with **10.5 percent of non-emergent complaints**.

[10] OFCO closed 681 complaints during the 2014-2015 reporting year, while it received 694. Some complaints received during the reporting year remain open for ongoing investigation.

Figure 7: **Completed Investigations, by Complaint Type**

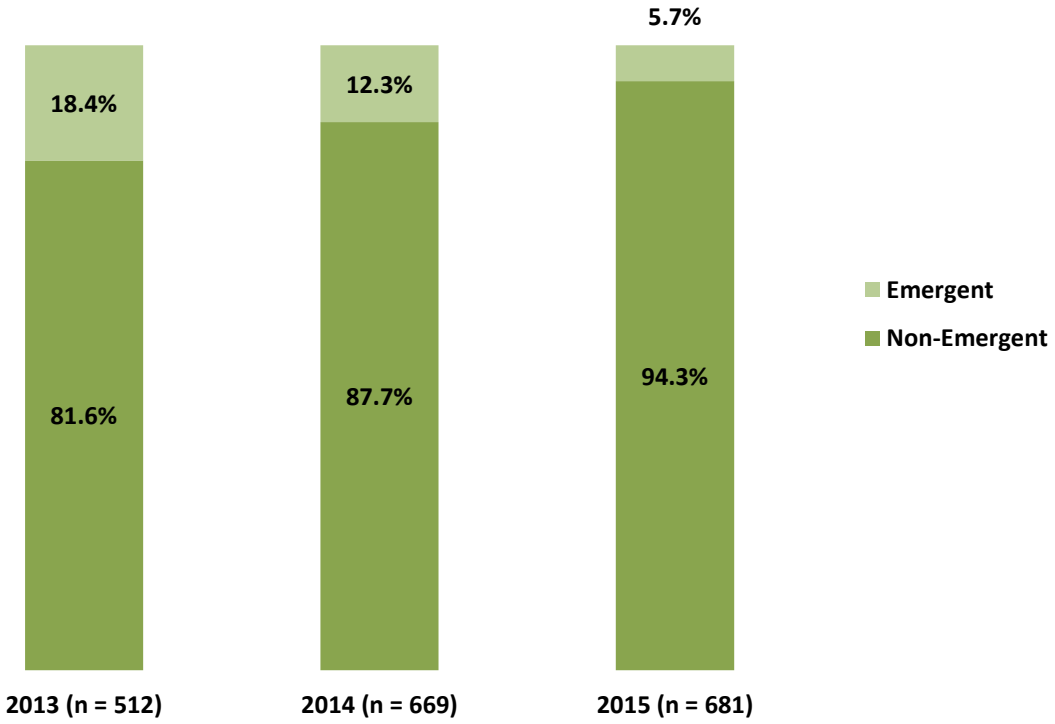
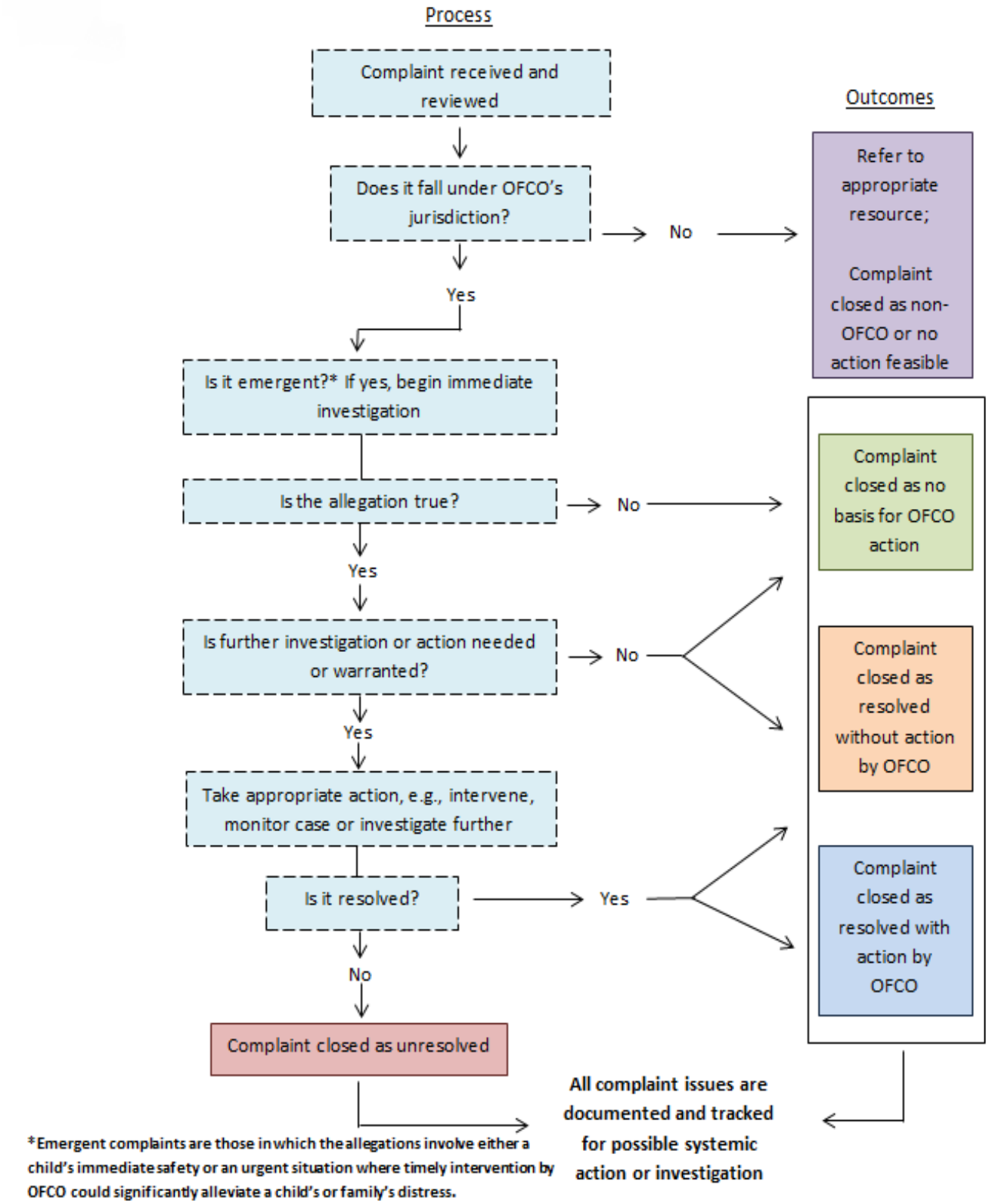


Figure 8: **How Does OFCO Investigate Complaints?**



INVESTIGATION OUTCOMES

As shown in Figure 8, complaint investigations result in one of the following actions:

- **OFCO Intervention:**
  - OFCO substantiated the complaint issue and intervened to correct a violation of law or policy, or to prevent harm to a child/family; OR
  - OFCO identified an agency error or other problematic issue, sometimes unrelated to the complaint issue, during the course of its investigation, and intervened to address these concerns.

- **OFCO Assistance:** The complaint was substantiated, but OFCO did not find a clear violation or unreasonable action. OFCO provided substantial assistance to the complainant, the agency, or both, to resolve the complaint.

- **OFCO Monitor:** The complaint issue may or may not have been substantiated, but OFCO monitored the case closely for a period of time to ensure any issues were resolved. While monitoring, the Ombuds may have had repeated contact with the complainant, the agency, or both. The Ombuds also may have offered suggestions or informal recommendations to agency staff to facilitate a resolution. These complaints are closed when there is either no basis for further action by OFCO or the identified concerns have been resolved.

In most cases, the above actions result in the identified concern being resolved. A small number of complaints remain unresolved.

- **Resolved without action by OFCO:** The complaint issue may or may not have been substantiated, but was resolved by the complainant, the agency, or some other avenue. In the process, the Ombuds may have offered suggestions, referred complainants to community resources, made informal recommendations to agency staff, or provided other helpful information to the complainant.

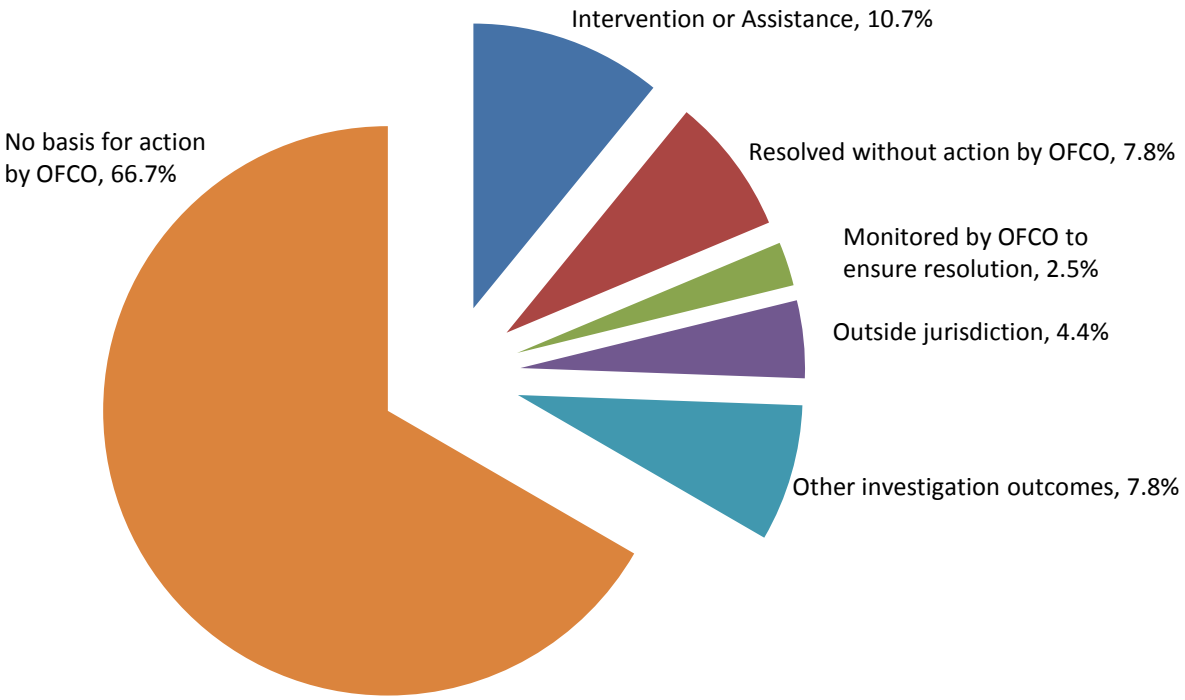
- **No basis for action by OFCO:**
  - The complaint issue was unsubstantiated and OFCO found no agency errors in reviewing the case. OFCO explained why and helped the complainant better understand the role and responsibilities of the child welfare agency; OR
  - The complaint was substantiated and OFCO made a finding that the agency violated law or policy or acted unreasonably, but there was no opportunity for OFCO to intervene (e.g. complaint involved a past action, or the agency had already taken appropriate action to resolve the complaint).

- **Outside jurisdiction:** The complaint involved agencies or actions outside of OFCO's jurisdiction. Where possible, OFCO refers complainants to another resource that may be able to assist them.

- **Other investigation outcomes:** The complaint was withdrawn, became moot, or further investigation or action by OFCO was unfeasible for other reasons (e.g. nature of complaint requires an internal personnel investigation by the agency – which is beyond OFCO's authority).

Investigation results have remained fairly consistent in recent years. OFCO **assisted or intervened** to try to resolve the issue in **nearly 11 percent of complaints** in 2015—this represents **73 complaints**. In 2014, OFCO assisted or intervened in 10.3% of complaints. Interventions or assistance by OFCO almost always result in the substantiated issues in the complaint being resolved – in 2015, 80 percent of these complaints were resolved. **Seventeen complaints (2.5 percent)** required careful **monitoring by OFCO** for a period of time until either the identified concerns were resolved, or OFCO determined that there was no basis for further action. OFCO found **no basis for any action after investigating two-thirds** of complaints this year (66.6 percent), a larger number than in 2014 (58 percent) and a little more than in 2013 (64 percent).

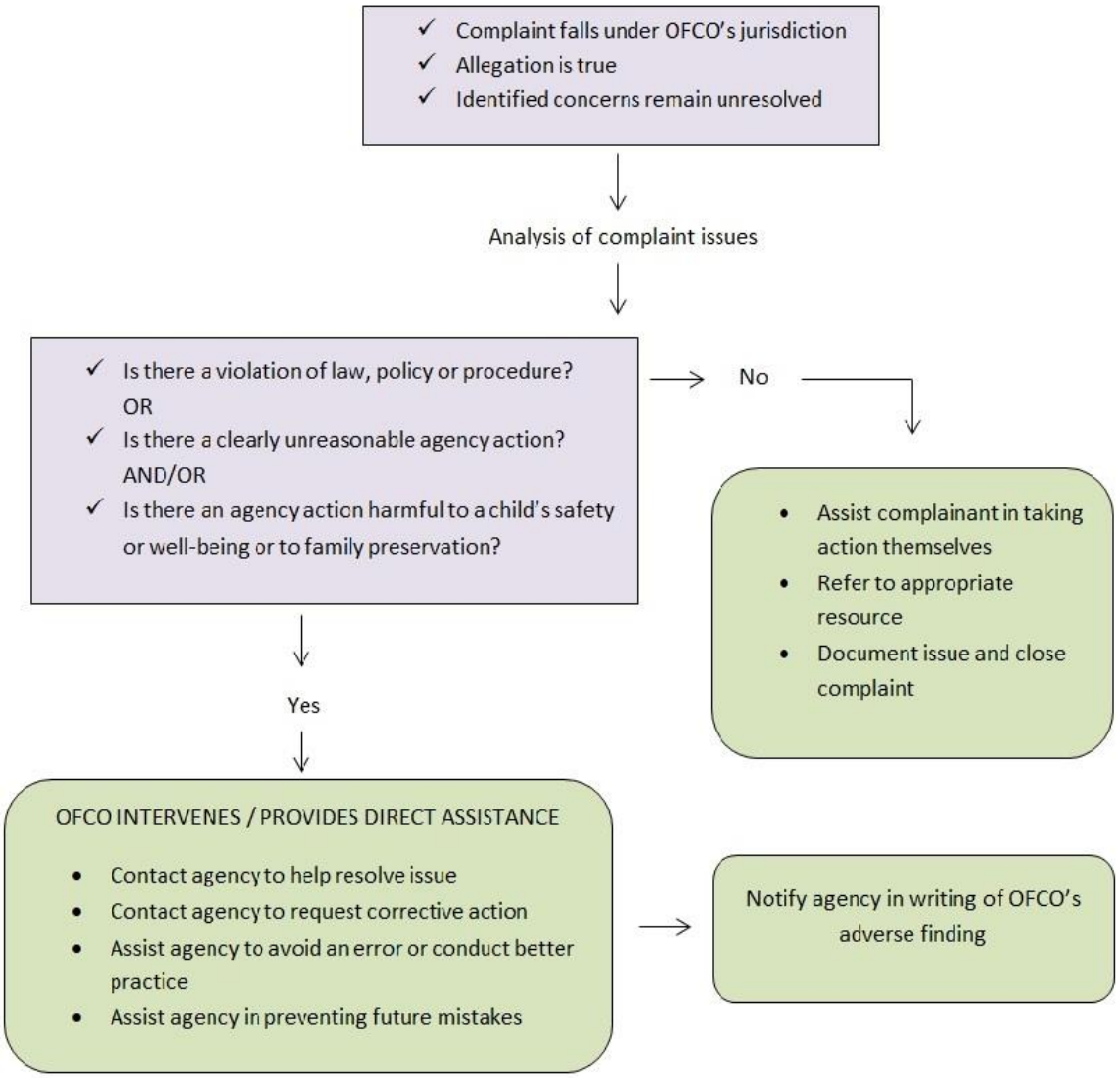
Figure 9: **Investigation Outcomes**



OFCO IN ACTION

OFCO takes action when necessary to avert or correct a harmful oversight or avoidable mistake by CA or another agency. **Forty complaints required intervention by OFCO in 2015.** This represents **5.9 percent** of all complaints, similar to last year (5.8 percent in 2014). Another **33 complaints (4.9 percent)** required **direct assistance from the Ombuds** to resolve the issue of concern. **Concerns were resolved in 80.1 percent** of complaints in which OFCO intervened or provided direct assistance.

Figure 10: **When Does OFCO Take Action?**



MOST INTERVENTIONS RESULT IN AGENCY CHANGING ITS POSITION

In the **majority of complaints** in which OFCO intervenes, **the agency changes its position** and the complaint issue is resolved (67.5 percent). The following are examples.

SAFETY PLAN FAILS TO PROTECT A VULNERABLE INFANT

OFCO received a complaint that the mother of two children in foster care was parenting a two week old infant. The mother had significant mental health and substance abuse history, and a recent evaluation concluded that she was not able to parent on her own. Nonetheless, the Division of Child and Family Services (DCFS) did not remove the child at birth, and instead entered into a safety plan deeming the alleged father as the primary caregiver and stating that the mother was never to be alone with the baby. OFCO contacted the DCFS supervisor and learned that DCFS already planned to remove the child because the parents were not following the safety plan. OFCO expressed concern for the current situation and support for removal. The court denied DCFS's request to remove the child, but kept the case open with the child placed with the parents under the supervision of the maternal grandmother. Again, the mother was not to be left alone with the baby. Over the next month, the parents failed to engage in services to address parenting skills, mental health concerns, and substance abuse. DCFS received new reports that the mother was not allowing the father to touch the baby, and that the mother was snorting drugs while breastfeeding.

OFCO contacted the Area Administrator and urged the Department to use the new allegations to again petition the court to remove the infant. The court denied the Department's request and ordered the baby to remain with the mother so long as she lived with the paternal grandmother and otherwise followed the prior safety plan. Within an hour of this order the grandmother reported the mother was verbally abusing her, and DCFS received yet another report about the parents. The supervisor brought this new information to the court's attention and the court granted the request to place the child in foster care.

A week later DCFS held a Family Team Decision Meeting and placed the baby back with the paternal grandmother, even though the parents were living in another building on her property. They also allowed the mother to care for the baby under the supervision of the grandmother.

OFCO again contacted the supervisor and worker with concerns for this plan, but they did not agree that this plan was problematic. OFCO then reached out to the Deputy Regional Administrator, and within a day DCFS removed the child and placed her in foster care.

DCFS REVERSES FINDINGS OF CHILD NEGLECT BY PARENTS

In two cases, OFCO's intervention resulted in findings of child neglect against parents being overturned. In one case, OFCO received a complaint that roughly 20 years ago DCFS made a finding that a mother neglected her child by sending her to school with no shoes. The mother said she had never sent her child to school without shoes, and that this erroneous finding was impacting her ability to provide care for a family member. OFCO reviewed the CPS history and discovered that the child's father was caring for the child when she went to school without shoes. OFCO contacted the Area Administrator and asked her to review the finding. The Administrator agreed that the mother was not responsible for the neglect and overturned the finding against her.

In the other case, OFCO received a complaint that 16 years ago DCFS erroneously made a finding that a mother neglected her three year old child. The mother had provisionally been offered a job working with foster children, but when the agency discovered the neglect finding they informed her she could not be hired. OFCO reviewed the investigation and determined that while there were concerns for the child's

health, the mother was addressing the child's needs and healthcare as best she could while struggling with poverty. OFCO concluded the evidence gathered did not support a finding of neglect. OFCO contacted the Area Administrator and requested that she review the investigation. The Administrator did so, agreed that the parent's conduct did not constitute child neglect, and reversed the finding.

When can a person contest a finding of child abuse or neglect?

Under the Child Abuse Prevention and Treatment Act (CAPTA), that took effect January 1, 1999, a person named as an alleged perpetrator in a founded report of child abuse or neglect has the right to seek review, and based on the evidence from the investigation, have the finding overturned. The department must provide written notice to the subject of the investigation that the allegation of child abuse or neglect was founded. The person must then make a written request, within 30 days, for a review. If a request for review is not made within 30 days, the person may not further challenge the finding and has no right to an administrative hearing or judicial review of the finding. CA however, will review to determine if proper service/notification was provided as required under RCW 26.44. If notice requirements were met, the subject is sent a letter denying any further review once the Area Administrator determines that the basis for the finding is sufficient. If however, proper notice was not made, CA sends the "Founded" letter by certified mail to the subject, and the due process right to appeal the administrative finding begins.

When an Area Administrator is asked to review findings that pre-date CAPTA (findings made before January 1, 1999), as in the two cases above, current practice permits review to ensure the factual information in the department's files is correct and that the documentation is sufficient to meet the definition of child abuse or neglect. [See RCW 13.50.010(13)]

DCFS INACCURATELY REPORTS FATHER TO BE OUT OF COMPLIANCE WITH COURT-ORDERED SERVICES

The father of two dependent children was court ordered to complete an evaluation for his dependency case. As a component of the evaluation DCFS also asked that the father engage in testing he had previously completed. In the course of the evaluation the evaluator determined that the father's previous testing was sufficient and did not require him to complete it again. DCFS inaccurately reported to the court that the father refused to complete the additional testing and so was not compliant with court ordered services. While this issue was brought to the court's attention by the father's attorney, the department's records continued to reflect the inaccurate information. OFCO contacted the Area Administrator and requested that DCFS correct its records and ensure future court reports contain the accurate information. The Administrator agreed, and also informed OFCO that the department removed the prior worker from the case. OFCO monitored the case until the new caseworker made the next report to court. [11] Finding both the agency records as well as the court report to be accurate, OFCO closed the complaint as resolved.

[11] Staff assigned to CA cases are referred to as "caseworkers" throughout this report. The title of "social worker" is protected in Washington State to allow only persons who have professional education or licensure as a social worker to use this title (see RCW 18.320). OFCO recognizes that many, though not all, CA staff are trained and/or licensed social workers, and OFCO does not intend to disrespect the highly skilled CA workers by use of this term.

OFCO ENSURES DEPENDENT CHILD'S SAFETY IN PARENT'S CARE

Over the department's objection, the court placed a five year old dependent child in his father's care. OFCO then received a complaint involving concerns about the child's safety, alleging the father had criminal history as well as CPS history for allegedly shooting his older child with a bb gun, and that he had limited experience parenting. The complainant told OFCO that the father's pregnant girlfriend was also living in the home and that the father hid this information from DCFS. OFCO's investigation revealed CPS records concerning the girlfriend relating to mental health and substance abuse issues, including reports that she had physically abused a child.

OFCO contacted the Area Administrator and expressed concern about the child's safety in the father's care. OFCO requested that DCFS do a thorough assessment of all adults living in the father's home, and offer services to his girlfriend if appropriate. The Child and Family Welfare Services (CFWS) caseworker followed through with this request and learned the girlfriend did move into the home and had recently completed inpatient treatment for methamphetamine addiction. She referred the girlfriend for sobriety services. OFCO contacted the Administrator again and requested that DCFS share the new information with the court and other parties, including the child's Court Appointed Special Advocate (CASA). The agency did so, and safety concerns were identified and addressed to the satisfaction of all parties. The child remained in the father's home with improved safety monitoring and a stronger service plan for the family, and the dependency case was ultimately dismissed.

In **nine cases** in which OFCO intervened, **the agency did not change its position**.[12] In some of these cases, the complaint issue was nevertheless resolved. For example:

DCFS PLANS TO MOVE DEPENDENT CHILDREN FROM STABLE, PRE-ADOPTIVE HOMES

OFCO received a complaint that DCFS was planning to move two dependent siblings from their respective foster homes so they could be placed together. OFCO's investigation found that one of the children had been in five different placements and was finally stabilized in a pre-adoptive foster home. The other child exhibited severe behavioral problems and had similarly been in multiple placements, but was also now stable in a pre-adoptive home able to handle his behaviors. The siblings had never lived together, and there was no identified home able and willing to care for them together. In gathering further information from the CASA, DCFS caseworkers, and current foster parents, OFCO concluded that the agency's ability to find a qualified home able to meet both of these children's special needs was questionable. For these reasons, OFCO found the agency's plan to move the children unreasonable and harmful, as the benefit of placing these siblings together was outweighed by the risks associated with disrupting their current permanent placements. OFCO contacted the Area Administrator who stated the department planned to hold an internal staffing before making any changes to the children's placement. While this staffing was pending the CASA asked the court to order that the children remain in their respective pre-adoptive homes. The agency did not oppose this motion and the court ordered the children to stay in their current placements. Because the agency did not oppose the motion and the court order resolved OFCO's concerns, OFCO did not make adverse findings against the agency in this case.

[12] The number of complaints in which OFCO intervened is slightly higher than the number of CA cases in which OFCO intervened, as OFCO sometimes receives more than one complaint about a particular case.

In **four cases in which OFCO intervened**, although the complaint issue remained unresolved, OFCO determined that the agency's decision not to change its position was ultimately acceptable. For example:

OFCO ATTEMPTS TO AVOID HARM TO DEVELOPMENTALLY DISABLED YOUTH

OFCO received a complaint from a foster parent that a DLR/CPS investigation conducted five years ago had resulted in a founded finding of neglect against the foster parent. The foster parent believed that the finding was unreasonable. Furthermore, the finding was now preventing the foster parent from working as a contracted provider to enable a developmentally disabled youth to remain in the foster home after turning 21 years of age. The youth had been living in the foster home for the past nine years following a number of placement disruptions, had developed strong ties with the foster family, and was doing well in their care. OFCO reviewed the DLR/CPS investigation in question, and found neither violations of law or policy nor clearly unreasonable actions by the agency, yet OFCO recognized the significant harm that could result for the youth should he have to move from his long term placement with this family. OFCO gathered additional information from the former CASA for this youth, and consulted with the Attorney General about possible administrative actions that could be taken to avoid disruption of this youth's placement. OFCO contacted the DLR Administrator to request a review of the case, and possibly consider reversing the finding to avoid disrupting this youth's placement. The Administrator reviewed the case, and responded that it would not be possible or appropriate to reverse the founded finding, as the foster parents had already appealed the finding through the CAPTA process resulting in their agreement to the finding in conjunction with a specific settlement, as approved by an administrative law judge.[13] OFCO determined that DLR's decision was not clearly unreasonable under the circumstances, despite the adverse impact on the youth.

In **four cases in which OFCO intervened,** the agency **did not change its position** despite OFCO's intervention, and OFCO determined that the agency's decision not to change its position was problematic. Examples of such complaints can be found in the section on OFCO's adverse findings against the agency (pages 36-42 of this report).

OFCO OFFERS ASSISTANCE TO RESOLVE COMPLAINTS

Complaints receiving "OFCO Assistance" are different from complaints in which OFCO intervenes, as the agency's conduct was *not*: a) a clear violation of law or policy; b) clearly unreasonable; or c) clearly harmful to a parent or child. Even so, the complaint warranted OFCO's assistance in trying to resolve the concerns. In 2015, **33 complaints** were resolved by OFCO in this manner by ensuring that *critical information was obtained and considered* by the agency, by *facilitating timely communication* among the people involved in order to resolve the problem, or by *mediating a compromise*. The following examples illustrate this process.

[13] The CAPTA* review constitutes the right to due process available to subjects of a founded finding made by CPS, who believe that the founded finding was made unreasonably or in error. The finding is initially reviewed internally by the CA Area Administrator, who may reverse the finding. If the Administrator upholds the finding, the subject can then seek review by an administrative law judge. *Child Abuse Prevention and Treatment Act

OFCO HASTENS PERMANENCY FOR DEPENDENT CHILD

OFCO received a complaint regarding unnecessary delays in establishing permanency for a five year old dependent child. The child had been dependent for nearly two years. Earlier in the case, DCFS filed for termination of parental rights, but the court denied the petition because the agency had not made sufficient efforts to address parental deficiencies, specifically one parent's significant mental health problems and the mother's incarceration. The case had also been transferred to multiple caseworkers, which contributed to delays in completing the casework necessary to establish a permanent home for this child.

OFCO contacted the social worker and discussed case delays and subsequent efforts to identify and provide services for the incarcerated parent. The CFWS caseworker, supervisor, and the agency's attorney then reviewed the case and decided to file a new petition for termination. OFCO monitored the complaint until the termination petition was completed and accepted by the court.

OFCO ADDRESSES CULTURAL INCOMPETENCE BY CASEWORKER

A community service provider contacted OFCO with a complaint that the CFWS caseworker for the mother of two Native American, dependent children was not providing appropriate or effective case management. The provider was particularly concerned that the caseworker attempted to persuade the mother to consent to her child receiving a haircut, and made culturally inappropriate comments about the child's appearance. OFCO investigated and learned that numerous community providers involved with the family had concerns regarding the caseworker's cultural competence. OFCO contacted the Area Administrator and the caseworker's supervisor to discuss these concerns. The supervisor and Administrator developed a plan to address the caseworker's lack of skills pending a decision whether the case would transfer to tribal court. The plan involved training the caseworker and including additional DCFS staff in the caseworker's communications with the mother. OFCO monitored the case until the tribal court accepted jurisdiction and DCFS closed its case.

OFCO ASSISTS RELATIVE CAREGIVER OBTAIN BENEFITS FOR NON-DEPENDENT CHILD

A grandparent stepped in to care for a 13 year old grandchild who was neglected by his parents. Prior to living with the grandparent the child had been left in an unsafe home with strangers while both parents were incarcerated, and was not attending school. CPS received a report about this situation, and upon investigation found that the child was now living with the grandparent through an informal arrangement with the parents and was receiving appropriate care. CPS referred the grandparent to resources to obtain legal custody of the child and closed the investigation.

The grandparent complained to OFCO that CPS had not offered any assistance, and she was experiencing financial stress and difficulty obtaining benefits for the child. OFCO contacted the Community Services Office and determined the child was eligible for a medical coupon. OFCO shared this information with the grandparent and monitored the case until the grandparent obtained the medical coupon for the child.

COMPLAINTS RESOLVED AFTER MONITORING BY OFCO

Seventeen complaints this year required monitoring by OFCO to ensure the agency adequately resolved the complaint issue. Many of the complaints monitored by OFCO involved **child safety concerns**, where OFCO could not determine whether the agency was appropriately addressing the child's safety until after monitoring agency action over a period of time. For example:

OFCO PROMPTS DCFS TO ASSESS PARENT'S HOME PRIOR TO CHILD BEING RETURNED

OFCO received a complaint that DCFS was failing to protect a ten-month-old non-dependent infant from neglect by the child's mother. The complainant said that following a domestic violence incident between the child's parents, the child had been living with a grandparent through a third party custody petition. The mother later obtained a court order returning the child to her care. However, when the mother picked the child up from the grandparent, the mother appeared to be intoxicated. The complainant said that this issue was reported to CPS but that the agency refused to take action.

OFCO's investigation revealed that the mother had extensive CPS history involving mental health concerns, drug and alcohol abuse, domestic violence, and criminal involvement. Further, there was a current open CPS case based on allegations of neglect relating to drug abuse and domestic violence between the parents. There were also two new CPS reports at the time the court returned the child to the mother, which had been screened out because the allegations were similar to those already being investigated. OFCO was concerned that there was no documentation that CPS had completed required health and safety visits, or seen the child in any capacity, since the case was opened five months previously.

OFCO contacted the Area Administrator to alert her to the lack of ongoing assessment and monitoring in this case. OFCO requested that a caseworker visit the mother's home and, given the age of the child, review the child's proposed sleeping environment. As a result of this intervention, DCFS held a Family Team Decision Meeting to discuss the safety concerns surrounding the child's pending return to the mother's care. The parties agreed to a safety plan and the mother agreed to engage in voluntary services. The assigned voluntary services worker assessed the home and the adults living there and found them appropriate.

Because of the poor casework practice in this case prior to OFCO's intervention, OFCO monitored the case for the next five months. During that time the mother failed to follow through with services and returned the child to the care of the grandparent. OFCO communicated with DCFS throughout to ensure that consideration was given to additional legal protection for the child (i.e. through filing a dependency petition), but DCFS assessed the child as safe with the grandparent. The case plan changed when the child's father became available to parent, and OFCO continued to monitor the case until he began participating in services and pursued a parenting plan.

OFCO made an adverse finding against the agency for failing to complete monthly health and safety visits, over the five month period the CPS case remained open.

In another example, OFCO monitored the safety of a child in foster care:

OFCO MONITORS CPS INVESTIGATION OF FOSTER HOME

OFCO received a complaint that DCFS was failing to protect a three year old dependent child from injury in his foster home. The complainant said the child suffered multiple injuries since living in the home and believed the child was either being physically abused or neglected. Further, the complainant said the assigned CFWS caseworker was notified of the injuries but took no action. OFCO's review of the records showed that CPS received one report about the foster family regarding a different child a year prior that did not result in a finding of abuse or neglect. More recently, the parent of this three year old child contacted the caseworker to express concern about a scratch on the child's neck. The foster parent had also contacted the worker to report the scratch the day it occurred, and provided a reasonable explanation. The caseworker did not feel that the scratch warranted further investigation.

Further, OFCO found the parent recently asked the court to remove the child from the foster home, on the basis that the injuries to the child were due to abuse or neglect in the home. The court determined that the child was safe in the foster home and that the agency had responded appropriately to the child's injuries.

While OFCO was gathering information, CPS received two new reports regarding injuries to this child, one involving a cut that warranted a trip to the emergency room, the other relating to a bruise. OFCO contacted the CFWS caseworker and supervisor, as well as the DLR investigator who was assigned the CPS investigations. These staff presented their independent assessments, leading them to conclude that the injuries resulted from the combination of the child's hyperactivity and behavioral difficulties, rather than from abuse or neglect. They also noted the candor and availability of the foster parents.

OFCO monitored the DLR/CPS investigation to ensure they were thorough and arrived at a reasonable conclusion. After the investigations were appropriately closed as unfounded for abuse or neglect, OFCO closed its complaint.

Another common theme of complaints OFCO monitored were **concerns about a child's placement disruptions, not being placed with a relative, or delays in permanency for the child**, as described in the following example:

OFCO MONITORS CHILD'S TRANSITION TO NEW PLACEMENT

A foster parent complained to OFCO that there have been unreasonable delays in achieving permanency for her ten year old foster child, who had been in out-of-home care for almost two years. The child's permanency plan had progressed to adoption, and her current foster home was the identified permanent placement. The agency had already filed a petition to terminate the parents' rights, but the trial had been continued several times. In addition, a relative who previously cared for the child filed a guardianship petition, contributing to further delays in the legal process. The child's parents were supportive of moving the child back with the relative, but the agency believed it was in the child's best interests to avoid another move and remain in her current placement with the foster parents. The child reportedly exhibited emotional difficulties and a psychological evaluation concluded that the child's uncertainty about the future contributed to her distress. Ultimately, the agency and parents entered into an agreed relinquishment of parental rights and adoption with the relative, and the agency began transitioning the child to the relative's home. Although OFCO found no violations of law or policy, nor clearly unreasonable decisions or actions by the agency, OFCO closely monitored the transition of the child to the new placement to ensure the prompt delivery of services to assist the child and relative.

COMPLAINTS RESOLVED WITHOUT SIGNIFICANT ASSISTANCE BY OFCO

In 2015, **7.8 percent of complaints were resolved between the agency and the complainant without significant assistance or intervention by OFCO**. In most of these cases, the Ombuds contacts the agency or reviews agency records, to confirm that steps are being taken to resolve the issue. **Some complainants report that the mere fact of OFCO contacting the agency and asking questions appears to assist in ensuring that any problems are resolved.**

DCFS OVERTURNS AN INSUFFICIENT FINDING FOR NEGLECT

A mother left her 19-month-old toddler in her car in the parking garage of her apartment building while she went back to her apartment to get a coat for the child. The child was strapped in a car seat. While returning to the car, the mother was briefly interrupted by a neighbor, who later reported her to CPS for leaving the child alone for several minutes. The CPS investigation concluded that while the parents of the child provided otherwise exemplary care for this child, the act of leaving the child unattended in the car constituted a finding of neglect. The mother submitted a complaint to OFCO and, with the assistance of an attorney, appealed the finding of neglect through the CAPTA review process.[14]

While OFCO found the mother may have exercised poor judgment, OFCO questioned whether her conduct created a clear and present danger of harm to the child's health, welfare, or safety. OFCO discussed its concerns with the agency supervisor who reported that she had consulted with CA Headquarters prior to making this finding, and the agency stood by this finding. OFCO took no further action, as the parent was following the CAPTA review process. OFCO monitored the CAPTA reviews, and although the Area Administrator upheld the finding, it was subsequently overturned for insufficient evidence in the process of being submitted for review by a judge. OFCO monitored the case until the finding was overturned and the agency's records reflected the reversal.

[14] See supra, note 13.

COMPLAINTS IN WHICH ACTION BY OFCO IS NOT FEASIBLE

In some complaints, even though the complaint is about a CA action or inaction, and therefore falls within OFCO's jurisdiction, intervention by OFCO to resolve the complaint is not feasible. For example, OFCO investigates a complaint about the behavior of a caseworker, and finds that the allegation is true. OFCO can ensure that agency management is aware of the issue, but cannot take direct action to resolve it as employee disciplinary matters are dealt with internally by DSHS. Another common scenario is a complaint in which the court has already made a decision that the agency's action was appropriate, such as in the following example:

OFCO INVESTIGATES THE TERMINATION OF A PARENT'S RIGHTS

OFCO received a complaint that three years earlier DCFS removed a non-dependent newborn child without good cause. The complaint also alleged that the following year DCFS petitioned the court to terminate the parent's rights without considering whether the mother's home was suitable for the child. OFCO reviewed the CPS and court records and learned that the child was removed due to reported concerns regarding mental health issues and drug abuse by the parents. The court then affirmed the removal of the child at the shelter care hearing and again at the dependency fact finding. A year later, DCFS filed for termination of parental rights. After considering the parent's progress towards addressing mental health and substance abuse issues, as well as other factors, the court terminated parental rights. The parent appealed the court's decision and lost. The child had since been adopted. OFCO explained to the complainant that because the actions and decisions of the agency were litigated, the court ruled in favor of the agency, and the decision was affirmed by the Court of Appeals, the actions and decisions of the agency were now outside OFCO's jurisdiction, and further action by OFCO was thus not feasible.

OFCO FINDS NO BASIS FOR INTERVENTION

In 2015, two-thirds of complaint investigations (66.7 percent) were closed after OFCO either found no basis for the complaint, or found no unauthorized or clearly unreasonable actions by the agency warranting intervention. If OFCO did find an unauthorized or clearly unreasonable action by the agency, there was no opportunity at the time of the complaint investigation to intervene to change the agency's position, usually because the violation occurred in the past.

Even if OFCO was unable to substantiate the complaint allegation, the Ombuds may still have facilitated better communication between the agency and the complainant, talked with the complainant and the agency about alternative courses of action for resolving the concerns, and educated the complainant about the role and responsibilities of the child welfare agency.

OFCO FINDS CPS INVESTIGATION WAS APPROPRIATELY CONDUCTED

OFCO received a complaint stating that CPS determined that an allegation of physical abuse of two non-dependent children by their mother was founded. The complaint also alleged that CPS had at one point overturned that finding, and then later reinstated it without cause. The complainant said that the finding of child maltreatment prevented the mother from working in her chosen field, health care. OFCO's investigation confirmed that CPS made a founded finding of physical abuse of these children by their

mother. OFCO reviewed the case records, and found the CPS investigation to be well documented. OFCO concluded that the investigation was conducted in compliance with all applicable law and policy, and a founded finding for physical abuse was reasonably based upon the evidence gathered during the investigation. The agency sent the mother a letter informing her of the finding and its basis. The letter also explained how the mother could appeal the finding, which required her response within a certain number of days. The mother did not request an appeal of the finding until a year later, at which time it was denied on the basis that she had not responded in a timely manner. OFCO found no evidence that the initial finding had been overturned or reinstated. Given that the underlying investigation was sound, and the mother failed to request review of the finding in a timely manner, OFCO determined that there was no basis for further action on this complaint.

OFCO-INITIATED INVESTIGATIONS

OFCO may initiate an investigation based on a report in the media, a critical incident notification from CA, or based on unrelated concerns arising from an open complaint investigation. The following is an example of an OFCO-initiated investigation.

OFCO PROMPTS AGENCY TO LOCATE MISSING CHILDREN

OFCO frequently reviews agency actions in cases reported by the media to ensure appropriate action is taken regarding identified concerns. OFCO saw a local news article reporting the removal of three children from their home by law enforcement after a domestic violence incident between the parents. In reviewing the family's CPS records, OFCO discovered that the family had not just three, but five children, and that during the domestic violence incident two of the children were apparently unaccounted for. OFCO also questioned the decision to screen out a recent CPS report regarding neglect of the children by their mother. OFCO contacted the Deputy Regional Administrator to discuss efforts to locate the missing two children and the CPS intake screening decision. The Deputy agreed with OFCO's concerns and made a new CPS report regarding the situation, which was screened in for investigation. The assigned CPS worker was able to locate the two missing children and ensure their safety. CPS filed a dependency petition to ensure the ongoing safety of all five children.

OFCO'S ADVERSE FINDINGS

After investigating a complaint, if OFCO substantiates a complaint issue, or discovers its own substantive concerns based on its review of the child welfare case, OFCO may make a formal finding against the agency. In many cases, the adverse finding involves a past action or inaction, leaving OFCO with no opportunity to intervene. In situations in which OFCO believes that the agency's action or inaction could cause foreseeable harm to a child or family, however, the Ombuds intervenes to persuade the agency to correct the problem. In such instances, the Ombuds quickly contacts a supervisor or manager to share the finding, and may recommend a different course of action, or request a review of the case by higher level decision makers.

Adverse findings against the agency fall into three broad categories:

- The agency **violated a law, policy, or procedure**;
- The agency's action or inaction was **clearly unreasonable** under the circumstances; or
- No violation or clearly unreasonable action was found, but **poor practice** on the part of the agency **resulted in actual or potential harm to a child or family**.

In 2015, OFCO made **33 adverse findings** in a total of 24 complaint investigations.[15] Pursuant to an inter-agency agreement between OFCO and DSHS,[16] OFCO provides written notice to CA of any adverse finding(s) made on a complaint investigation. The agency may respond in writing to the finding, present additional information, and request a modification of the finding. In 2015, CA responded to all notifications of an adverse finding, and **requested a modification of the finding in five of those cases**. OFCO **modified its finding in three of these five** cases.

Table 4 shows the various categories of issues related to adverse findings. Some complaints had several findings, related to more than one issue, either raised by the complainant or identified by OFCO in the course of investigating the complaint. The number of adverse findings against the agency **decreased slightly in 2015** (a total of **33 findings**) from 2014 (36 findings), continuing a decreasing trend since 2013 (49 findings). Similar to last year, findings related to the safety of children (14 findings), as well as findings involving violations of parents' rights or services to parents (12 findings), were by far the two most common issues resulting in adverse findings.

[15] Some complaint investigations result in more than one adverse finding.
[16] Available at ofco.wa.gov/documents/interagency_ofco_dshs.pdf

Table 4: **Adverse Findings by Issue**

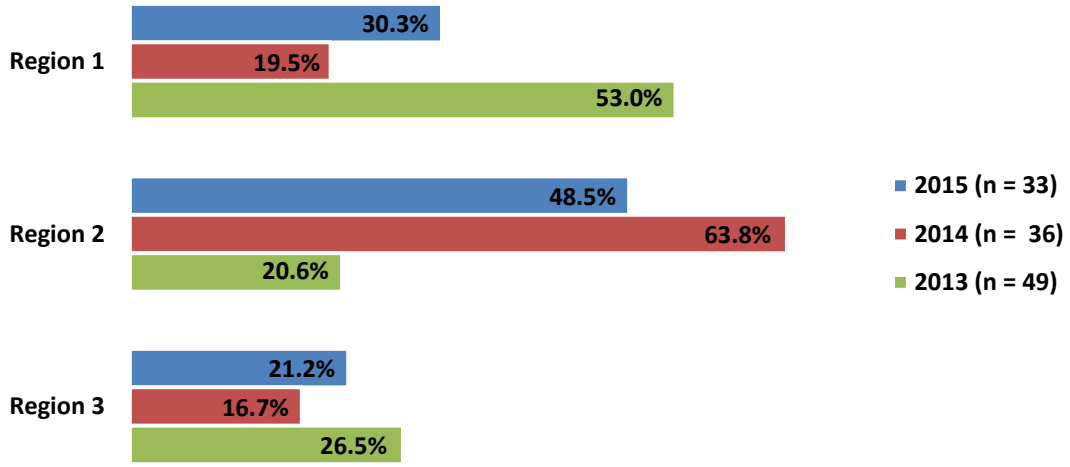
	2012	2013	2014	2015
Child Safety	**14**	**10**	**12**	**14**
Failure by DCFS to ensure/monitor child's safety:				
• Failure to conduct required monthly health and safety visits	2	--	--	6
• Unsafe placement of dependent child	1	1	5	2
• Failure to file runaway report in timely manner	--	--	--	1
• Other failures to ensure/monitor child safety	6	2	3	1
Inadequate CPS investigation or case management	2	4	2	1
Inappropriate CPS finding (unfounded)	2	--	1	1
Delay in notifying law enforcement of CPS report	--	--	1	1
Failure to complete safety assessment	--	1	--	1
Other child safety findings	1	3	--	--
Family Separation and Reunification	**6**	**5**	**4**	**2**
Failure to place child with relative	1	3	3	1
Failure to make reasonable efforts to reunify family	--	--	--	1
Other findings related to family separation/reunification	5	2	1	--
Dependent Child Well-being and Permanency	**3**	**10**	**1**	**2**
Unnecessary/multiple moves	--	1	--	2
Other findings related to dependent child well-being/permanency	3	9	1	--
Parent's Rights	**8**	**9**	**13**	**12**
Failures of notification/consent, public disclosure, or breach of confidentiality	1	4	3	6
Delay in completing/closing CPS investigation	7	5	7	3
Failure to provide services to parent	--	--	1	1
Other violations of parents' rights	--	--	2	2
Poor Casework Practice Resulting in Harm to Child or Family	**6**	**12**	**1**	**2**
Poor communication between DLR and CFWS	--	--	--	2
Other poor practice	6	12	1	2
Foster Parent/Relative Caregiver Issues	**3**	**1**	**2**	**--**
Other Findings	**1**	**2**	**3**	**1**
Failure to provide meaningful assistance and services to adoptive family	--	--	--	1
Number of findings	**41**	**49**	**36**	**33**
Number of closed complaints with one or more finding	**31**	**34**	**29**	**24**

Adverse findings involving child safety accounted for 42.4 percent of findings, with the agency's failure to conduct required health and safety visits to children in care being the most common finding related to child safety. Over one-third of overall findings involved parent's rights, with the agency's failure to notify or obtain consent from a parent, or breaching the confidentiality of a parent, representing half of the findings in this category. Findings in almost all other categories were equal to or lower in 2015 than in previous years. In 2015, OFCO made no adverse findings related to issues concerning foster parent or relative caregivers,' such as licensing problems, failures to notify caregivers of a plan to move a child from the caregiver's home, or delays in completing DLR/CPS investigations. However, the absence of findings specifically related to foster parent or relative caregiver issues does not mean that foster parents or relative caregivers were not negatively impacted by agency actions related to other findings, however. For example, unnecessary moves of children, or inappropriate permanency plans for dependent children, often have negative impacts on caregivers as well as the children in their care. Similarly, poor casework practice may have been a factor in findings listed under many of the categories in the above table; but it is only listed as an adverse finding when poor casework practice resulting in clear harm to a child or family was the specific finding made by OFCO in that case.

ADVERSE FINDINGS BY DSHS REGION

The number of complaint investigations resulting in adverse findings by OFCO varied across each of the three DSHS Regions. Of the **33 adverse findings** OFCO made against the agency in 2015, **nearly 50 percent were in Region 2**. The number of adverse findings in **Region 1 totaled ten (30.3 percent)** and in **Region 3 totaled six (21.2 percent)**. Bearing in mind that with such small numbers, it is not statistically meaningful to draw conclusions about increases or decreases in different regions, we nevertheless show OFCO's findings for the past three years by region for stakeholders who are interested in tracking these numbers. These numbers are broken down by sub-region and office in Appendix C.

Figure 11: **Number of Adverse Findings in Complaint Investigations, by DSHS Region**



Note: 2015 and 2014 data reflects the total number of adverse findings per region; some complaint investigations resulted in more than one adverse finding. 2013 data reflects the number of *complaint investigations* resulting in one or more adverse finding.

EXAMPLES OF ADVERSE FINDINGS

CA AGREEMENT WITH ADVERSE FINDING, NO REQUEST FOR MODIFICATION

In most cases, the agency agrees with OFCO's finding, as in the following example.

OFCO Finding Prompts Staff Training on Engaging Incarcerated Parents

OFCO received a complaint that a CFWS caseworker had not communicated with or provided services to the incarcerated father of two dependent children. OFCO's investigation found that the dependency case had been open for a year and a half, and, although the caseworker's office was located within 30 minutes of the facility where the father was incarcerated, she had never visited him. Further, she never replied to his numerous letters requesting information about his children and assistance with accessing court-ordered services. OFCO contacted the caseworker who stated that because of her high caseload she was unable to complete all of her assigned work, and had not explored services for this father. She said she would contact the father, provide him with information about his children, and help connect him to available services. The caseworker attempted to contact the father three weeks later, but by then he had been released from the corrections facility and his whereabouts were unknown.

OFCO made an adverse finding that the agency violated law, policy, and procedure by failing to communicate with and provide services to the father. These failures adversely impacted both the agency's duty to make reasonable efforts to provide remedial services, to address the father's parental deficiencies, and ultimately, timely permanency for these children.

The Area Administrator did not dispute the finding and acknowledged the concerns OFCO raised. She said her staff would receive training on the importance of, and expectations surrounding, parent engagement in dependency cases.

CA Disagreement, OFCO Declines to Modify an Adverse Finding

In the following example, CA disagreed with OFCO's finding and requested that OFCO withdraw the finding. After reviewing the information provided by the agency, OFCO found no basis for withdrawing or modifying the finding.

DCFS Refuses Placement for Child Who Could Not Return Home

A family that adopted six children through DCFS accessed voluntary services from the agency when one of the adopted children, age 13, began displaying dangerous behaviors such as assaulting others, sexually abusing younger siblings, hurting animals, and attempting to set fires. Eventually he was admitted to a long term inpatient psychiatric hospital, and the family no longer needed services from DCFS. Upon closing their case, DCFS agreed that, if at discharge the facility recommended out of home placement, then the family could contact DCFS for further services.

When the child was ready to leave inpatient treatment his treatment team recommended placement in a highly structured and supervised setting and that he not return home at that time for safety reasons. The family then contacted DCFS as planned. The agency, however, only offered to provide in-home services to the family and would not provide placement for this youth despite the safety risks identified by his psychiatric treatment team. The agency suggested that the family explore private residential treatment options, which they did, but found none affordable even with the adoption support they received. The family again requested state assistance with out-of-home placement for their son. DCFS told the family they could file a dependency themselves if that was what they felt their son needed.

OFCO contacted the Deputy Regional Administrator to discuss concerns that the services DCFS was offering were inadequate to meet the needs of the family. The Administrator remained unwilling to consider filing a dependency based on the adoptive parents' inability to provide a safe home environment for the youth, stating that other services were being explored. OFCO consulted with an agency practice consultant for that region, the psychiatric hospital, and CA Headquarters, and had several further conversations with the Administrator in an attempt to get this family the services they needed, without success. OFCO also referred the family to a youth legal advocacy organization. To avoid further unnecessary hospitalization of their son, the family filed a dependency petition with the assistance of a private attorney. The department ultimately agreed to the dependency action and accepted placement responsibility for this child. He was placed into a specialized foster home through the Behavioral Rehabilitation Services program.

OFCO made an adverse finding that the agency's refusal to file a dependency regarding this child in order to assist the family in accessing ongoing recommended residential behavioral rehabilitation was clearly unreasonable under the circumstances. Under RCW 13.34.030(5)(c) a dependency petition may be filed when the child has no parent capable of adequately caring for the child, such that the child is in circumstances that constitute a danger of substantial damage to the child's psychological or physical development. In making this finding, OFCO considered: the family's demonstrated efforts to meet the child's needs; the recommendations of his inpatient treatment providers; the danger posed to the younger children in the home; and the agency's earlier assurance to the family that it would assist if the child needed further out-of-home care upon discharge.

The agency requested that OFCO reconsider its finding, asserting that the parents were capable of caring for the child and had not perpetrated abuse or neglect, so a dependency petition was not warranted under RCW 13.34.030(5)(c). CA further cited WAC 388-25-0020 for the proposition that CA is under no obligation to place into care children for whom the need for placement is primarily based on protecting the community. It stated the family should be accessing community resources through the mental health

system to meet the child's needs.

OFCO responded that it disagreed with CA's interpretation of RCW 13.34.030(5)(c) and said that a child's special needs, and limitations on a parent's ability to meet the child's needs in the home, were proper bases for the filing of a dependency petition, per case law. OFCO therefore declined to modify this adverse finding.

CA Disagreement, OFCO Modification of an Adverse Finding

In the following example, CA disagreed with OFCO's finding and requested a modification of the finding. As a result, OFCO agreed to modify the finding.

Communication Breakdown by DLR Results in Harm to Foster Children

OFCO received a complaint regarding communication failures by DLR, that resulted in an unreasonable and preventable placement disruption for three dependent siblings, ages 1, 5 and 10. OFCO's investigation found that these children had recently been moved from a relative placement. The move was anticipated to be difficult for these children, who had a strong bond with their relative caregiver. DCFS identified newly-licensed foster parents who were well known to the children through their church. As the foster parents already had three children placed in their home, and were licensed to care only for a maximum of four children, DLR granted an overcapacity waiver allowing these three siblings to be placed together in that home. The CFWS caseworker for the children already placed in this home expressed concerns about the foster parents' ability to manage six foster children, given that the previously placed foster children had special needs, and the foster parents were not experienced. Based on these and other concerns, DLR then limited the waiver to only two weeks. As a result, the three siblings who were the subject of OFCO's complaint were abruptly moved to another foster home. The 10 year old was distraught, and exhibited significant emotional instability at home and at school, including threats of self-harm. DCFS and the child's CASA requested that DLR consider allowing just the 10 year old to return to the previous foster home, where the child had an existing relationship, and where she had done well. DLR agreed, as this one additional child would not exceed the foster home's licensing capacity of four children. The child was told she could return to her former foster home, and her emotional state and behavior stabilized immediately. However, before the move occurred, DLR decided that the foster home should only be licensed for a maximum of three children, and rescinded its approval of the placement.

While OFCO found DLR's ultimate decision to reduce the licensing capacity of the foster home to be reasonable, OFCO found DLR's communication with DCFS during this short period of time was poor. The poor communication resulted in contradictory placement decisions that had a significant adverse impact on at least one of the children in this family. These contradictory decisions also resulted in an unnecessary temporary placement for all three children. With clear communication between DLR and DCFS these placement disruptions could have been avoided.

DLR provided a detailed response to OFCO's adverse finding, including additional information explaining the context of the decisions. DLR also pointed out that CA policy does not require DLR to consult with DCFS regarding its licensing decisions. OFCO agreed to modify its adverse finding by including a statement

that DLR's actions did not violate law or agency policy, but stood by its overall finding that poor communication resulted in preventable harm to the children in this family.

OFCO Withdrawal of an Adverse Finding

In one case, OFCO agreed to reverse its finding after receiving additional information from the agency.

Foster Children Go Unmonitored During Extended Visit to Out-of-State Relatives

OFCO received a complaint that during a two-and-a-half month period, the out-of-state grandparents caring for two dependent grandchildren, aged seven and two, received neither financial assistance nor any visits or contact from Washington DCFS or the child welfare agency in their state. OFCO substantiated these allegations, but found that rather than being officially "placed" with their grandparents, the court order approved an extended summer visit for these children with the grandparents. The court order further specified that the visit was to be limited to six weeks. OFCO found that even though the grandparents were licensed as foster parents, since the children were not officially placed with the grandparents indefinitely, Washington was not responsible for providing foster care payments. OFCO also found, however, that the visit had been extended beyond six weeks, and had actually continued for about two and a half months, and that during this time, the children had not received monthly health and safety visits by the out-of-state child welfare agency. OFCO notified DCFS of this violation of Washington's requirement that children in out-of-home care be visited on a monthly basis to monitor and ensure their health and safety.

CA Headquarters (Interstate Compact on the Placement of Children [ICPC] unit) provided a detailed response stating its disagreement with OFCO's adverse finding, and requesting a modification of the finding. CA noted that regulations governing the ICPC placements allow only "placements" and not "visits" to be supervised through ICPC, and since the court had specified that this was a visit, not a placement, Washington was unable to request supervision of the children by the receiving state. CA pointed out that once the agency became aware that the children's visit would extend beyond six weeks, it had taken steps to begin supervision of the children by the out-of-state agency.

Based on this additional information, OFCO decided that the agency's interpretation of state law and ICPC regulations, as well as its reading of the court order in this case, was not clearly unreasonable under the circumstances. OFCO therefore withdrew its adverse finding in this case, but noted that the ICPC regulations arguably provided a basis for initiating courtesy supervision of the children by the other state at the outset of the children's visit in any case, since the visit was to last over 30 days, and ICPC regulations limit the duration of "visits" to 30 days.

IV. IMPROVING THE SYSTEM

PART ONE: WORKING TO MAKE A DIFFERENCE

- Shortage of Foster and Other Residential Care Placements
  - Placement Exceptions: Motels Used as Emergent Placements for Foster Children
  - Increase Placement Options for Children with Behavioral and Mental Health Needs
- Family Assessment Response

PART TWO: 2015 LEGISLATIVE UPDATE

PART ONE: WORKING TO MAKE A DIFFERENCE

SHORTAGE OF FOSTER AND OTHER RESIDENTIAL CARE PLACEMENTS

PLACEMENT EXCEPTIONS: MOTELS USED AS EMERGENT PLACEMENTS FOR FOSTER CHILDREN

The department may only place a child when it has legal authority, and then only in a licensed foster home or facility, or with a relative or other suitable person. Furthermore, children must be placed in the most family-like setting able to meet the child's needs.[17] While department policy specifically prohibits placement of a child at a DSHS office or in an "institution not set up to receive foster children",[18] a Regional Administrator may approve a "placement exception" at a DSHS office, apartment or motel if no appropriate licensed foster home or relative caregiver is available and as long as the child is adequately supervised.[19] Examples of situations resulting in motels being used for temporary placements include:

- *A 17 year old dependent youth was released from a Juvenile Rehabilitation Administration (JRA) facility. DCFS's attempts to locate an appropriate placement were initially unsuccessful. This youth is a level 2 registered sex-offender and prior to placement at JRA, assaulted and threatened a group home worker.[20] While DCFS pursued a contract with an out-of-state group home specializing in sex offender treatment, this youth was placed for two nights in a motel, supervised by two awake DCFS staff.*

- *A 14 year old youth was involuntarily committed to a hospital due to mental health issues and assaultive behavior. Upon discharge from the hospital, law enforcement took this child into protective custody after his parents refused to pick him up. DCFS contacted placement resources throughout the state but no homes were willing to take this youth, even with additional funds. Two DCFS workers accompanied this youth to stay in a motel. The youth ran from the motel twice and was missing for several hours, but eventually returned. The following morning, the youth became agitated and assaulted one of the DCFS workers. The youth was then taken into custody by the police.*

- *A three year old child was taken into protective custody due to neglect related to the parent's substance abuse. The child had a severe medical condition and had an extreme case of head lice, which was exacerbated by the medical condition. Attempts to locate a placement were*

[17] CA Case Services Policy Manual, Section 3240 & 4422
[18] CA Practices and Procedures Guide, Section 4413
[19] CA Operations Manual, Section 5130
[20] Level 2 Sex Offenders have been assessed as having a moderate risk of re-offending within the community. Level 1 refers to low risk re-offenders, Level 3 to high risk of re-offending. See RCW72.09.345(2).

unsuccessful and two workers stayed with this child overnight in a motel. The next day, DCFS located a relative placement.

- *Siblings, ages 10, 9 and 8 years old were neglected, sexually abused and suffered severe trauma while in their parents' care. Because of their sexualized and aggressive behavior, it was difficult to find long-term placements and these children experienced multiple motel stays as well as night-to-night foster care placements over a period of several weeks. These children required a high level of supervision, particularly around younger children. Law enforcement was called during one motel stay due to the 9 year old's behavior and threat to run.*

When Placement Exceptions Occur

Not surprisingly, placement exceptions typically occur following a sudden placement disruption or when a child enters state care, leaving DCFS with little notice or time to locate an appropriate placement. In these cases, efforts to locate a foster home, HOPE Center, Crisis Residential Center or other placement were unsuccessful because the facility was at capacity or unwilling to take the child. Unless required by contract, a foster parent or licensed facility may decline to accept or keep a child in their care.[21]

OFCO Review of Placement Exceptions

OFCO receives notification of critical incidents through CA's Administrative Incident Reporting System (AIRS). From September 1, 2014 to August 31, 2015, OFCO received AIRS reports describing 120 placement exceptions involving 72 children.[22] The vast majority of these placement exceptions (116) were overnight stays in motels, and the remaining four were in DCFS offices. For most motel stays, two awake DCFS workers supervised the children overnight. These stays were the result of unsuccessful attempts to locate a relative caregiver or licensed foster home equipped to meet the child's needs. Some children had histories with group care facilities, such as fire setting or assault of staff members and therefore could not return. Many of these children were also served by other state systems such as juvenile rehabilitation or mental health treatment facilities.

OFCO reviewed the 120 placement exceptions reported by CA, and our analysis of this data reveals that this is primarily a **regional problem** and that the majority of **children placed in motels have significant mental health and behavior needs**.

A Regional Problem

Placement exceptions over this one-year period indicate that motel stays primarily occur in four western Washington counties, and most often in April through August. All but four of the placement exceptions were cases assigned to DCFS offices in Region 2: King County (57%); Snohomish County (20%); Skagit County (10%); and Whatcom County (8%).[23] Very few placement exceptions were reported in eastern Washington; only two office stays, for example, were reported from the Spokane DCFS Office. While King County has a larger population and more children in state care, it would also be expected to have

[21] WAC 388-148-1395

[22] Other critical incidents OFCO is regularly notified about include: child fatalities, child near fatalities, child abuse allegations in licensed foster homes or residential facilities, and high-profile cases, among others.

[23] There was one placement exception each in Cowlitz and Pierce Counties, and two in Spokane County.

more placement and service resources available than rural areas of the state. Furthermore, as Figure 12 shows, nights spent in motels were greatest during spring and summer months, while no motel stays were reported from October 2014 through February 2015.

Image 1: **Counties with the Highest Number of Placement Exceptions**[24]

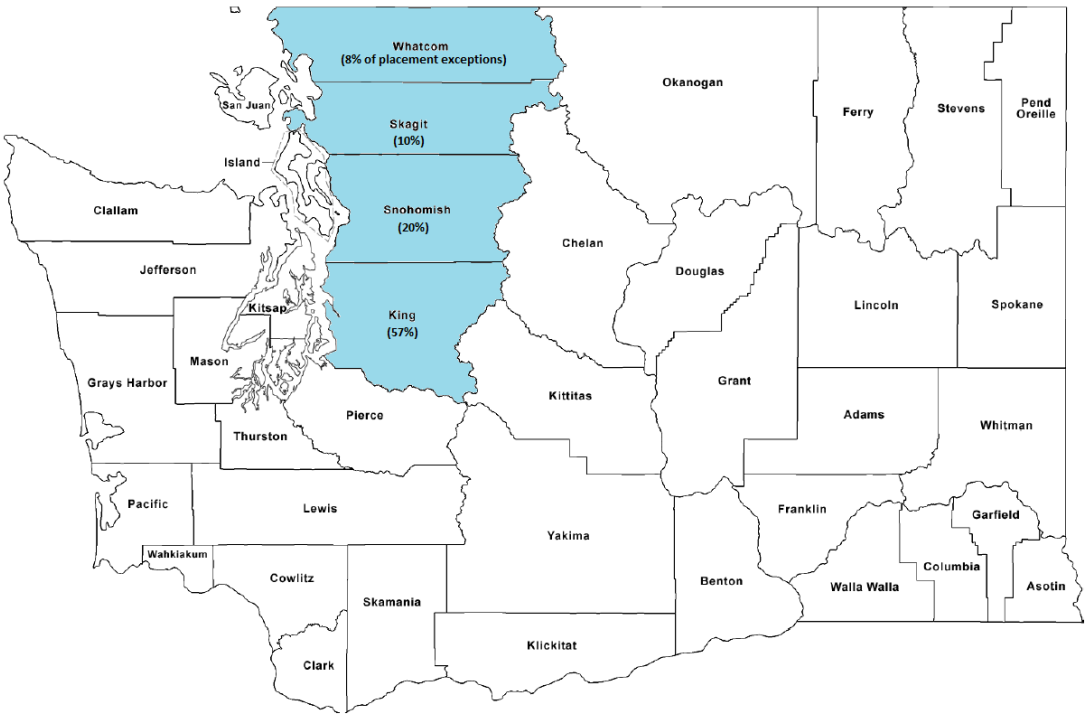
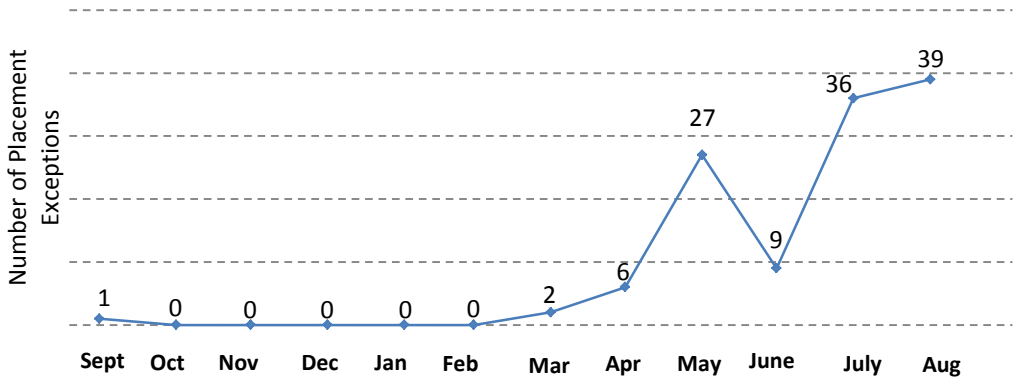


Figure 12: **Placement Exceptions by Month, 2014-2015**[25]



[24] The number of placement exceptions (number of motel or DCFS office stays) per month, September 1, 2014 – August 31, 2015
[25] Id.

Demographics of Children Experiencing Placement Exceptions

Of the 72 children experiencing placement exceptions, 42 were male (58 percent) and 30 were female (42 percent).[26] The youngest child was three years old and the oldest was 19 and in the Extended Foster Care Program. Most children were between ages 12 and 15 (46 percent). Children of color disproportionately experience placement exceptions: Nearly 21% of children spending a night in a motel were African American and 11% were Native American. The DCFS placement rate for African American children in Region 2 is 14.5% and for Native American children is 6.6%. Hispanic children were more evenly represented as compared to DCFS Region 2 placements: 19% of children experiencing a placement exception were identified as Hispanic compared to 17.3% Hispanic children in out-of-home care in Region 2. However, the majority of placement exceptions (57%) occurred in King County, which also has an overall higher placement rate for children of color than other counties in Region 2.

Figure 13: **Child Age in Placement Exceptions**[27]

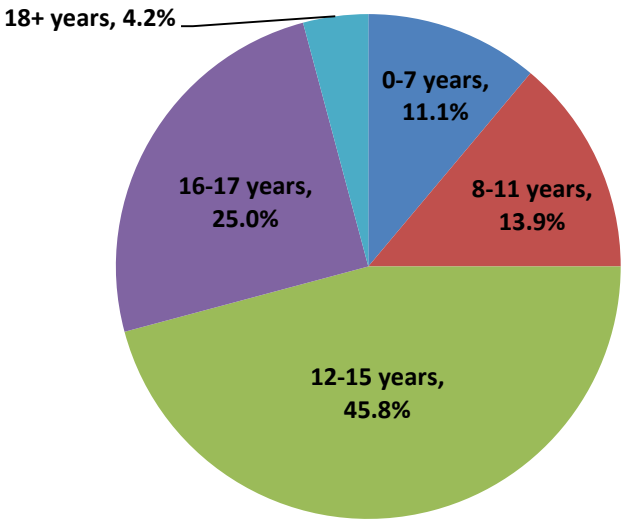


Table 5: **Child Race and Ethnicity in Placement Exceptions**

	Placement Exception Population	Region 2* DCFS Placement Population**
Caucasian	61.1%	59.10%
African American	20.8%	14.50%
American Indian or Alaska Native	11.1%	6.70%
Asian or Pacific Islander	1.4%	2.40%
Other	0.7%	0.16%
Multiracial	5.6%	16.70%
Latino / Hispanic	19.4%	17.30%
Non-Hispanic	80.6%	82.70%

**Region 2 encompasses King, Snohomish, Skagit and Whatcom counties*
***Data reported by Partners for Our Children (partnersforourchildren.org, 2015)*

[26] Several children experienced multiple motel stays during the review period. There were 72 children involved in 120 placement exceptions.
[27] Id. Fn. 12

Children with Significant Mental Health and Behavior Rehabilitation Needs

Many of these children have significant treatment and placement needs which pose barriers to locating and maintaining an appropriate placement. The children temporarily placed in motels often shared several characteristics, including:

- significant mental health needs (present in 44.4% of children);
- history of running from placements (shared by 41.7% of children);
- previous stays in group care facilities or Crisis Residential Centers (41.7%);
- physically aggressive behaviors (38.9%);
- substance abuse struggles (29.2%); and
- sexually aggressive behaviors (15.3%)

Conclusions and Recommendations

The number of placement exceptions approved, compared to the number of children in state care on any given night indicates that the department is using this policy in a cautious manner.[28] However, even **i**nfrequent use of motels as a temporary overnight placement raises safety concerns for the children in state care, the staff responsible for supervision, and other individuals staying at the motel. As discussed above, motel stays have resulted in children running from these temporary placements, and in at least one incident, a caseworker was assaulted. Having no other place to go can also further traumatize children who have experienced abuse or neglect. These cases are indicative of a larger problem – placement instability for children with significant behavioral or mental health needs. Further study of this problem is needed to gain greater understanding of why these placement exceptions occur and how to increase services and placement options for children who need specialized placements.

Specific questions that need to be addressed include:

- What is the root cause of placement exceptions?
- What challenges are present in Region 2 and why are motel stay-placement exceptions primarily an issue only in this region?
- How do other DCFS offices, where motel stays are rarely or never needed, avoid placement exceptions?
- Where are the gaps in placement and service resources?
- What is required to develop additional placement resources?
- How can different state departments, hospitals, and other private agencies involved in serving children better coordinate services to provide appropriate placements in a timely manner?

[28] From September 1, 2014 through August 31, 2015 there were 120 placement exceptions, while on January 1, 2015 there were 8,385 children in out-of-home care. *Partners for Our Children, Data Portal http://data.partnersforourchildren.org/data-portal/visualizations/out-home-care/trends*

INCREASE PLACEMENT OPTIONS FOR CHILDREN WITH BEHAVIOR AND MENTAL HEALTH NEEDS

Each year, OFCO receives complaints concerning families who encounter difficulty obtaining out-of-home placement for children with special needs. Some of these children have developmental delays; others have behavioral or mental health concerns that can no longer be managed at home without presenting a significant risk of harm to themselves or other family members. The child may have sexually abused other siblings or physically assaulted family members. Treatment providers may be recommending that the child not yet return home based on the child or family's progress in therapy, or the parents' unwillingness to provide the specialized care the child needs. Often, the family has been involved with multiple state or regional systems such as: schools, mental health providers, juvenile justice, and child welfare services. These cases often reach a crisis point when the child is released from detention, or discharged from a hospital or other treatment facility, and the parent refuses to pick up the child. However, when parents seek help with out-of-home placement and ongoing treatment for the child, it is not clear which agency is responsible for assisting the family.

The summaries of two complaints made to OFCO illustrate the challenges for obtaining out of home placements for children with special behavior and mental health needs:

- *A 14 year old child was hospitalized and received psychiatric treatment because of his behavior, mental health diagnosis, and threats to harm himself and others. The child's legal guardian worked for several months with the community mental health system to increase her ability to manage the child, but did not feel she could safely parent him in her home. Prior to hospitalization, the child had been staying at an emergency shelter for homeless youth because the parent refused to allow the child to return home. During that time CPS received several referrals alleging that the guardian was not meeting the child's basic needs of medical care, clothing, and a home in which to live. These referrals were screened to Family Assessment Response (FAR). At a case staffing, community professionals asked CPS to file a dependency and secure an appropriate placement for this child. CA determined that a dependency action was not appropriate, as there were no allegations of child abuse or neglect. In CA's view, this child's needs should be addressed through the community mental health system. When the child was ready for discharge from the hospital, the guardian refused to take him home and the child returned to the emergency shelter for homeless youth.*

- *A family who adopted six children through DCFS accessed voluntary services from the agency when the oldest, aged 13, began displaying dangerous behavior, such as assaulting others, sexually abusing younger siblings, hurting animals, and attempting to set fires. The parents appropriately sought community-based mental health treatment, but his behaviors continued to escalate and eventually he was admitted to a long term inpatient treatment facility, and the family no longer needed services from DCFS. DCFS agreed that, if at discharge the hospital recommended out of home placement, then the family could contact DCFS for further services. When he was ready to leave inpatient treatment (now aged 14), his treatment team recommended placement in a highly structured and supervised setting and that he not return home at this time, as he was not yet ready to live in an environment that included younger children. The family contacted DCFS as planned, yet the Department declined to provide placement for this youth despite the safety risks identified by his psychiatric treatment team.*

The agency suggested that the parents explore private residential treatment options, which they did, but no affordable option was available even with the adoption support they were receiving. The parents again requested state assistance with out of home placement for their son. DCFS told the family they could file a dependency themselves if that was what they felt their son needed. The parents retained an attorney, and filed a dependency petition. After the court approved the dependency action, DCFS agreed to provide out-of-home placement and services for this child.

Legal Basis for a Dependency Action When a Parent is not Capable of Caring for a Child

The filing of a dependency petition in juvenile court provides oversight and structure for the out-of-home placement of a child and services for the family when parents cannot adequately protect or care for their children.[29] While state intervention to protect a child is generally based on allegations of child abuse or neglect, DCFS may also file a dependency petition alleging that a child requires out-of-home placement because there is no parent, guardian, or custodian capable of adequately caring for the child.[30] In such cases, a dependency does not turn on allegations of maltreatment or parental unfitness, rather, it allows consideration of both a child's special needs and any limitations or other circumstances which affect a parent's ability to respond to the child's needs.[31] A parent's inability to provide necessary medical care, including mental health care, may support a finding of dependency.[32] Nevertheless, DCFS is often unwilling to file for dependency absent allegations of child abuse or neglect, based solely on the parent's inability to adequately care for the child.

OFCO Recommendations

Require DSHS to provide an adequate supply and range of residential placement options for children with mental health or behavioral issues, developmental disabilities, or other special needs.

Regardless of whether the placement is administered through DCFS or the mental health system, appropriate placements must be available to meet the child's needs. To address this issue, DSHS must develop a range of placement options including group care and therapeutic foster homes. The ongoing use of detention facilities, emergency homeless shelters, or motels as placement resources for children is not acceptable.

Establish Effective Statewide and Local Protocols between State Agencies to Provide and Expedite Out-of-Home Care

DSHS is the umbrella agency for various social service divisions and administrations serving children and their families. Although much has been attempted over the years to increase collaboration between DSHS divisions and eliminate barriers to the range of DSHS services available to families, the cases above illustrate that children continue to be underserved and without appropriate placement and services.

[29] A parent may also file a "CHINS" petition, seeking temporary out-of-home placement for a child. A CHINS proceeding however, is time limited and often insufficient to meet the treatment and placement needs of children with significant behavioral or mental health problems.
[30] RCW 13.34.030(6)(a)-(c).
[31] In re Schermer, 161 Wn.2d 927, 169 P.3d 452 (2007).
[32] In re Schermer.

DSHS must establish effective protocols between DCFS, the Developmental Disabilities Administration (DDA), and Behavioral Health and Service Integration Administration (BHSIA) to ensure that necessary and timely residential and treatment services are provided to children with behavioral or mental health problems or other special needs. Protocols must also address communication and collaboration at the local level between DCFS offices and the Regional Support Networks for mental health services.

FAMILY ASSESSMENT RESPONSE

OFCO MONITORS THE NEW PATHWAY FOR CPS REPORTS

Background

Family Assessment Response (FAR) provides an alternative to the traditional CPS investigation for allegations of abuse or neglect that are rated as low to moderate risk. A CPS investigation involves conducting interviews and gathering evidence to assess child safety and determine the existence or absence of child abuse or neglect. CPS investigations are designed to safeguard children from maltreatment and to seek legal intervention when needed to protect the child.

FAR is less adversarial and more flexible than a CPS investigation as the FAR worker engages with the family to identify resources and services to reduce the risk of future child maltreatment. Through FAR, CPS conducts a comprehensive assessment of child safety, as well as the family's strengths and needs, and provides services and concrete supports to address the problems identified in the CPS report.

Key features of FAR include:

- A parent is not the subject of an investigation and the department does not make an administrative finding as to whether or not child abuse or neglect occurred.
- Parents sign their consent to participate in FAR, and receive a written explanation about FAR and their rights under this program.
- Family involvement is voluntary. Instead of participating in FAR, parents can opt for a CPS investigation.
- CPS may change its response from FAR to an investigation based on new information that indicates a higher safety risk to the child than initially assessed at intake.
- A FAR case can be open up to 45 days, but can be extended up to 90 days if the parents agree.

Because a differential response system must not compromise child safety, a family is not eligible for FAR if the allegations in the CPS intake:

- Pose a risk of imminent harm;
- Pose a serious threat of substantial harm to a child;
- Are reported by medical professionals regarding children under age five;
- Constitute conduct involving a criminal offense in which the child is the victim;
- Concern an abandoned child; or
- Concern a dependent child or a child in a licensed facility.

On January 1, 2014, CA implemented FAR in three locations- Aberdeen, Lynnwood, and two zip codes in Spokane. Since then, CA has incrementally implemented FAR in **29** offices throughout the state. There are still thirteen offices that have not yet implemented FAR.

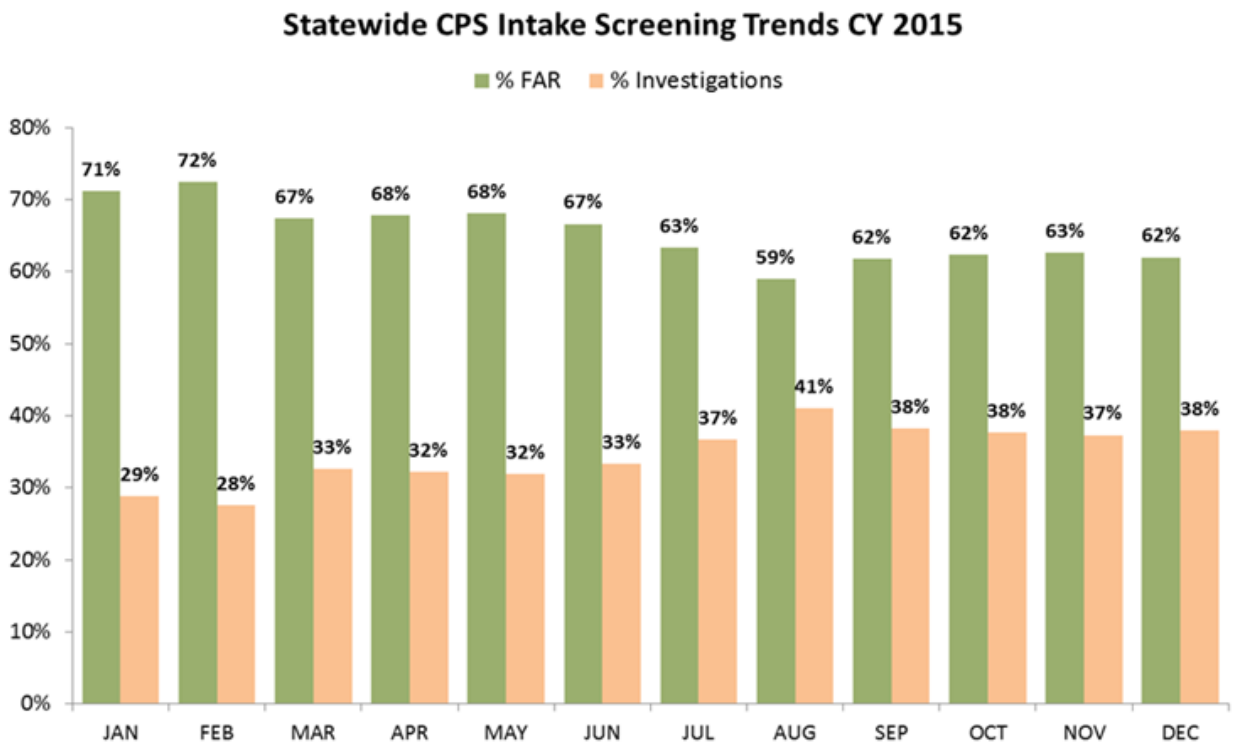
Table 6: **Statewide FAR Data Reported by CA, January 2015 – October 2015** [33]

Month	Intakes assigned to FAR	FAR cases transferred to Investigations due to safety or risk concerns	Families who declined to participate *(transferred to Investigations)*	FAR cases in process of transfer to investigations	Percent Transferred to Investigations Total	Dependencies Filed (by family)	Percent Dependencies Filed
January	889	16	14	-	3.37%	11	1.24%
February	945	21	16	-	3.92%	19	2.01%
March	980	21	49	-	7.14%	18	1.84%
April	1,097	19	18	-	3.37%	25	2.28%
May	1,218	16	26	-	3.45%	15	1.23%
June	1,230	19	33	-	4.23%	27	2.20%
July	1,016	18	11	-	2.85%	38	3.74%
August	920	24	13	27	6.96%	34	3.70%
September	1,135	34	24	11	6.08%	23	2.03%
October	1,374	31	30	28	6.48%	33	2.40%
Total	**10,804**	**219**	**234**	**66**	**4.80%**	**153**	**1.42%**

CA has been tracking CPS intake trends since January 2014. CA reports that if FAR were available statewide, approximately 65 percent of the intakes would have gone to FAR in 2015. However, these trends do not account for intake decisions that the intake supervisor might change after reviewing the information in the CPS report. Intake supervisors make changes to 5-10 percent of intakes. In June 2015, CA adopted a new policy that all intakes alleging physical abuse of children birth – three years old are assigned for a CPS investigation with a 24 hour response time (rather than screened to FAR) for face-to-face safety assessment of the child.

[33] Per email received from Family Assessment Response Project Manager Dawn M. Cooper, MSW, December 14, 2015

Figure 14: **Statewide CPS Intake Screening Trends, Calendar Year 2015**



Complaints to OFCO involving FAR

OFCO received 23 complaints involving the FAR pathway in the 2014-2015 reporting year. Review of these complaints identified the following concerns:

1. Screening decisions – CPS intakes alleging serious domestic violence, physical abuse of a child, or sexual abuse by an older sibling, were screened in for FAR.
2. CPS's authority to interview a child – Confusion over whether a FAR caseworker can interview a child without first obtaining parental consent.
3. FAR not available statewide – Parents subjected to CPS investigation and findings of maltreatment were denied an opportunity to engage in FAR due to their location.

Each of these three areas of concern is discussed in further detail below.

Screening Decisions - What is "low or moderate risk" and when is the FAR pathway appropriate?

FAR is designed for screened-in reports of child maltreatment that are assessed as having low to moderate child safety risk. FAR is not intended to address reports of child abuse or neglect that pose a high safety risk such as imminent harm or serious threat of substantial harm to a child, or that constitutes a criminal offense.[34] Through complaint investigation and reviews, OFCO found CPS reports

[34] (RCW 26.44.030(11)(b)(vi))

alleging domestic violence, physical abuse potentially posing more than a moderate level of risk to a child, as well as sexual abuse of a child, assigned to FAR. OFCO's reviews of these cases raised questions about FAR screening decisions and whether child safety issues in such cases are adequately addressed through this alternate response.

Examples of complaints OFCO received about FAR include:

- *The mother of four young children was severely injured and taken to the hospital when her husband threw alcohol at her and then lit a match, causing acute burns. The father has reportedly been physically abusive to the mother in the past and verbally abusive towards the children. The children were at home at the time of this incident, and were hiding in another room. The father was taken into custody, but at the time of the report to CPS, it was not known if he had been released. The children were staying with a relative while the mother was hospitalized.*

- *A mandated reporter called CPS and reported concerns about physical abuse of an 8 year old child. Pursuant to a custody agreement, the child split time living with her mother, and with her father and step-mother. The child reportedly disclosed that her step-mother kicked her in the back and called her names. The child also said that she had told her father, but he had done nothing to protect her.*

- *CPS received a report alleging sexual abuse of a 9 year old child by the mother's boyfriend. This was screened in for CPS investigation. The investigation resulted in an unfounded finding against the mother for neglect, and a founded finding as to the boyfriend for sexual abuse. The boyfriend was in jail at the time that the CPS case was closed, but three months later, CPS received another report alleging that the boyfriend was released on bail, that the mother was having contact with him and was possibly allowing contact between the boyfriend and the child. This second report was screened to FAR.*

- *A mandated reporter called CPS to report that a 4 year old child disclosed physical abuse by a babysitter. The child stated that the babysitter sometimes hits her with belts and hangars leaving bruises on her bottom.*

- *A report made to CPS regarding the safety of a 14 year old child alleged that the father gets drunk and yells a lot at the child. On one occasion, the father allegedly held the child down to the ground so that she couldn't get up, and called her a "bitch". A few months ago, the father pinched her hard enough to leave marks which were seen by the child's friend. The child reportedly had a black eye in the past year which was also seen by a friend. There was no clear description about how the black eye occurred, but the implication was that it was caused by the father.*

- *CPS received a report alleging that a 7 year old child disclosed sexual abuse by her 14 year old brother. The referral information indicates that once the parents became aware of the allegation, they agreed to provide necessary supervision of the children and would wait for further contact from CPS.*

CA actions to address issues with screening decisions

When reports of possible child maltreatment are received by CPS intake staff, they use a structured decision making tool to assign (a) an appropriate timeframe for first contact with the alleged victim(s), and (b) an appropriate pathway: CPS investigation or FAR. This tool offers a common framework for consistent, reliable and equitable decision making. However, the tool does not unilaterally dictate screening decisions; rather, it is designed to be used in conjunction with workers' professional judgment and proper supervisory oversight.

Each intake decision is reviewed by a supervisor who can decide to increase or decrease the response time or move it to or away from the FAR pathway. CA's Semi-Annual FAR Report (released in August, 2015) reports that between January and June of 2015, intake supervisors changed between five and ten percent of screening decisions made by intake workers. The report notes that "supervisors change intake screening decisions for a number of reasons, including: family history of child abuse and neglect, additional information from collateral contacts, and disagreement with the intake worker's screening decision".[35]

Through CA's internal FAR case review process, the department identified concerns about its screening decisions, particularly regarding allegations of physical abuse of young children that were assigned to FAR. In response, CA enacted policy requiring that all intakes alleging physical abuse of a child ages birth to three years old be assigned to a CPS investigation, with a 24 hour response time for face-to-face assessment of the child's safety.

CA reports that it has been striving to achieve consistency in screening decisions by holding monthly meetings and case staffings to review and discuss the screening tool, actual examples of screening decisions, and policy and practice. CA also provided structured decision making refresher trainings to intake staff statewide.

FAR and Authority to Interview a Child – Is parental consent required?

Several OFCO complaints identified confusion as to whether or not a FAR worker could interview a child without first obtaining the parent's permission. While the preferred practice is to request a parent's permission prior to interviewing the child, it is not required if doing so would compromise the safety of the child or the integrity of the assessment.[36]

CA actions to address FAR workers' authority to interview children

OFCO notified CA of an adverse finding that the department violated policy by not interviewing a seven year old child about allegations of physical abuse, in a case that was assigned to FAR. The CPS report alleged that the parent's partner kicked the child and that the parent was not protective. While the FAR worker met with the family and observed the child on two occasions, the child was not interviewed about the concerns raised in the CPS report.

[35] https://www.dshs.wa.gov/sites/default/files/CA/acw/documents/far-semiannual-JanJun2015.pdf
[36] RCW 26.44.030(14)(a)(i); CA Practices and Procedures, Section 2332

The department acknowledged that a formal interview with the child had not been done. CA took corrective actions at the local and regional level to address this error, including:

- The FAR supervisor reviewed policies and protocols for interviewing children with the assigned worker;
- The FAR team discussed initial face to face contact with and interviewing children, child interview techniques, and the value of child interviews in the Family Assessment process;
- The issue was discussed with the Safety Program Manager/FAR Regional Lead, emphasizing that policy requires an interview and not simply an informal discussion with the child; and
- A regional CPS/FAR training discussed the requirements for a child interview.

Fundamental Fairness - For some families, FAR is not an Option

OFCO received a complaint that a parent was unfairly the subject of a CPS investigation, and that instead, the concerns should have been handled via the FAR pathway. The CPS report alleged child neglect related to the parent's alcohol abuse. After completing the CPS investigation, the department concluded that the allegation of child neglect was "founded." The CPS finding of child neglect jeopardized the parent's employment working with vulnerable populations. The department confirmed that the allegations reported in the CPS intake would have met the criteria for the FAR pathway, however FAR was not yet implemented in this CA office. OFCO concluded that the CPS report was screened appropriately in that region of the state, and that the finding of the investigation was not clearly unreasonable. OFCO was therefore unable to intervene to request a review of this finding.

Thirteen CA offices have not yet implemented FAR.[37] CA did not receive funding in the 2015 – 2017 budget for statewide expansion of FAR, pausing implementation in these remaining offices. In order to keep momentum, CA reports it is considering implementation in offices that will not require additional full time employees. CA remains committed to FAR and will pursue options available to complete its implementation throughout the state.

Conclusion

OFCO is reassured to note that the issues and areas of concern identified through OFCO's independent complaint investigations are similar to those noted by the department's own case review process. In response to identified concerns, the department implemented the following changes since FAR's inception:

- Strengthened training for caseworkers on child safety;
- Changed policy to require a CPS investigation with a 24 hour response for allegations of physical abuse of children ages birth – three; and
- Revised policy to clarify that FAR caseworkers do not need to obtain a parent's permission prior to interviewing a child to complete a safety assessment.

Independent evaluations of FAR, with a focus on child safety measures, out of home placement rates, recurrent maltreatment, and case load sizes are underway. OFCO will continue to monitor the safety of children served via the FAR pathway for child safety issues through investigating any further complaints involving FAR cases.

[37] See Appendix D for a list of CA offices that have implemented FAR.

PART TWO: 2015 LEGISLATIVE UPDATE

OFCO facilitates improvements in the child welfare system by identifying issues and recommending responses in reports to the Governor, Legislature, and agency officials. Many of OFCO's findings and recommendations are the basis for legislative initiatives. Consistent with statutory requirements and OFCO's role, the Ombuds always remains neutral when providing testimony on proposed legislation.

During the 2015 legislative session, OFCO reviewed, analyzed, and commented on several pieces of proposed legislation aimed at strengthening Washington's child welfare system. Many of the issues addressed in proposed legislation were areas of focus in previous OFCO reports. OFCO provided written or verbal testimony on bills related to the following legislation:

CHILD NEAR FATALITY REVIEWS[38]

Legislation was passed and became law requiring that DSHS notify OFCO and conduct a review in the event of a near fatality of a child who was in the care of or receiving services from DSHS, within three months prior to the near fatal incident. A near fatality is defined as "an act that, as certified by a physician, places the child in serious or critical condition."[39] DSHS must also immediately conduct a review of the caseworker's and caseworker's supervisor's files and actions taken during the initial report of alleged child abuse or neglect. The purpose of the review is to determine if there were any errors by employees under DSHS policy, rule, or state statute. If any violations of policy, rule, or statute are found, DSHS must conduct a formal employee investigation.

OFCO supported the intent of this legislation. Formal reviews of near fatalities will increase the agency's understanding of the circumstances around the critical incident and the department's prior involvement with the family. The review process also evaluates practice, programs, and systems to improve the health and safety of children.

STATUS – This legislation was signed into law by Governor Inslee.[40]

PARENTS FOR PARENTS PROGRAM[41]

Fifty percent of the complaints to OFCO are from parents, and the top issue identified in complaints concerns family separation and reunification. OFCO supported the intent of legislation establishing a program to engage parents at the outset of a dependency case through education and peer support. A key component of this program is that it connects a parent who has been through the dependency process and successfully reunited with their children, with parents who are now involved in the child welfare system and are often confused, frightened, and distrustful of government agencies and systems. Components of the Parents for Parents Program include: outreach and support to parents beginning at the initial dependency court hearings; educating parents about the dependency process and child welfare system; helping them understand and support the needs of their children; assisting parents to

[38] SB 5888
[39] Chapter 298, Laws of 2015 (Aiden's Act)
[40] Id.
[41] SSB 5486

overcome barriers to successfully completing their case plan; and providing curriculum based peer support.

STATUS – This legislation was signed into law by Governor Inslee

HOMELESS YOUTH ACT[42]

Legislation was passed and became law in 2015 creating the Office of Homeless Youth Prevention and Protection Programs, with goals to: decrease the number of homeless youth and young adults; identify the causes of youth homelessness; and increase permanency rates among homeless youth caused by a youth's separation from their family or legal guardian. This act aims to increase and improve services targeting the primary needs of this population: stable housing; family reconciliation; permanent connections; education and employment opportunities; and social and emotional wellbeing. The Office will also manage and oversee: HOPE Centers; Crisis Residential Centers; and street youth services. Additionally, the Office will develop recommendations to address gaps within the state system to prevent youth from being discharged into homelessness.

OFCO supported the intent of the Homeless Youth Act. Many of the complaints we investigate concern youth who are in foster care. Youth who enter adulthood from foster care often lack the education or skills to adequately provide for themselves and are unlikely to have family members who can act as a safety net. Many foster youth experience homelessness or housing instability at some point after emancipation.

STATUS – This legislation was signed into law by Governor Inslee.[43]

REVIEWS OF CHILD FATALITIES IN CHILD CARE FACILITIES[44]

OFCO supported the intent of legislation requiring the Department of Early Learning (DEL) to convene a child fatality review committee to conduct a review when a child fatality or near fatality occurs in an early learning program or a licensed child care facility.

OFCO internally reviews child fatalities when the child or child's family had history with CA within the last calendar year. Additionally, OFCO participates in Executive Child Fatality Reviews convened by CA. The purpose of reviewing child fatalities is to increase the agency's understanding of the circumstances around the child's death and to evaluate practice, programs, and systems to improve the health and safety of children. OFCO also reports on the implementation status of recommendations made in these child fatality reviews. Significant system improvements have resulted from reviewing child fatalities, such as: addressing infant safe sleep environment; strengthening the adoption process; and improving collaboration between CA and community partners. The fatality review process informs policy and drives system improvement. OFCO's 2014 report found that 73% of recommendations from fatality reviews had been implemented or were in the process of implementation.

The legislation requiring similar reviews of child deaths in child care facilities specifies that the child fatality review committee must be comprised of individuals with appropriate expertise, as well as a

[42] SB 5404
[43] Chapter 69, Laws of 2015
[44] ESHB 1126

parent or guardian who had a child die in a child care setting. During the review, the committee develops recommendations regarding changes in licensing requirements, practice, or policy to prevent fatalities and strengthen safety and health protections for children in child care. In the case of a near fatality, the DEL must consult with OFCO to determine if a review should be conducted. The DEL must issue a report on the results of the review within 180 days, unless an extension is granted by the Governor.

STATUS – This legislation was signed into law by Governor Inslee.[45]

EXTENDED FOSTER CARE[46]

OFCO supported the intent of legislation providing extended foster care services to youth who would otherwise age out of the foster care system. Over the past several years, the legislature has taken significant steps to address the needs of youth on the verge of aging out of foster care at age 18 by extending foster care services for those who are pursuing secondary or post-secondary education, vocational programs, and youth who are employed or participating in a program to remove barriers to employment. Legislation passed into law in 2015 extended foster care services to youth who are unable to engage in education or employment activities due to a documented medical condition.

STATUS – Signed into law by Governor Inslee.[47]

[45] Chapter 199, Laws of 2015.
[46] SB 5740
[47] Chapter 240, Laws of 2015.

V. APPENDICES

APPENDIX A:

Complaints Received by Region and Office

APPENDIX B:

Child Demographics

APPENDIX C:

Adverse Findings by Region and Office

APPENDIX D:

DCFS Offices Offering FAR Services

APPENDIX A: COMPLAINTS RECEIVED BY REGION AND OFFICE

The following section provides a detailed breakdown of CA regions and offices identified in OFCO complaints.

Image 2: **Map of DSHS Regions**

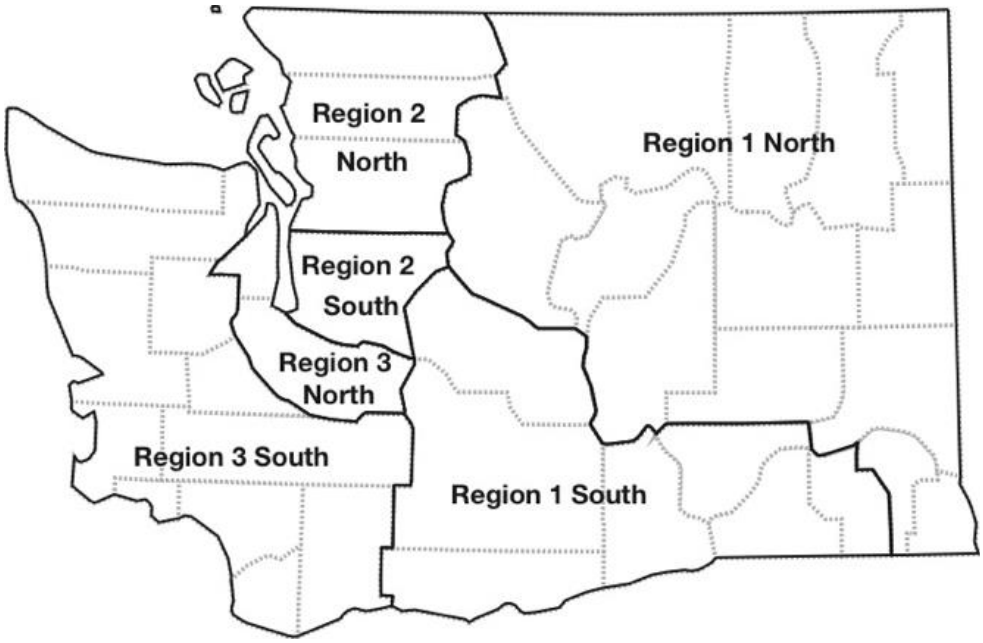


Table 7: **Populations by DSHS Region**

	Children Under 18 Years*	Percent of Washington State Children Under 18 Years
Region 1 North (Spokane)	208,855	13.2%
Region 1 South (Yakima)	175,566	11.1%
Region 2 North (Everett)	263,539	16.6%
Region 2 South (Seattle)	418,141	26.4%
Region 3 North (Tacoma)	256,552	16.2%
Region 3 South (Vancouver)	264,157	16.6%

*Partners for Our Children (http://partnersforourchildren.org/), 2013)

Figure 15: **OFCO Complaints by DSHS Region**

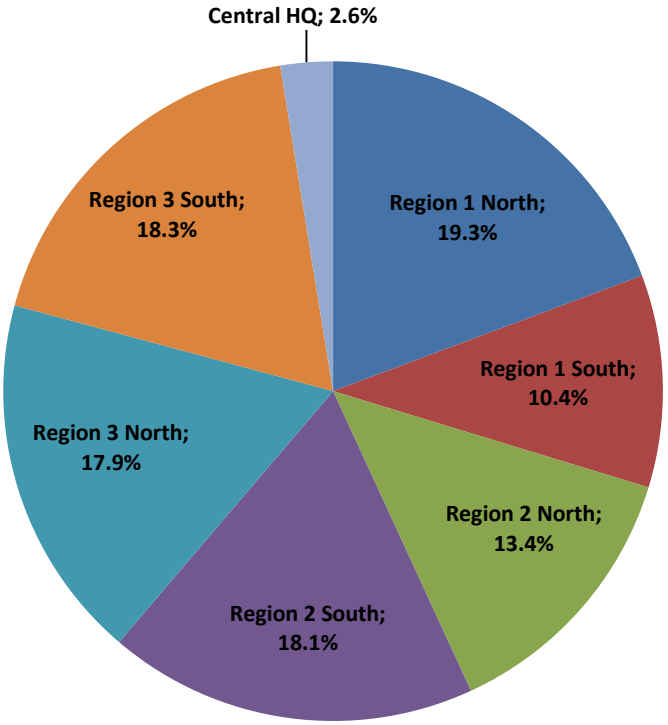


Table 8: **OFCO Complaints by Office**

REGION	OFFICE	
1 North	Spokane DCFS	65
	Colville DCFS	17
	Moses Lake DCFS	17
	Wenatchee DCFS	12
	Omak DCFS	7
	Colfax DCFS	4
	Republic DCFS	2
	Clarkston DCFS	1
	DLR (Region 1 North)	1
1 South	Yakima DCFS	25
	Richland DCFS	15
	Walla Walla DCFS	10
	Ellensburg DCFS	6
	Toppenish DCFS	4
	Goldendale DCFS	2
	Sunnyside DCFS	2
	DLR (Region 1 South)	3
2 North	Bellingham DCFS	21
	Alderwood / Lynnwood DCFS	17
	Arlington / Smokey Point DCFS	17
	Everett DCFS	9
	Mount Vernon DCFS	8
	Monroe / Sky Valley DCFS	5
	Oak Harbor DCFS	4
	DLR (Region 2 North)	3
	DCFS Adoptions (Region 2 North)	2

REGION	OFFICE	
2 South	King South DCFS	37
	King West DCFS	24
	Martin Luther King Jr. DCFS	20
	King East DCFS	17
	DLR (Region 2 South)	7
	White Center	1
	DCFS Adoptions Region 2 South	2
3 North	Pierce West DCFS	34
	Pierce South (Lakewood) DCFS	20
	Pierce East DCFS	27
	Bremerton DCFS	19
	DLR (Region 3 North)	3
	DCFS Adoptions Region 3 North	1
3 South	Vancouver DCFS	31
	Aberdeen DCFS	18
	Tumwater DCFS	14
	Kelso DCFS	11
	Shelton DCFS	10
	Centralia DCFS	9
	Port Angeles DCFS	8
	Port Townsend DCFS	5
	South Bend DCFS	2
	Stevenson DCFS	2
	Forks DCFS	1
	Long Beach DCFS	1
	DLR (Region 3 South)	2
Other	Central Intake Unit	5
	Children's Administration HQ	11
	Complaints About Non-CA Agencies	58

APPENDIX B: CHILD DEMOGRAPHICS

The ages of children identified in OFCO complaints closely mirrors that of the entire DCFS out of home care placement population, as shown below in Table 9. Youth over 18 years of age identified in complaints might be participants in the Extended Foster Care Program (eligible youth may participate until they turn 21 years) or they may reflect a complaint about department actions that happened when the youth was under 18.

Table 9: **Child Age, 2015**

	2015 OFCO	2015 Out of Home Care Population
0 - 4 Years	38.5%	41.9%
5 - 9 Years	31.5%	26.4%
10 - 14 Years	20.5%	18.6%
15 - 17 Years	8.5%	13.1%
18 Years and Older	1.0%	-

APPENDIX C: ADVERSE FINDINGS BY REGION AND OFFICE

The following section provides a breakdown of CA regions and offices identified in adverse findings.

Figure 16: **Adverse Findings by Region**

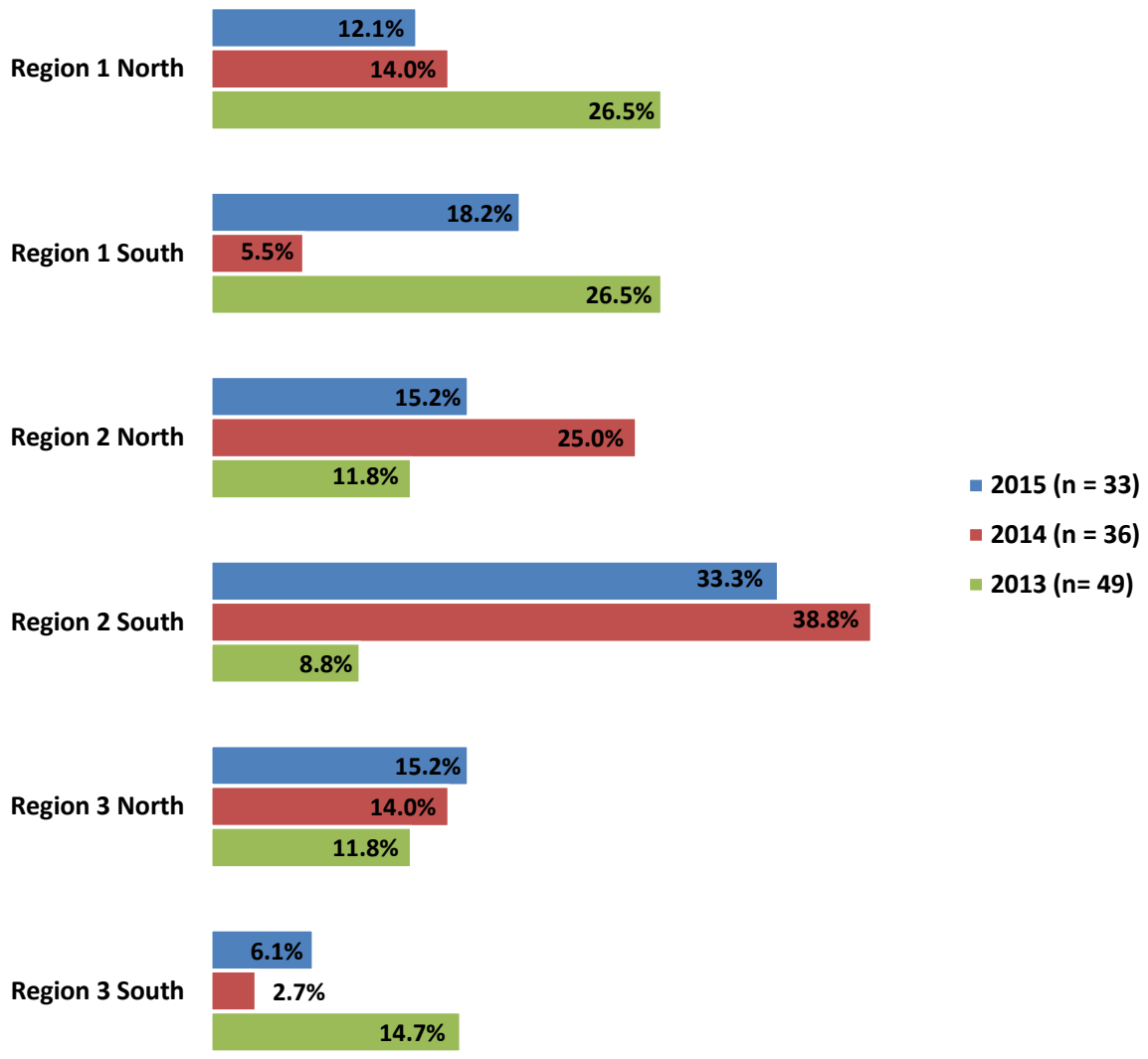


Table 10: **Adverse Findings by Office**

REGION	OFFICE	#
1 North	Wenatchee DCFS	2
	Spokane DCFS	1
	Omak DCFS	1
1 South	Richland DCFS	4
	Yakima DCFS	1
	Toppenish DCFS	1
2 North	Arlington / Smokey Point DCFS	1
	Everett DCFS	1
	Oak Harbor DCFS	1
	Alderwood / Lynnwood DCFS	1
	Monroe / Sky Valley DCFS	1
2 South	King South DCFS	7
	Region 2 South DLR	4
3 North	Pierce South (Lakewood) DCFS	2
	Pierce West DCFS	3
3 South	Vancouver DCFS	2
	Port Angeles DCFS	1

APPENDIX D: DCFS OFFICES OFFERING FAR SERVICES

The following section shows the list of 32 DCFS offices where FAR has been implemented.

Table 11: **DCFS Offices With FAR**

Rural Central Washington

1. Ellensburg
2. Sunnyside
3. Moses Lake

Northwest Washington

4. Mount Vernon
5. Oak Harbor

Tacoma

6. Pierce East
7. Pierce West
8. Pierce South

Rural Eastern Washington

9. Colville
10. Newport
11. Republic

Western Washington

1. Lynwood
2. Sky Valley
3. Smokey Point
4. Bremerton
5. Vancouver
6. Stevenson
7. Aberdeen
8. Kelso

Washington Coast

9. Long Beach
10. South Bend
11. Forks
12. Port Townsend
13. Port Angeles

Seattle

14. Martin Luther King Jr.*
15. King East*

Eastern Washington

16. Spokane
17. Lincoln County
18. Walla Walla
19. Richland
20. Clarkston
21. Colfax

**OICW office serves Native American families in these two offices.*

The following thirteen offices have not yet implemented FAR:

Region 1: Toppenish, Wenatchee, Omak, Goldendale, Yakima
Region 2: King West, White Center, Everett, Bellingham, Kent
Region 3: Tumwater, Centralia, Shelton

OFCO STAFF

Director Ombuds

Patrick Dowd is a licensed attorney with public defense experience representing clients in dependency, termination of parental rights, juvenile offender and adult criminal proceedings. He was also a managing attorney with the Washington State Office of Public Defense (OPD) Parents Representation Program and previously worked for OFCO as an ombuds from 1999 to 2005. Through his work at OFCO and OPD, Mr. Dowd has extensive professional experience in child welfare law and policy. Mr. Dowd graduated from Seattle University and earned his J.D. at the University of Oregon.

Ombuds

Cristina Limpens is a social worker with extensive experience in public child welfare in Washington State. Prior to joining OFCO, Ms. Limpens spent approximately six years as a quality assurance program manager for Children's Administration working to improve social work practice and promote accountability and outcomes for children and families. Prior to this work, Ms. Limpens spent more than six years as a caseworker working with children and families involved in the child welfare system. Ms. Limpens earned her MSW from the University of Washington. She joined OFCO in June 2012.

Ombuds

Mary Moskowitz is a licensed attorney with experience representing parents in dependency and termination of parental rights. Prior to joining OFCO, Ms. Moskowitz was a dependency attorney in Yakima County and then in Snohomish County. She has also represented children in At Risk Youth and Truancy proceedings; and has been an attorney guardian ad litem for dependent children. Ms. Moskowitz graduated from Grand Canyon University and received her J.D. from Regent University.

Ombuds

Elizabeth Bokan is a licensed attorney with experience representing Children's Administration through the Attorney General's Office. In that position she litigated dependencies, terminations, and day care and foster licensing cases. Previously, Ms. Bokan represented children in At Risk Youth, Child In Need of Services, and Truancy petitions in King County. Prior to law school she worked at Youthcare Shelter, as a youth counselor supporting young people experiencing homelessness. Ms. Bokan is a graduate of Barnard College and the University of Washington School of Law.

Ombuds

Melissa Montrose is a social worker with extensive experience in both direct service and administrative roles in child protection since 2002. Prior to joining OFCO, Ms. Montrose was employed by the Department of Family and Community Services, New South Wales, Australia investigating allegations of misconduct against foster parents and making recommendations in relation to improving practice for children in out-of-home care. Ms. Montrose has also had more than five years of experience as a caseworker for social services in Australia and the United Kingdom working with children and families in both investigations and family support capacity. Ms. Montrose earned her MSW from Charles Sturt University, New South Wales, Australia.

Special Projects / Database Administrator

Jessica Birklid is a public policy professional with experience in child welfare policy and research, health care, and organizational development. Prior to joining OFCO she helped hospital patients navigate the healthcare system and understand their rights and responsibilities. She also spent time conducting research and administratively supporting the Washington Commission on Children in Foster Care, with the goal of improving collaboration between the courts, child welfare partners and the education system. Ms. Birklid is a graduate of Western Washington University and the University of Washington Evans School of Public Policy and Governance.

Intake and Referral Specialist / Office Administrator

Kerry-Ann Blackwood holds a Bachelor's degree in Psychology from Portland State University. Since earning her degree she has worked with youth in various settings. Ms. Blackwood worked as a behavioral specialist at Ruth Dykeman Children's Center, youth case manager at Therapeutic Health Services, and as an intake and referral specialist with the Seattle Youth Violence Prevention Initiative before joining the OFCO team. In each role Ms. Blackwood was providing direct services to youth and their families and connecting them to community resources to assist in removing barriers to success.