



Office of the
Family & Children's
Ombudsman
An Independent Voice for Families and Children

2007 & 2008 Annual Report

Mary Meinig, Director Ombudsman
www.governor.wa.gov/ofco



STATE OF WASHINGTON

OFFICE OF THE FAMILY AND CHILDREN'S OMBUDSMAN

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December 2008

To the Residents of Washington State:

I am pleased to submit the combined 2007 and 2008 Annual Report of the Office of the Family and Children's Ombudsman (OFCO). As we enter 2009, new leadership is underway within the Department of Social and Health Services (DSHS). Both Robin Arnold-Williams as Secretary of DSHS, and Cheryl Stephani, Assistant Secretary, Children's Administration (CA), recently announced their resignations. We appreciate their tenure and wish them well.

New leadership provides an opportunity to re-examine the structure of the State's child welfare agency and assess whether it is poised to effectively serve and protect our most vulnerable children and families during these challenging economic times. It becomes more critical than ever to recognize and support important public-private partnerships that can help advance these goals and bring about durable reform. OFCO anticipates a very active year of oversight as DSHS absorbs these many changes.

We recognize the Governor's significant efforts to keep measures in place to prioritize child safety, including ongoing oversight of the child welfare agency by an independent Ombudsman. This is particularly commendable in an economic climate requiring difficult decisions about funding priorities.

The 2008 legislative session brought about expanded statutory duties for the Ombudsman, which we have begun to implement. Newly enacted 2SSB 6206 will result in greater scrutiny of families with a history of multiple referrals for child abuse or neglect, greater attention to reports made by mandated reporters, and improved tracking and implementation of recommendations that arise from child fatality reviews. We highlighted these as shortcomings in earlier annual reports and thank the Legislature for recognizing the merits of our recommendations to address these issues. It was no small task for the Legislature to translate these into new law that will improve outcomes for children.

This report provides an account of OFCO's activities from September 1, 2006 to August 31, 2008 and our recommendations for systemic improvements. Based on our investigation of complaints and ongoing tracking of patterns of problems and systemic shortcomings, we have identified three issues that need further review and improvement. First, the system needs to better support and maintain placement of dependent children with relatives. Second, dependent children need timely permanence through child welfare agency compliance with the timeframes established by the Adoption and Safe Families Act. Finally, DSHS should re-commit to agency accreditation through the Council on Accreditation.

On behalf of all of us at OFCO, thank you for taking an interest in the work we do and allowing us to give voice to the concerns of families and children across the State of Washington.

Sincerely,

Mary Meinig
Director Ombudsman

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*MEMBER THROUGH 2008

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36th District

Senator Val Stevens
39th District

Representative Ruth Kagi
32nd District

Representative Judy Clibborn
41st District

STAFF

Director - Ombudsman

Mary Meinig, Director of the Office of Family and Children's Ombudsman (OFCO), has served as an ombudsman with the office since it opened in 1997. Prior to joining OFCO, Ms. Meinig maintained a successful clinical and consulting practice specializing in treating abused and traumatized children and their families. Her previous experience includes working in special education, child protective services and children's residential treatment settings. Ms. Meinig is nationally known for her work developing Family Resolution Therapy, a protocol for the long-term management of relationships in abusive families. She is frequently asked to present her work at national conferences, and has authored several professional publications on this topic. Ms. Meinig is a graduate of Central Washington University, and received a Master of Social Work degree from the University of Washington. She is a Licensed Independent Clinical Social Worker and member of the Academy of Certified Social Workers. Ms. Meinig serves as the co-chair of the United States Ombudsman Association, Family and Children Chapter.

Ombudsman

Colleen Hinton is a social worker with broad experience working with children and families. Prior to joining OFCO in 2000, she provided clinical assessments of children in foster care through the Foster Care Assessment Program, and provided training on child maltreatment to community professionals through Children's Response Center (within Harborview Medical Center). Prior to this work, Ms. Hinton helped to establish assessment and treatment services for abused children at Children's Advocacy Center of Manhattan, and worked as a therapist for the Homebuilders intensive family preservation program in King County. She is a graduate of the University of Natal in South Africa, and received her MSW from the University of North Carolina at Chapel Hill. She is a Licensed Independent Clinical Social Worker and member of the Academy of Certified Social Workers.

Ombudsman

Linda Mason Wilgis is a senior attorney who before joining OFCO in 2004 served as an Assistant Attorney General for the State of Washington. From 1991 to 2001,

she gained extensive experience in dependency and guardianship cases involving both children and vulnerable adults. Before joining the Office of the Attorney General, Ms. Mason Wilgis was in private practice with a Seattle law firm. She is a graduate of Skidmore College and received her law degree from the University of Virginia. Prior to attending law school, Ms. Mason Wilgis served under Senator Henry M. Jackson as a professional staff member on the U.S. Senate Committee on Energy and Natural Resources.

Ombudsman

Steven Wolfson is a social worker with extensive experience working with families and youth. Prior to joining OFCO in 2004, Mr. Wolfson served as a court appointed Guardian ad Litem, investigating and making recommendations to the court regarding child custody and visitation disputes. From 1990 to 2000, Mr. Wolfson served as Clinical Director at Kent Youth and Family Services. Mr. Wolfson is a graduate of Clark University in Worcester, Massachusetts and received his MSW from the University of Washington. He is a Licensed Independent Clinical Social Worker.

Ombudsman

Colleen Shea-Brown is a licensed attorney with experience representing parents and other relatives in dependency and termination of parental rights proceedings at Legal Services for New York's Bronx office. She received her law degree from New York University, where she participated in the school's Family Defense Clinic. Ms. Shea-Brown has also worked extensively with victims of domestic violence, advocated for women's rights in India, and served as a residential counselor for a women's shelter in Washington, D.C. Following law school, Ms. Shea-Brown served as a clerk to the Honorable Gabriel W. Gorenstein in the Southern District of New York.

Ombudsman

Corey Fitzpatrick Wood is a licensed attorney with experience representing parents in dependency proceedings as well as youth in truancy and at-risk youth proceedings. She received her law degree from the University of Washington, where she participated in the school's Children and Youth Advocacy Clinic. Ms.

Wood has worked extensively with at-risk youth and currently serves as Board President for Street Youth Legal Advocates of Washington. Prior to law school, Ms. Wood worked for OFCO as an Information and Referral Specialist.

Ombudsman

Megan Palchak first came to OFCO in 2003 as an Information and Referral Specialist/Office Administrator. She left to pursue a Masters degree in Policy Studies from the University of Washington, and soon returned as a Research Analyst to assist with special projects. After graduate school, Ms. Palchak spent a year promoting equity in education as a Communications and Research Specialist at the Governor's Office of the Education Ombudsman, the first state-level K-12 focused ombudsman in the nation. Prior to joining OFCO in 2003, Ms. Palchak worked to secure housing for youth exiting the foster care system. She also coordinated youth development programs in a low-income housing complex, in collaboration with local families, community professionals, educators, and youth.

Special Projects/Database Coordinator

Rachel Pigott holds a Dual Master's degree in Social Work and Education from Boston University. Before joining OFCO in 2005, she worked to improve school attendance by working with families through the Boston Public Schools. She spent a year in the AmeriCorps program working to strengthen families and to connect undergraduate students from Western Washington University to their community by coordinating service-learning projects. She was also a Program Specialist for the Boston Center for Adult Education.

Information Specialist/Office Administrator

Amy Johnson earned a Bachelor's degree in Communication and Sociology from Pacific Lutheran University. Prior to joining OFCO she worked as a Ticket Sales Coordinator for the Seattle Mariners. She also served as a case aide for DSHS Division of Children and Family Services in 2004. While attending PLU she completed an internship with the Prison Pet Partnership Program within the Washington Correctional Center for Women.

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EXECUTIVE SUMMARY

The Office of the Family and Children’s Ombudsman (OFCO) was created by the 1996 Legislature in response to several high-profile incidents involving the safety of children in state care, including ongoing abuse at the OK Boys Ranch and the death of three year-old Louria Grace.

ROLE OF THE OMBUDSMAN: NEUTRAL INVESTIGATOR

Since its inception, OFCO has provided families and citizens across the Washington State with an independent and impartial review of the decisions made by DSHS and other state agencies. The Ombudsman focuses its resources—8.5 full-time employees and a biennial budget of just over 1.5 million dollars on complaint investigations, complaint intervention and resolution, and system investigations and improvements. OFCO also provides agency officials and policymakers with valuable information about complex problems within the child welfare system, and recommends responses in public reports.

INQUIRIES AND COMPLAINTS RECEIVED

The Ombudsman received more inquiries and complaints regarding DSHS during its 2007 and 2008 reporting years than in any previous year. During the two-year period, the Ombudsman responded to over 2,000 inquiries and received over 1,200 complaints. Since 2006, the total number of complaints received has increased by 30%, while complaints presenting emergent issues, including imminent child safety concerns, have increased by over 40%. The only DSHS Region in which complaints decreased was Region 4, in 2008. There have been significant increases in complaints from Regions 3 and 5.

Consistent with previous years, the Ombudsman heard most frequently from parents and other family members. The top two complaint issues citizens brought to the Ombudsman continued to include family separation and reunification and child safety (alleging that the agency did not respond adequately to reported maltreatment, or the safety of a child in out-of-home care).

RESPONDING TO COMPLAINTS

The Ombudsman completed 521 complaint investigations in 2007 and 627 in 2008—an all time high. Notably, the Ombudsman found a higher percentage of agency violations in 2008 than in any previous year. While the majority of complaints received were investigated on a standard non-emergent basis, one in five complaints met the Ombudsman’s criteria for an emergent investigation in 2007. In 2008, the percentage of emergent complaints decreased slightly, comprising 15% of all of completed investigations.

OMBUDSMAN IN ACTION

Interventions

Since 2006, the total number of Ombudsman interventions has increased. The Ombudsman intervened in 12% of all complaints in 2007, and 10% in 2008. The Ombudsman intervenes to induce corrective action, facilitate resolution, assist the DSHS in avoiding errors and conducting better practice, and prevent future mistakes. Narrative examples of Ombudsman interventions are provided in this report.

Case Specific Investigations

In March 2006, the Secretary of DSHS requested that the Ombudsman investigate the agency's practice regarding a particular case. The investigative results and a summary of the agency's response are provided in this report.

In June 2008, the Secretary of DSHS requested that the Ombudsman conduct a review of child welfare and protection practices and procedures at the Colville Division of Children and Family Services (DCFS). Joel Kretz, State Representative for the 7th legislative district, contacted DSHS with concerns about agency practice in Colville. This investigation is underway. The results of this investigation will be issued in a separate report.

Reviewing Child Fatalities

The Ombudsman receives notice from DSHS on every fatality and critical incident within the State known to DSHS. The Ombudsman reviewed more than 150 child fatalities and near fatalities during its 2007 and 2008 reporting years combined.¹ An in-depth Child Fatality Review Report is forthcoming.

Implementing 2SSB 6206

The Ombudsman began implementing its new statutory duties, established by 2SSB 6206, which became effective in June 2008. The provisions of 2SSB 6206 expand the Ombudsman's investigative reporting duties and reflect previous recommendations OFCO made to the Legislature.

LISTENING TO YOUTH IN GROUP CARE

In the summer of 2007, OFCO visited 22 group homes across the state to speak directly with 120 youth about their experiences, elicit their ideas about how to improve group care, and explain to them how to access the Ombudsman as a resource. The summary of this report is incorporated in this report.²

RECOMMENDATIONS TO IMPROVE THE SYSTEM

In this year's report, the Ombudsman has identified three areas of concern that are the subject of recommendations:

- 1) *Maintaining the Family Connection*
Recommendation: Increase Long-Term Placements of Dependent Children with Relatives
- 2) *Live up to the Promise of Greater Permanence for Children*
Recommendation: Comply with Permanency Timeframes in the Adoption and Safe Families Act (ASFA) of 1997
- 3) *Improving the Child Welfare System Through Peer Review and Outside Accreditation*
Recommendation: Reinstate the COA Accreditation Process and Make Achieving - and Maintaining - these Standards a Priority.

DSHS RESPONSE TO 2006 RECOMMENDATIONS

Excerpts of DSHS Secretary's responses to the Ombudsman 2006 Annual Report recommendations are provided verbatim in this report. Per the Ombudsman's recommendations, Indian Child Welfare caseloads are now weighted, and significant efforts have been made to reduce caseloads overall. However, cross-system protocols to expedite permanency and improve services for children with special

¹The Ombudsman records fatalities by calendar year. The data for 2008 is not complete. Moreover, OFCO seeks to reconcile our figures with that of CA. Consequently, there may be some slight shift in these figures depending upon continued data received by CA.

²The full report is available at <http://www.governor.wa.gov/ofco/reports>.

needs are not yet complete. Additionally, wait-lists for children’s long-term inpatient programs (CLIP) have *increased*.

LEGISLATIVE ACTIVITIES

As part of the Ombudsman’s duty to recommend systemic change, the Ombudsman reviews and analyzes proposed legislation, and testifies before the Legislature on pending bills. A summary of the bills the Ombudsman testified on during the 2008 legislative session is provided in this report.

BRAAM UPDATE

In June 2008, Whatcom County Superior Court Judge Charles R. Snyder agreed with plaintiffs that DSHS had violated the terms of the Settlement Agreement and mandated the submittal of detailed compliance plans, some of which have since been approved, while others are pending. A detailed update is provided in this report.

ROLE OF THE OMBUDSMAN

The Washington State Legislature created the Office of the Family and Children’s Ombudsman in 1996, in response to two high profile incidents that illuminated the need for oversight of the child welfare system: the death of three-year-old Louria 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 youth-on-youth sexual abuse at the DSHS-licensed OK Boys Ranch. The establishment of the office also coincided with growing concerns about DSHS’ participation in the Wenatchee child sexual abuse investigations. In all of these instances, families and citizens who previously had reported concerns about DSHS’ conduct lacked an appropriate agency to turn to for an independent review when DSHS did not address their concerns.

In creating the Ombudsman, the Legislature sought to provide families and citizens an avenue through which they could obtain an independent and impartial review of DSHS decisions. The Legislature also authorized the Ombudsman to intervene to induce DSHS to reconsider or change problematic decisions that have placed a child or family at risk of harm, and charged the Ombudsman with the mission of recommending system-wide improvements to the Legislature and the Governor.

INDEPENDENCE

The Ombudsman’s most important feature is its independence. The ability of OFCO to review and analyze complaints free of political bias and influence allows the office to maintain its reputation for integrity and objectivity. The Ombudsman is located in Tukwila and although it comes under the Office of the Governor, it conducts its operations independently of the Governor’s Office in Olympia. OFCO is a separate agency from DSHS.

The Ombudsman acts as a **neutral investigator** of complaints, rather than as an advocate for citizens who bring their complaints to our attention, or for the governmental agencies investigated. This neutrality reinforces the credibility of the Ombudsman.

OFCO maintains the **confidentiality** of citizens who contact the Ombudsman to initiate a complaint investigation unless such confidentiality is waived by the citizen. This protection makes citizens,

The Office of the Family and Children’s

Ombudsman was

established to investigate complaints involving children and families receiving child protection or child welfare services, or any child reported to be at risk of abuse, neglect or other harm.

The Ombudsman was also established to monitor the state’s protection of children’s safety in state-operated and -regulated facilities. In addition, the Legislature directed the Ombudsman to recommend system-wide improvements that benefit children and families. The Ombudsman carries out its duties with independence and impartiality.

including professionals within DSHS, more likely to contact OFCO and to speak candidly with the Ombudsman about their concerns.

AUTHORITY

Under chapter 43.06A RCW, the Legislature enhanced the Ombudsman's investigative powers by providing it with broad access to confidential DSHS records and the agency's computerized case-management system. It also authorized OFCO to receive confidential information from other agencies and service providers, including mental health professionals, guardians ad litem, and assistant attorneys general. The Ombudsman operates under a shield law which allows OFCO to protect the confidentiality of the Ombudsman'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 by others.

The Ombudsman publishes its investigative findings and recommendations to improve the child welfare system in public reports to the Governor and the Legislature. This is an effective tool for educating legislators and other policy makers about the need to make, change or set aside laws, policies or agency practices so that children are better protected and cared for within the child welfare system.

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

WORK ACTIVITIES

The Ombudsman performs its statutory duties through its work in four areas.

- ▶ **Listening to Families and Citizens.** Families and citizens who contact the Ombudsman with an inquiry or complaint often feel that DSHS or another agency is not listening to their concerns. By listening carefully to families and citizens, the Ombudsman can effectively assess and respond to individual concerns and also identify recurring problems faced by families and children throughout the system.
- ▶ **Responding to Complaints.** The Ombudsman impartially investigates and analyzes complaints against DSHS and other agencies. We spend more time on this activity than any other. Thorough complaint investigations and analyses enable the Ombudsman to respond effectively when action must be taken to change an agency's decision and to accurately identify problematic policy and practice issues that warrant further examination. They also enable the Ombudsman 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 Ombudsman intervenes when necessary to avert or correct a harmful oversight or mistake by DSHS or another agency. The Ombudsman's actions include: prompting the agency to take a "closer look" at a concern; facilitating information sharing; mediating professional disagreements; and sharing the Ombudsman's investigative findings and analyses with the agency to correct a problematic decision. Through these actions, the Ombudsman is often successful in resolving legitimate concerns.

Improving the System. The Ombudsman is responsible for facilitating improvements to the child protection and child welfare system. The Ombudsman works to identify and investigate system-wide problems, and it publishes its findings and recommendations in public reports to agency officials and state policymakers. Through these efforts, the Ombudsman helps to generate better services for children and families.

The Ombudsman utilizes virtually all of its resources – 8.5 full-time employees (FTEs) and a biennial budget of approximately 1.5 million dollars – to perform these activities*. The Ombudsman’s work activities are described in more detail in the sections that follow.

*In the FY 2007-2009 biennium the Legislature appropriated resources necessary to fulfill OFCO’s additional duties under newly enacted 2SSB 6206, concerning DSHS reviews and reports on child abuse, neglect, and near fatalities. This appropriation increased OFCO’s biennial budget to approximately \$1.5 million, and added two full-time employees.

INQUIRY AND COMPLAINT PROFILES

The Ombudsman listens to families and citizens who **contact** the office with questions or concerns about services provided through the child protection and child welfare system. By listening carefully, the Ombudsman is able to respond effectively to their **inquiries** and **complaints**.

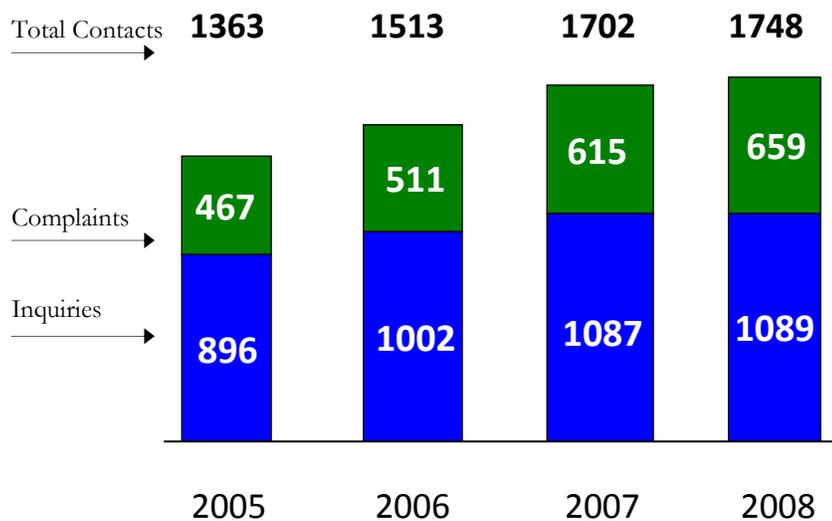
This section describes contacts made by families and citizens during the Ombudsman’s 2007 and 2008 reporting years.³ Data from previous years are included for comparison.

CONTACTS

Families and citizens contacted the Ombudsman **1702** times in 2007 and **1748** times in 2008. These contacts were **inquiries** made by people seeking information and assistance. Approximately **one third** of these contacts were formal **complaints** seeking an Ombudsman investigation.

Contacts to the Ombudsman

September 1 to August 31



Contacts. When families and citizens contact the Ombudsman, the contact is documented as either an inquiry or complaint.

Inquiries. Persons call or write to the Ombudsman wanting basic information on how the office can help them with a concern, or they have questions about the child protection or child welfare system. The Ombudsman responds directly to these inquiries, some of which require additional research. The office refers other questions to the appropriate agency.

Complaints. Persons file a complaint with the Ombudsman when they have a specific complaint against the Department of Social and Health Services (DSHS) or other agency that they want the office to investigate. The Ombudsman reviews every complaint that is within its jurisdiction.

³ The Ombudsman’s annual reporting period is September 1 to August 31.

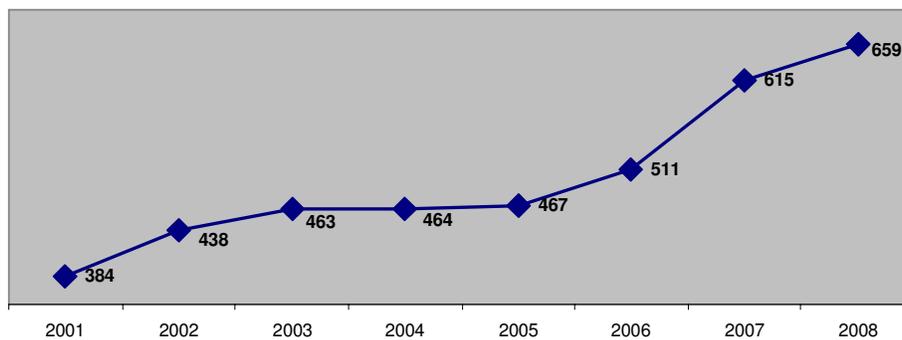
COMPLAINTS RECEIVED

A complaint to the Ombudsman must involve an act or omission by the Department of Social and Health Services (DSHS) or another state agency that affects:

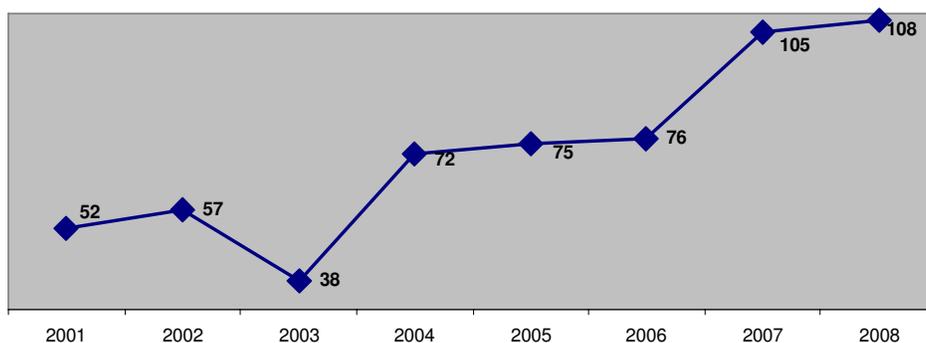
- A child at risk of abuse, neglect or other harm by a parent or caretaker.
- A child or parent who has been the subject of a report of child abuse or neglect, or parental incapacity.

Total complaints to the Ombudsman have increased by nearly 30% since 2006. The Ombudsman received 615 complaints in 2007, an increase of 20% over 2006. In 2008, complaints increased 7% over 2007. The graphs below describe the increase in total and emergent complaints since 2001. **Emergent complaints have increased over 40% since 2006.**

Total Complaints Received
September 1 to August 31



Emergent Complaints Received
September 1 to August 31



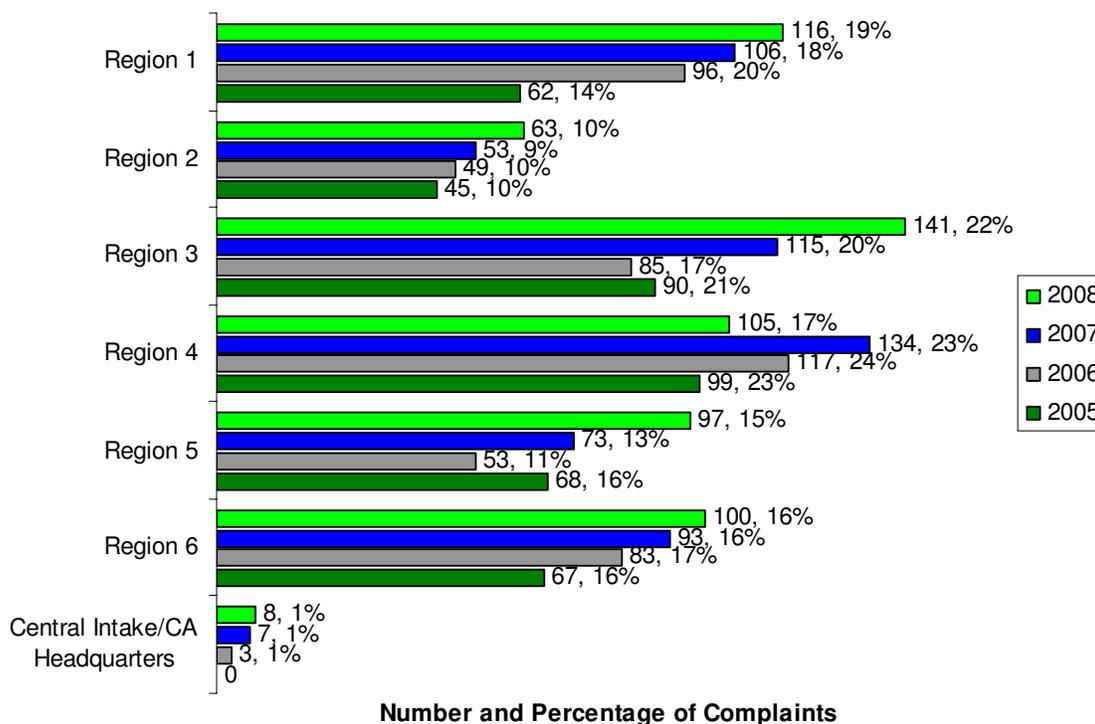
DSHS REGIONS AND DIVISIONS IDENTIFIED IN COMPLAINTS

The Department of Social and Health Services' (DSHS) Children's Administration (CA) is the state's largest provider of child protection and child welfare services. It is therefore not surprising that the Children's Administration was the subject of 94% of complaints in 2007 and 96% of complaints in 2008 to the Ombudsman.⁴

Of the complaints against the Children's Administration, 97% were directed at the Division of Children and Family Services (DCFS), which includes Child Protective Services, Child Welfare and Adoption Services, and Family Reconciliation Services. A small percentage (3%) involved the Division of Licensed Resources (DLR), which licenses and investigates alleged child maltreatment in foster homes, group homes, and other residential facilities for children.

During the 2007 reporting year, complaints increased from all 6 regions. In 2008, all regions except for Region 4 had an increase in complaints received, with the most significant increases coming from Regions 3 and 5.

Complaints about the Children's Administration by DSHS Region



⁴ The remaining complaints were directed against other DSHS divisions (such as Developmental Disabilities and Mental Health), Washington Courts, local CASA/GAL programs, DSHS contract providers, and tribal welfare services.

Complaints by DSHS Region and Office

Regional Offices:

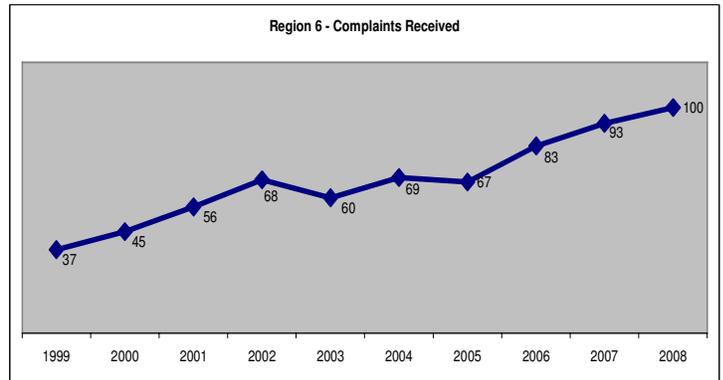
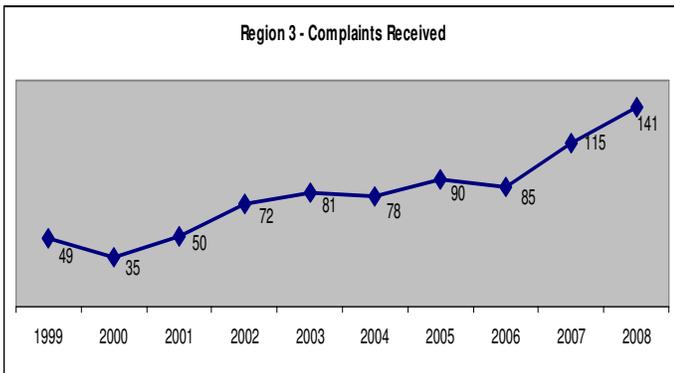
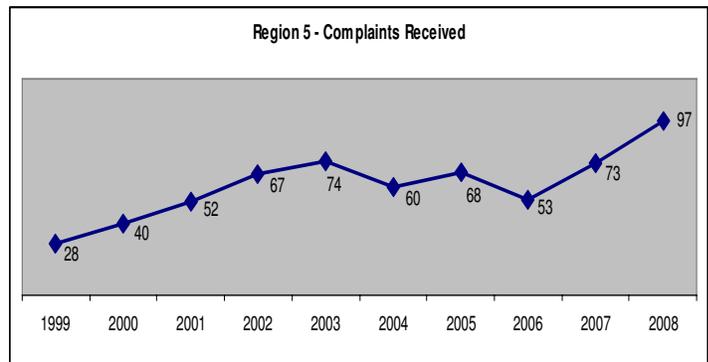
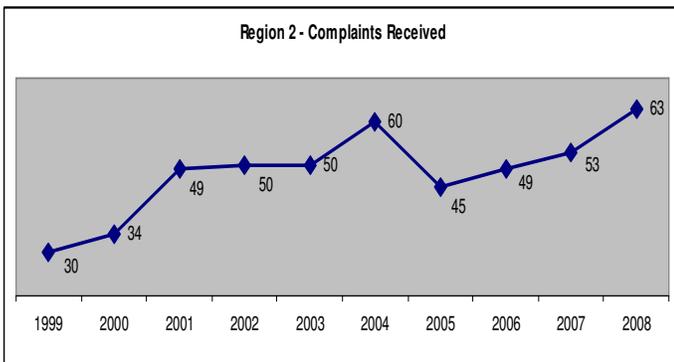
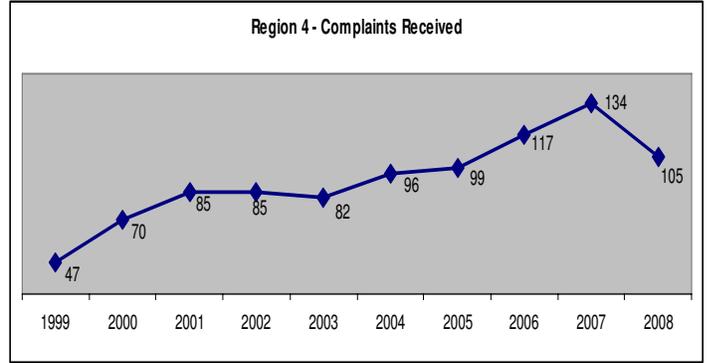
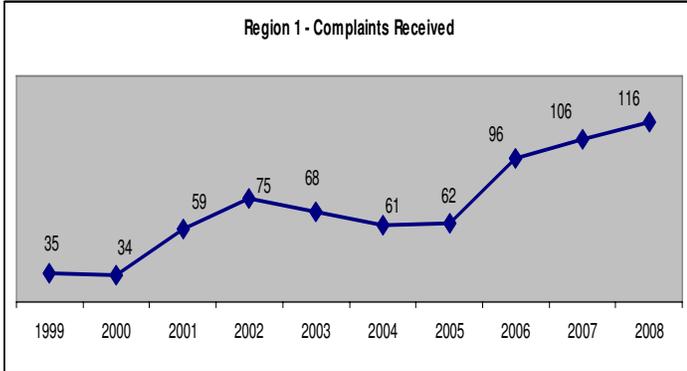
- Region 1 – Spokane
- Region 2 – Yakima
- Region 3 – Everett
- Region 4 – Seattle
- Region 5 – Tacoma
- Region 6 – Vancouver



	2007		2008	
	DCFS	DLR	DCFS	DLR
Region 1 Totals	105	1	115	1
Spokane	61	1	54	1
Colville	15		23	
Moses Lake	10		20	
Wenatchee	4		8	
Colfax	3		4	
Newport	4		3	
Omak	6		1	
Republic	1		1	
Clarkston	1		1	
Region 2 Totals	49	4	62	1
Yakima	14	3	20	1
Richland/Tri-Cities	16		16	
Walla Walla	8		16	
Toppenish	3	1	7	
Ellensburg	5		3	
Sunnyside	1		0	
White Salmon	1		0	
Goldendale	1		0	
Region 3 Totals	112	3	137	4
Everett	29	2	39	3
Bellingham	13		31	
Alderwood / Lynnwood	16	1	20	
Arlington/ Smokey Point	23		16	1
Mount Vernon	12		15	
Monroe / Sky Valley	10		9	
Oak Harbor	9		7	
Friday Harbor	0		0	

	2007		2008	
	DCFS	DLR	DCFS	DLR
Region 4 Totals	123	11	98	7
King South/ Kent	37	10	25	2
Martin Luther King Office	20		18	
King West	26	1	17	1
King East/ Bellevue	19		16	
Office of Indian Child Welfare	13		14	
Seattle Centralized Services	5		3	
White Center			3	
Seattle Central	3		2	4
Region 5 Totals	71	2	93	4
Tacoma	57	2	71	3
Bremerton/Kitsap	14		22	1
Region 6 Totals	90	3	96	4
Vancouver	25	1	33	4
Aberdeen	18		16	
Port Angeles	10		9	
Centralia	14		7	
Tumwater	9		7	
Kelso	4		7	
Shelton	6		6	
Stevenson	2		3	
Lacey/Olympia	2	2	3	
South Bend			3	
Long Beach			1	
Port Townsend			1	
Forks			0	
Statewide	7	0	8	0
Children's Administration Headquarters	2		6	
Central Intake	5		2	

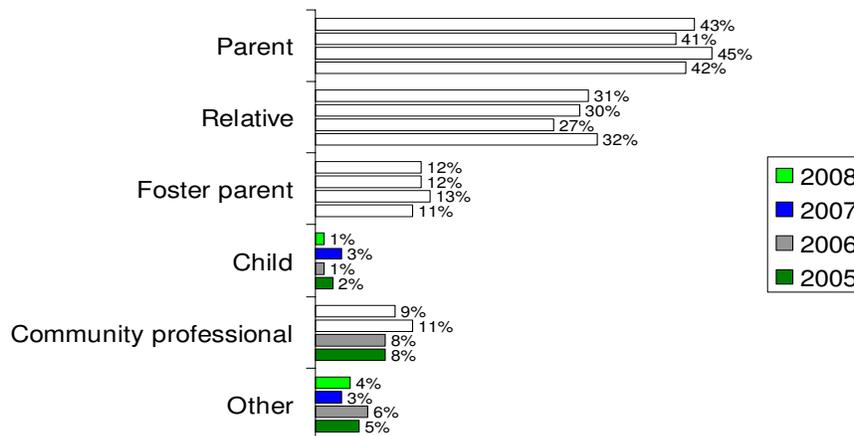
Regional Complaint Trends, 1999-2008



COMPLAINT PROFILES

Relationship of Persons Who Complained

As in previous years, parents, grandparents and other relatives of the child whose family is involved with DSHS filed the majority of the complaints to the Ombudsman. We continue to have very few children contacting the Ombudsman directly on their own behalf. Our outreach to adolescents as part of our 2007 survey of youth in group care (see page 35) resulted in a spike of complaints received from youth. We believe that the newly-developed pamphlet on the rights of youth in foster care (developed and distributed by The Mockingbird Society), which contains contact information for the Ombudsman, will greatly assist in our efforts to increase awareness of OFCO's existence and purpose among youth in out-of-home care, and we aim to broaden our outreach to youth by continuing to visit youth in group care at regular intervals in the future.



Race/Ethnicity of Persons Who Complained

OFCO's complaint form has an optional question asking complainants to identify their race or ethnicity, for the purposes of tracking whether the office is adequately serving and representing all Washington citizens. We include this data here to show which sectors of the community we are reaching and where we need to improve our outreach.

Race/Ethnicity	OFCO 2006*	OFCO 2007*	OFCO 2008*	WA State Census**
Caucasian	80.6%	80.2%	80.1%	85.0%
African American	8.6%	11.5%	9.7%	3.5%
American Indian/Alaska Native	9.0%	8.5%	6.7%	1.7%
Hispanic	3.9%	2.8%	5.0%	8.8%
Asian/Pacific Islander	1.4%	0.8%	1.8%	6.4%
Other	1.8%	0.5%	1.5%	--
Multi-Racial	3.7%	4.4%	5.5%	3.0%
Declined to Answer	2.3%	2.9%	5.6%	--

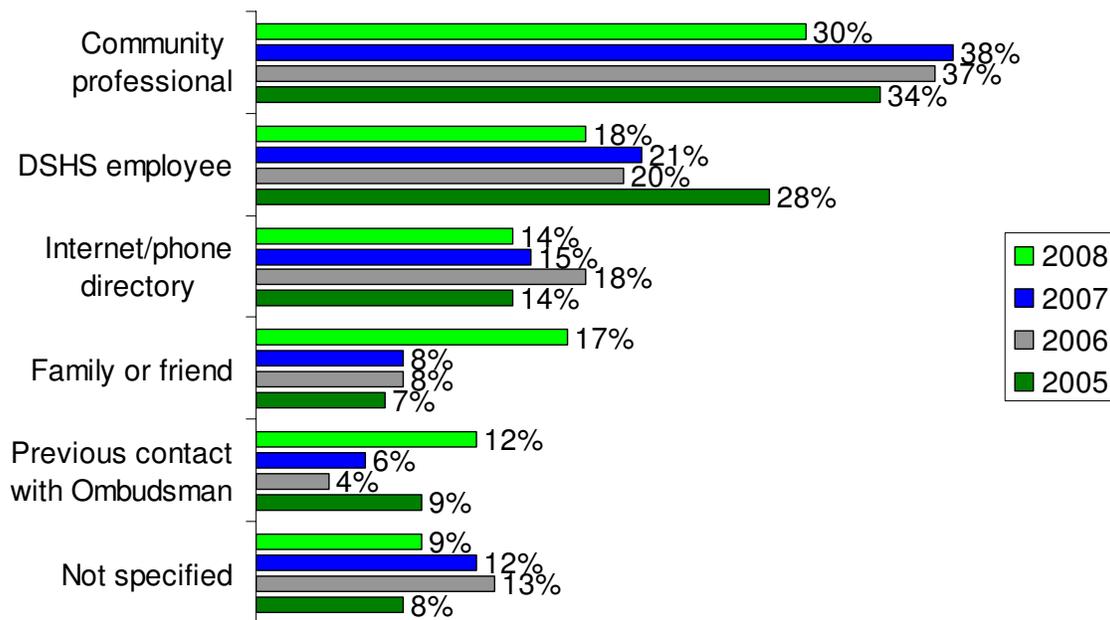
*Annual totals equal over 100% because the OFCO complaint form allows complaint forms to select more than one race/ethnicity.

**Source: US Census 2006 estimates (<http://quickfacts.census.gov/qfd/states/53000.html>)

As the table above shows, African Americans and American Indians are overrepresented in complaints made to OFCO as compared with their representation in state population data, while Hispanic and Asian populations are underrepresented. OFCO may need to strengthen outreach efforts to Hispanic and Asian groups. However, when race/ethnicity data of children who were identified in complaints is compared with the population of children served by the Children’s Administration, complaints to OFCO appear to evenly reflect the population of children in the child welfare system (see page 14).

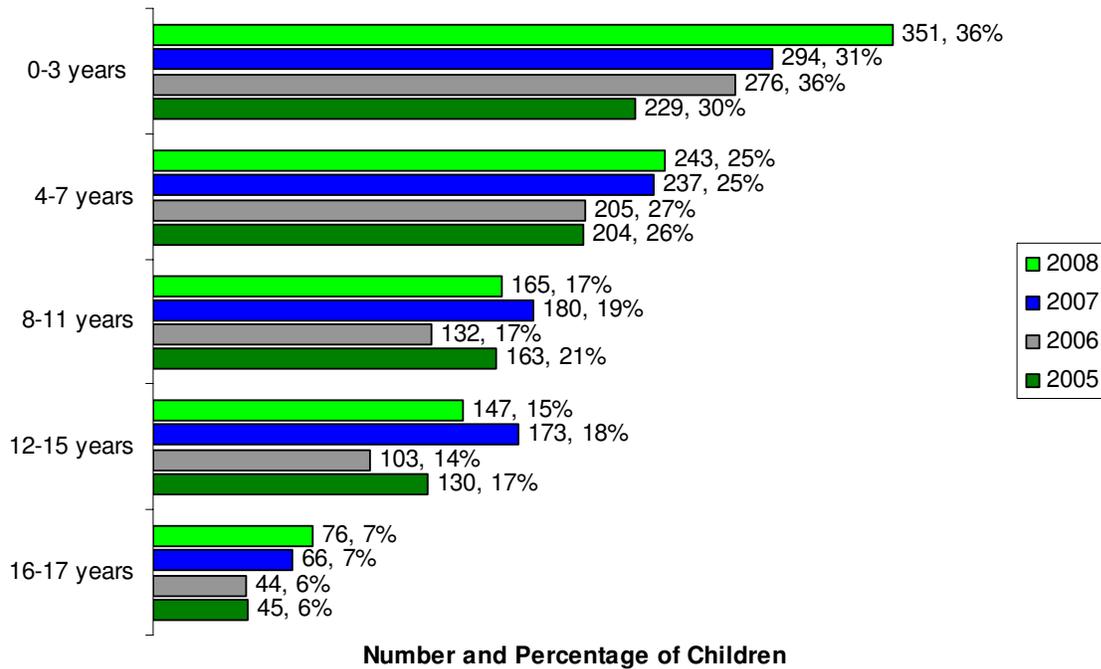
How they Heard about the Ombudsman

The majority of individuals filing complaints with the Ombudsman indicated that they were referred to the office by someone else. Many individuals reported that they were referred by a **community professional/service provider** (e.g., teacher, counselor, child care provider, doctor, private agency social worker, mental health professional, attorney, CASA/GAL, legislator’s office) or **DSHS worker**. A growing number of individuals were referred by a **friend or family member**. Other individuals had **previous contact** with the Ombudsman or stated they found the office via the **Ombudsman web site or telephone directory**. The remaining complainants did not specify how they heard about the Ombudsman.



Age of Children Identified in Complaints

As in previous years, most of the children identified in complaints to the Ombudsman were age seven or younger. Older adolescents continue to be identified in much smaller numbers.⁵



Race/Ethnicity of Children Identified in Complaints

Because children may identify with more than one race, it is difficult to accurately measure whether complaints to OFCO represent children of various races proportionate to the state population and the total number of children in placement (as indicated in the table below). However, it does appear that Caucasian and African American children are overrepresented in complaints to the Ombudsman, while all other groups are fairly evenly represented. When these figures are compared with the state child population, however, both children in placement and children who are the subject of complaints to the Ombudsman are greatly overrepresented in the African American and American Indian population groups.

Race/Ethnicity	OFCO 2006*	OFCO 2007*	OFCO 2008*	Children's Administration**
Caucasian	78.9%	76.8%	80.8%	60.6%
African American	14.7%	20.0%	17.2%	10.1%
American Indian/Alaska Native	11.4%	11.1%	11.3%	12.2%
Hispanic	11.7%	8.7%	12.5%	14.4%
Asian/Pacific Islander	2.2%	1.4%	3.5%	1.5%
Other	1.7%	1.6%	2.7%	3.5%
Multi-Racial	9.3%	11.4%	15.5%	10.7%
Declined to Answer	--	0.5%	0.1%	1.6%

*Data adds up to over 100% because people may self-report more than one race

**Source: Children's Administration Performance Report 2007 (<http://www1.dshs.wa.gov/pdf/ca/07Report2Intro.pdf>)

⁵ Some children were counted more than once because they were identified in more than one complaint.

FREQUENTLY IDENTIFIED COMPLAINT ISSUES^{6 -}

ISSUE	NUMBER OF COMPLAINTS		
	2006	2007	2008
Child Safety	188	211	250
Failure to protect children from parental abuse or neglect	108	122	138
Physical abuse	33	37	48
Sexual abuse	25	22	24
Emotional abuse	9	8	13
Neglect/lack of supervision	35	50	53
Other	6	5	0
Developmentally disabled child in need of protection	4	2	2
Children with no parent willing/capable of providing care	14	18	17
Failure to address safety concerns involving child in foster care or other substitute care	54	58	76
Failure to address safety concerns involving child being returned to parental care	8	11	17
Dependent Child Health, Well-being & Permanency	113	134	165
Inappropriate change of child's placement, inadequate transition to new placement	33	43	45
Failure to provide child with medical, mental health, educational or other services, or inadequate service plan	34	43	52
Inappropriate permanency plan or unreasonable delay in achieving permanency	29	33	47
Failure to provide appropriate adoption support services / other adoption issues	14	7	14
Inappropriate placement / inadequate services to children in institutions and facilities	3	8	7
Family Separation and Reunification	236	224	309
Unnecessary removal of child from parental care	54	40	40
Unnecessary removal of child from relative placement	25	9	28
Failure to place child with relative (including siblings)	43	54	68
Other inappropriate placement of child	19	19	22
Failure to provide appropriate contact between child and family	33	41	43
Failure to reunite family	46	51	86
Inappropriate termination of parental rights	8	6	5
Concerns regarding voluntary placement and/or service agreements for non-dependent children	3	2	10
Other family separation concerns	5	2	7
Complaints about Child Protective Services	--- ⁷	13	19
Inadequate CPS investigation	--	0	7
Failure to screen in CPS referral	--	1	3
Delay in completing CPS investigation	--	0	3
Failure to notify subject of CPS investigation of CPS findings	--	2	3
Heavy-handedness by CPS worker/unreasonable demands on family	--	10	3

⁶ Note that many complaints identified more than one issue.

⁷ Data not reported in 2006.

Other Common Complaint Issues	80	76	100
Foster parent retaliation	1	5	6
Other foster care licensing / foster parent issues	10	16	15
Relative caregiver issues	--	1	4
Breach of confidentiality by agency	7	3	7
Unprofessional conduct, harassment, retaliation or discrimination by agency staff			
Children's legal issues	10	15	9
Violation of parent's rights/failure to provide parent with services	4	9	4
Communication failures	35	22	39
	13	5	16

The above table shows the number of times various issues within these categories were identified in complaints. As in previous years, the **safety of children living at home or in substitute care** (raised in **461** complaints over the two year reporting period, 2007-08), as well as issues involving the **separation and reunification of families** (**533** complaints), were by far the most frequently identified issues in complaints to the Ombudsman. Both *child safety* and *family separation* issues **increased by about one-third** from 2006 to 2008. Concerns about the agency's *failure to protect children from physical and emotional abuse* and *safety of children in out-of-home care* increased significantly since 2006. However, the highest increase in safety-related complaints was seen in **safety concerns involving children being returned home**, slightly more than **doubling** since 2006.

Family separation and reunification issues likewise saw some dramatic increases. Complaints regarding the agency's **failure to reunify** a family increased by 87% since 2006. Concerns about **children not being placed with a relative or sibling** have increased by 58% since 2006. Issues involving *services to parents and parents' rights* decreased by half in 2007 but went back up to 2006 levels in 2008.

Also as in previous years, the **welfare and permanency of dependent children** remained our third-highest category of complaints (**299** over the two-year period). These issues *increased even more sharply (by 46% since 2006)* than child safety and family separation issues. Issues involving **inappropriate permanency plans or delays in permanency** saw the **sharpest increase** in this category (by **62%** since 2006).

Who Complains About What?

Over the years there have been **consistent themes** in complaints made by particular **types of complainants**. These are the top complaint issues by complainant type, from 2005-2008:

- **Parents** typically raised concerns about family separation and reunification.
- **Relatives** raised concerns about both family separation and reunification and child safety.
- **Community professionals** reported concerns about both child safety and the health and well-being of dependent children.
- **Foster parents** typically reported concerns about dependent children's health and well-being.
- The few **children** who have contacted OFCO over the years have reported concerns about their own well-being or safety.

RESPONDING TO COMPLAINTS

The Ombudsman investigates every complaint received.⁸ Through impartial investigation and analysis, the Ombudsman determines an appropriate response. In cases where the Ombudsman finds that the agency has properly carried out its duties, no further action is taken. In cases in which an adverse finding is made, the Ombudsman may work to change a decision or course of action by the Department of Social and Health Services (DSHS) or another state agency.

ANALYZING COMPLAINTS

The objective of a complaint investigation is to determine whether DSHS or another agency has violated law, policy or procedure, or unreasonably exercised its authority. The Ombudsman then assesses whether the agency should be induced to change its decision or course of action.

After initial investigation, the lead Ombudsman presents a report for review by the team, or a senior Ombudsman. Staff may pose questions, test assumptions, identify information gaps, identify problematic policy or practice issues, raise additional issues for investigation or analysis, or offer an alternative analysis by playing “devil’s advocate”. The investigation continues until it can be determined whether the allegations in the complaint meet one or more of the criteria for intervention by the Ombudsman (see sidebar). If these criteria are not met, no further action is taken and the complainant is notified by telephone or in writing. If the criteria are met, the Ombudsman decides what action to take to address the concerns raised by the specific complaint or any additional concerns uncovered during the course of the investigation. The complainant is informed of the progress and final resolution of the investigation.

Criteria for Analysis

The Ombudsman acts as an impartial fact finder and not as an advocate, so the investigation focuses on determining whether the issues raised in the complaint meet the following objective criteria:

- The alleged agency action (or inaction) is within the Ombudsman’s jurisdiction.
- The action did occur.
- The action violated law, policy or procedure, or was clearly inappropriate or unreasonable under the circumstances.
- The action was harmful to a child’s safety, health, well-being, or right to a permanent family; or harmful to appropriate family preservation/reunification or family contact.

⁸ The Ombudsman may also initiate an investigation without a complaint. During the 2007-08 reporting period, OFCO initiated 17 investigations and monitored the cases of three families as a result of information obtained by means other than a formal complaint, for example, by way of news reports. Three of these investigations/case monitors were closed without Ombudsman intervention after the concerns were resolved, and are not included in the data in this section. One investigation was closed after the Ombudsman intervened to resolve the concerns. Thirteen of the OFCO-initiated investigations remained open at the end of the reporting period.

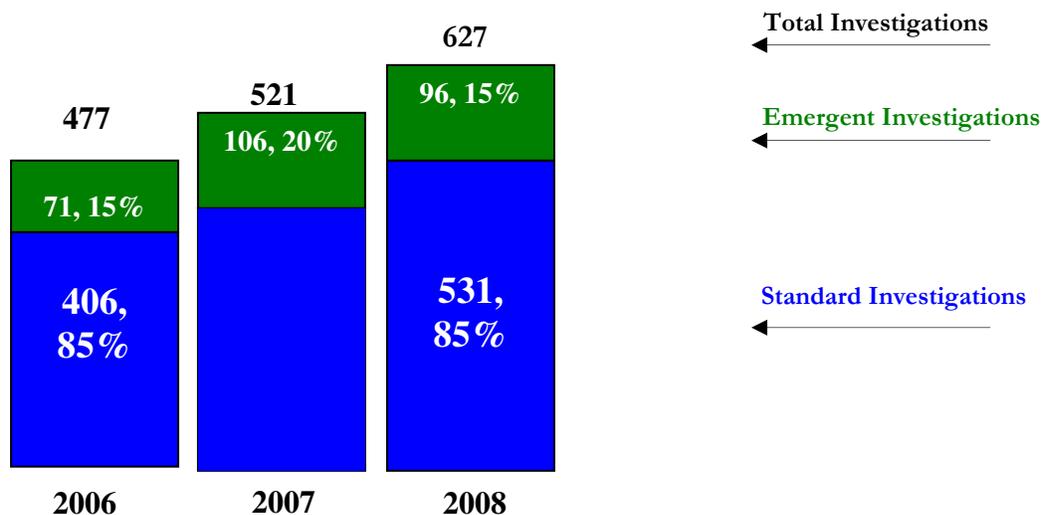
INVESTIGATION OUTCOMES

Completed Investigations

The Ombudsman completed 521 complaint investigations in 2007², representing a **9% increase over the previous year**; in 2008, investigations **increased another 20%**, to reach an all-time high of 627. This increase is attributable to the sharp increase in the number of complaints received by OFCO over this period, as well as OFCO's increased productivity resulting from the addition of staff (three FTEs over the two-year period) to meet both the demand for our services as well as to carry out new responsibilities assigned by the legislature. As in previous years, the majority of these investigations were **standard non-emergent investigations** (80% in 2007, and 85% in 2008). In 2007, one out of every five investigations met the Ombudsman'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 the Ombudsman could significantly ease a child or family's distress. In 2008, emergent investigations decreased to slightly less than one out of five.

Type of Investigations Completed

September 1 to August 31



² Of the 2007 complaints, 83% were investigations of complaints received during that reporting year, while 17% were of complaints received in a previous year. At the end of 2007, 25% of complaint investigations remained open. For the purposes of this section, investigations of complaints raising identical issues involving the same child/family are counted only once. The actual number of complaints closed in 2007, including these identical complaints from more than one complainant, was 556; for 2008, it was 681.

Ombudsman’s Findings

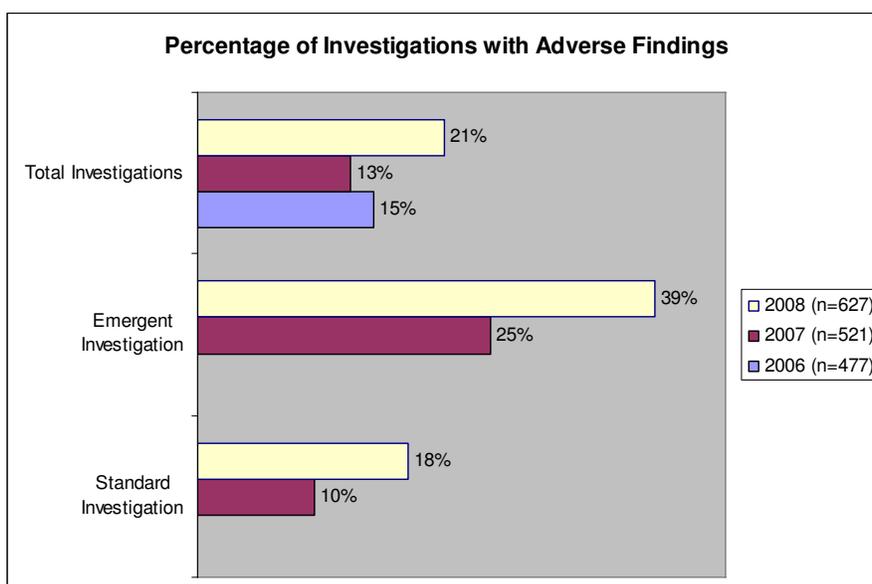
As shown in the graph below, the majority of complaint investigations resulted in **no adverse findings** (452, or **87% in 2007**, and 496, or **79% in 2008**). However, the number of adverse findings decreased slightly from 2006 (15% of complaints) to 2007 (13%), but increased significantly in 2008, to 21% of complaints. This was partly due to OFCO’s improved data capturing resulting in more accurate reflection of agency violations of policy and poor practice; other reasons for the increase in the number of adverse findings as well as the number of interventions by the Ombudsman are discussed in the next section of this chapter (see “Investigation Results, page [currently 7]).

Approximately one in eight investigations (13%) resulted in an adverse finding in 2007; this number went up to **about one in five (21%) in 2008**. It should be noted that a finding by the Ombudsman may or may not be related to the complaint issue/s raised by the complainant, but rather to other violations or unreasonable actions found by the Ombudsman in the course of investigating the complainant’s concerns. The number of adverse findings was also significantly higher in emergent complaints than in standard complaints.

Adverse findings fell into three broad categories:

- the agency violated a law, policy or procedure;
- the agency’s action or inaction was clearly unreasonable under the circumstances;
- no violation or clearly unreasonable action was found, but harm to the child or family had occurred as a result of poor practice on the part of the agency.

The Ombudsman intervened in some way to resolve the situation in 54% (37) of the 69 complaints with findings in 2007, and in just over one-third (45) of 131 in 2008. In the remaining complaints, the action had either already occurred or did not require or allow for intervention for other reasons.



The following table shows the various categories of issues in which findings were made. Some complaints had several findings related to different issues that were either raised by the complainant or discovered by the Ombudsman in the course of investigating the complaint.

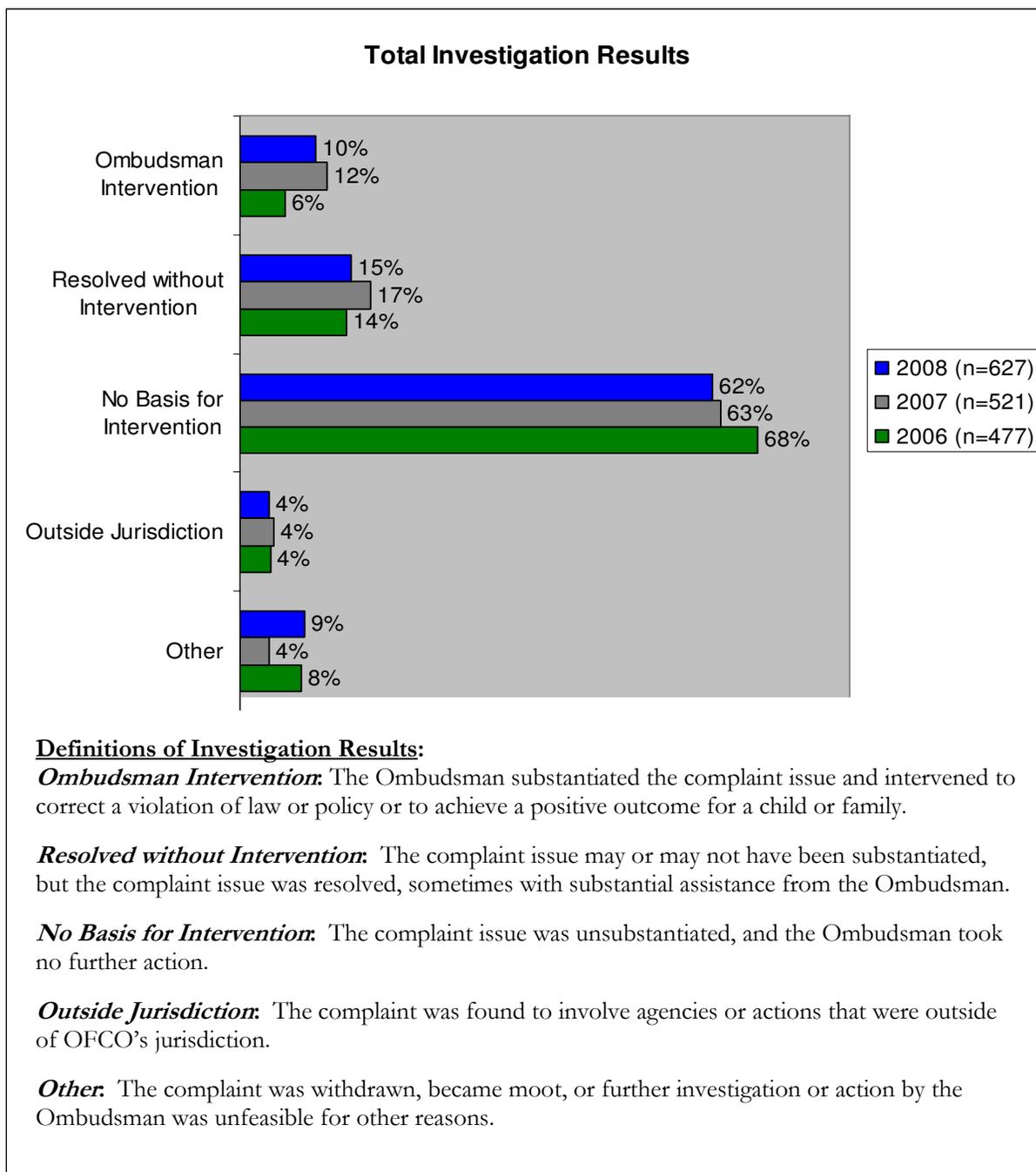
FINDINGS BY ISSUE		Number of Findings	
Issue	2007	2008	
Child Safety	29	68	
Failure by CWS to ensure/monitor dependent child's safety (examples: failure to conduct Health & Safety visits; inadequate monitoring of supervised parent-child visits; failure to report child injuries to CPS)	11	28	
Failure by CPS to ensure/monitor non-dependent child's safety	5	16	
Inadequate CPS investigation/case management	4	11	
Failure to screen in CPS referral for investigation/other screening errors	5	8	
Inappropriate CPS finding	--	3	
Failure by DLR to ensure safety of foster home/facility	4	2	
Family Separation and Reunification	3	20	
Failure to/delay in placing child with relative	--	9	
Failure to provide appropriate contact between parent and child	2	4	
Delay in reunification	1	3	
Failure to provide visits with siblings	--	2	
Failure to provide contact with other relative	--	2	
Dependent Child Permanency	10	19	
Delay in permanency	9	15	
Inadequate permanency planning	1	3	
Inadequate preparation of youth aging out of foster care	--	1	
Parents' Rights	6	18	
Failures of notification, public disclosure, or breach of confidentiality	4	8	
Delay in completing CPS investigation	1	6	
Failure to provide services to parent	--	2	
Other violations of parent's rights	1	2	
Foster parent/foster care issues	5	16	
Poor communication by agency, unreasonable treatment	--	7	
Violation of foster parent rights	3	2	
Overly lengthy DLR/CPS investigation, inappropriate findings	1	2	
Failure to provide foster parent with support services	--	2	
Retaliation by agency	--	2	
Unreasonable licensing delays/other licensing errors	1	1	
Dependent Child Health and Well-being	16	13	
Failure to provide adequate medical care	4	5	
Failure to provide appropriate services to meet special needs	1	3	
Placement issues (unnecessary moves, delays in placement, lack of availability, inappropriate placement type)	7	3	
Failure to meet basic physical needs	1	1	

Unreasonable delay in providing Children's Long-Term In-Patient treatment (CLIP)	3	1
Legal Issues	6	3
Lack of attorney or guardian ad litem for dependent child	2	2
Violations of Indian Child Welfare Act	4	1
Poor casework practice resulting in harm to child or family	11	10
Other poor practice	6	9
Communication failures	4	1
Unprofessional conduct by agency staff	1	--
Relative caregiver issues	--	4
Poor communication, poor treatment, lack of support	--	4
Adoptive parent/adopted children's issues	4	2
Inadequate services for adopted children with special needs	3	2
Inadequate pre-adoption services	1	--
Other findings	1	--
Failure to conduct child death review	1	--
TOTAL # OF FINDINGS⁹	91	171
Total # of Complaints with one or more finding	69	131

Of note in the above table is that the number of adverse findings made by the Ombudsman increased significantly (sometimes more than doubled) in almost every category from 2007 to 2008. Findings related to child safety under CWS or CPS supervision, increased sharply, as did the agency's failure to place or delay in placing a child with a relative, and delays in achieving permanency for dependent children. Violations of parents' rights tripled, as did foster parent issues; and in 2008, OFCO paid close attention to documenting relative care issues as a distinct category. A cautionary note regarding the above data is that OFCO gathered data regarding adverse findings more meticulously in these last two years, and we only have two years of comparison data showing findings in this kind of detail. The large swings in some of the numbers from one year to the next may even out once several years of data have been reported.

⁹ Note that several complaints raised more than one issue and resulted in more than one finding.

Investigation Results



In 2007, complaint investigations requiring direct intervention by the Ombudsman doubled, jumping from 6% to 12% of all investigations. In 2008, interventions decreased slightly to 10%, which still represents a significant increase over the 2006 rate of intervention. This sharp increase in interventions is attributable to several factors:

- Administrative changes in the way OFCO gathers complaint data has greatly improved our ability to capture a more accurate reflection of the Ombudsman's efforts to resolve substantiated complaints;

- Institutional experience garnered by OFCO over its 11 years of operation has taught us to quickly recognize the types of situations in which the Ombudsman can best utilize its unique role to prompt Children’s Administration in achieving positive outcomes for families and children, resulting in more decisive and timely interventions; and
- Correspondingly, we have observed that our outreach and educational efforts as well as the reputation OFCO has gained over the years as an entity that can negotiate the child welfare system to achieve more positive outcomes, has resulted in greater awareness within the child welfare community as well as the general public regarding this unique resource and the types of problems it can effectively resolve. We speculate that OFCO has been able to effectively intervene on behalf of many more families and children each year, in part due to our stakeholders becoming more astute and timely in bringing complaints to our attention.

The vast majority of complaints requiring intervention by the Ombudsman resulted in the complaint issue being resolved (83%).¹⁰ In the remaining 17% of complaints in which the Ombudsman intervened, the agency did not change its position and the issue became moot or remained unresolved.

For example, the former foster parent of a dependent youth with severe behavior problems contacted the Ombudsman with concerns about DCFS placing the youth in a group care facility close to the foster home. The youth had repeatedly broken into the foster parent’s home since being moved, and the foster parent was concerned that she would be forced to defend herself, with potentially tragic results. The Ombudsman contacted the CA Regional Administrator (RA) regarding these safety concerns. Regional management explained that the agency recognized the risk, but its efforts to find another suitable placement for this youth had been unsuccessful. The RA agreed to staff the case with CA Headquarters. Ultimately, Headquarters agreed that DCFS had done all that it could at that point. A couple of months later, DCFS was able to move the youth to another group home that was further away from the foster home.

In 2007-08 an average of 16% of investigations were resolved without intervention. Resolution of the complaint sometimes occurred as a result of the Ombudsman’s assistance, for example by ensuring that critical information was obtained and considered by the agency, or by facilitating timely communication among the people involved in order to resolve the problem.

In one example, the Ombudsman found that CWS failed to notify the CASA and other parties of a scheduled CPT meeting in which important decisions were being made regarding the child’s placement. The Ombudsman requested that the CPT be reconvened to include these parties, but the agency was unsuccessful. OFCO monitored the situation for several months as the case moved forward to ensure this did not recur. The CASA and other parties were notified in advance of subsequent decision making meetings.

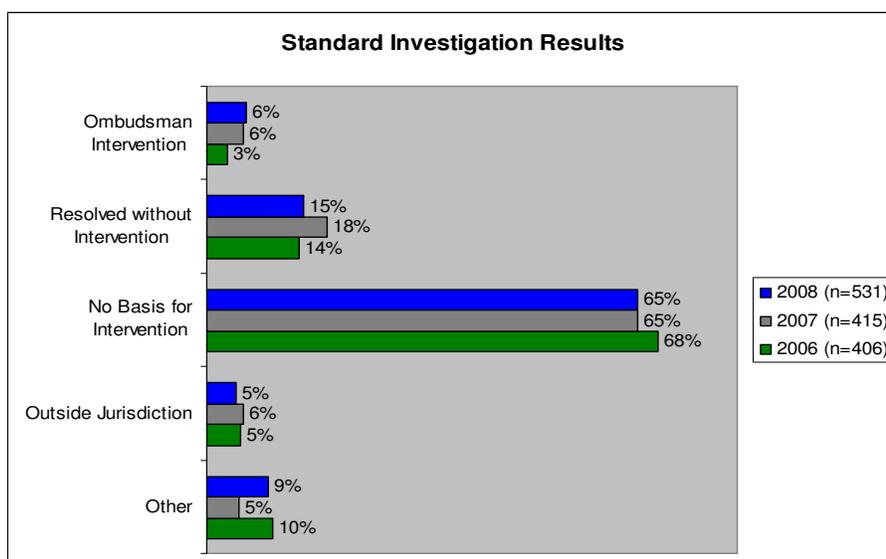
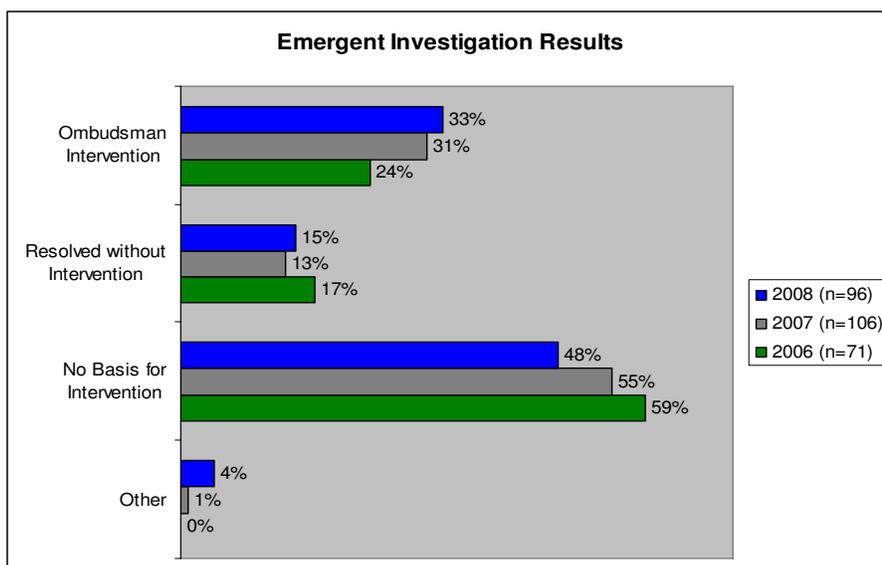
Since 2006, just under two-thirds of complaint investigations were closed after the Ombudsman either found no basis for the complaint, or found no unauthorized or unreasonable actions by the agency warranting intervention. In some of these cases, the Ombudsman may have made an adverse finding regarding a violation of law or policy or an unreasonable action that was not raised by the complainant but that was discovered by the Ombudsman in the course of investigating the complaint. However, the adverse finding did not require further action or could not be remedied.

¹⁰ See the following chapter, Ombudsman in Action, for examples of interventions.

For example, the Ombudsman found that CWS failed to place a two-year-old dependent child with relatives. In discussing this with the agency, CWS admitted that policy and procedures were not followed in this case, partly due to the caseworker’s high caseload, and that the relatives were not fairly considered in a timely manner as a result. Meanwhile, enough time had passed that the child had developed a strong attachment to the foster parents, who wished to adopt him, and the court ordered the agency to pursue a plan of adoption by the foster parents. The Area Administrator reported that staffing changes were being made to ameliorate heavy caseloads.

Emergent vs. Standard Complaint Investigations

Investigation results differ quite significantly in complaints that are investigated on an emergent basis compared to our standard investigation process. The following charts depict the various outcomes for these categories of complaints. The largest increase in interventions was seen in **emergent** complaints (a 9% increase over two years). Correspondingly, in the last three years, complaints that were not substantiated and did not require Ombudsman action decreased steadily (68%, 63%, and 62% from 2006 to 2008; see “Total Investigations” table).



OMBUDSMAN IN ACTION

INTERVENTIONS

The Ombudsman takes action when the findings of a complaint investigation indicate that action is necessary to avert or correct a harmful oversight or avoidable mistake by the Department of Social and Health Services (DSHS) or another agency.

After investigating the complaint, if the Ombudsman concludes that the agency's actions are either outside of the agency's authority or clearly unreasonable under the circumstances, and the action could cause foreseeable harm to a child or parent, the Ombudsman intervenes to persuade the agency to correct the problem. The Ombudsman shares the investigation findings and analysis of the problem with supervisors or higher-level agency officials to induce corrective action. In cases in which an agency error is brought to the Ombudsman's attention after-the-fact, and corrective action is no longer possible, the Ombudsman brings it to the attention of high-level agency officials, so they can take steps to prevent such incidents from recurring in the future.

Frequently, a concern is resolved before corrective action is necessary. In these cases, the Ombudsman actively facilitates resolution by ensuring that critical information is obtained and considered by the agency, and by facilitating communication among the people involved. In some cases, the Ombudsman finds that the agency's actions are not in clear violation of law or policy, but rather, represent poor practice. In these cases, if the complaint involves a current action, the Ombudsman intervenes where possible to assure better practice. When it involves a past action, the Ombudsman documents the issue and brings it to the attention of agency officials.

As indicated in the previous section, the Ombudsman's investigation resulted in **an adverse finding in 13% of complaints in 2007, and 21% of complaints in 2008**. As previously noted, sometimes the finding is unrelated to the issue raised by the complainant but was discovered by the Ombudsman in the process of investigating the issues that were raised. For example:

This section of our report contains examples of situations in which the Ombudsman made an adverse finding and took action to address the problem.

A parent complains to OFCO that the agency is failing to reunify the family, without justification. The Ombudsman investigates and finds no basis for this complaint, but finds that there are safety concerns in the home of the relative where the child has been placed, which the agency is not appropriately addressing. The Ombudsman makes a finding regarding the agency's failure to address the safety issues, and intervenes to ensure the child's safety.

Inducing Corrective Action

Examples

Investigative Finding	Ombudsman Action	Outcome
<p>CPS failed to notify a parent of the findings of a CPS investigation into allegations of sexual abuse of a child. The investigation had been completed six weeks prior, and the agency had the parent's correct address. OFCO found this to be clearly unreasonable given the serious nature of the allegations and the potentially harmful impact of the finding on the parent.</p>	<p>The Ombudsman requested that the parent be notified of the finding immediately.</p>	<p>The agency wrote a findings letter to the parent which was delivered 3 days later.</p>
<p>CPS failed to screen in a referral alleging abuse of a 16-year-old non-dependent youth by a sibling. The referral was not screened in for investigation as the information reported did not contain specifics about the alleged abuse. However, there was a clear allegation of abuse, and the named subject of the allegations had been charged with sexual molestation of other children in the past. The family history also indicated that the parents had been unsupportive of the youth's disclosure of abuse.</p>	<p>The Ombudsman requested that the screening decision be reviewed by the CPS intake supervisor. The screening decision was upheld by the supervisor. The Ombudsman requested further review by the Area Administrator, who also upheld the decision.</p>	<p>The Ombudsman took the matter up to the Office of Risk Management at CA Headquarters. Based on their review of the referral and the family's CPS history, CA HQ directed that the screening decision be changed. The report of abuse was investigated and the family received assistance with needed services.</p>
<p>CWS failed to address the need for the appointment of a guardian ad litem in the dependency matter of three siblings, ages 5, 1, and five months respectively. The prior GAL had retired, and a new one had not yet been appointed. Meanwhile, court hearings were being delayed in this complex case, and the children's best interests were not being represented in the legal process. Given that this was a highly contested case, and the case had just been transferred to a new DCFS worker unfamiliar with the case history, OFCO found the gap in representation of the children's best interests to be clearly unreasonable.</p>	<p>The Ombudsman contacted the guardian ad litem program in that county to request that a new GAL be assigned as soon as possible.</p>	<p>A guardian ad litem was appointed by the judge two days later.</p>
<p>CWS delayed permanency with regard to a 3-year-old dependent child who had been in out-of-home care for nearly two years. The parent had not been in compliance with court-ordered services for some time, despite reasonable efforts by the agency, and CWS had not set a trial date for termination of parental rights. The child was in a safe, stable foster home that wanted to adopt the child if she became legally free. Service providers were reporting that the child was exhibiting increased anxiety during visits with the parent. The Ombudsman found that the termination process had been delayed by CWS's failure to provide discovery to the AAG and defense counsel in a timely manner.</p>	<p>The Ombudsman contacted the Area Administrator and requested that discovery protocols in that DCFS office be reviewed and evaluated to curtail delays, and that training and improved oversight be provided to caseworkers on the discovery process and its relationship to the termination process.</p>	<p>The discovery protocols were reviewed and improvements were implemented within three months.</p>

Facilitating Resolution

Examples

Investigative Finding	Ombudsman Action	Outcome
<p>CPS failed to screen in for investigation a referral alleging neglect of a 2-year-old non-dependent child. The report alleged that the parent was using methamphetamines and living in a truck (with the child). The agency screened out the referral based on the parent's exact whereabouts being unknown and due to no specific allegation of harm to the child. The parent had a history of meth use, including during pregnancy with this child, resulting in medical problems for the child.</p>	<p>The Ombudsman verified that the parent was receiving TANF and that DCFS had contact information for the parent and various relatives. OFCO requested that CPS make collateral contacts with relatives.</p>	<p>Further information gathered by CPS indicated that since the referral, the parent had placed the child with a relative voluntarily. The child was now in a safe environment.</p>
<p>CPS delayed in obtaining a pick-up order regarding a non-dependent infant at imminent risk of harm due to the parent's mental illness. The family resided on a military base, and the child's other parent was serving overseas. CPS was seeking assistance from military police in taking the child into protective custody. The MP refused, and CPS believed it had no further authority to intervene. OFCO found that the agency had independent authority under the law to pursue a pick-up order in this case.</p>	<p>The Ombudsman recommended that DCFS staff the situation with an AAG to determine whether a dependency petition should be filed.</p>	<p>The AAG filed a dependency petition and obtained a pick-up order. The child was placed with a relative until the child's other parent returned. CPS assisted the non-offending parent in addressing the family situation to ensure the safety of the child.</p>
<p>CWS failed to respond to requests by the grandparents of a 6-year-old dependent child placed in foster care, for contact with the child. The child had previously lived with the grandparents and they had a close relationship. The grandparents had been granted some visits with the child up until nine months previously, when the foster parent reported increased behavior problems after visits and the agency discontinued them. The grandparents requested phone contact, and had one phone call, but further requests were ignored. The grandparents reported to OFCO that some time later, the child left a phone message for them, stating that he wanted to talk to his grandfather. The grandparents did not have the phone number for the foster home but was able to call the number recorded by her phone's incoming call log. CWS reprimanded the grandparents for calling the foster home. OFCO found the agency's failure to reconsider visits or phone contact to be unreasonable.</p>	<p>The Ombudsman requested that some kind of contact be reconsidered, and that the child's therapist be consulted regarding whether contact would be in the child's best interests.</p>	<p>CWS arranged a visit between the child, the parent, and the grandparents, as part of the parent's process of relinquishing parental rights process. CWS did not consult with the child's therapist regarding the advisability of ongoing contact.</p>
<p>CWS failed to keep its agreement to pay for a couple of months' rent for a room for a parent of a dependent 6-year-old child. The child was in the hospital for treatment of a serious illness, and when the case aide providing 24/7 bedside assistance to manage the child (as required by the hospital) abruptly ended services, the parent stepped in to be with the child daily. The parent rented a room close to the hospital and was unable to work due to caring for the child. However, when the caseworker submitted the funding request for the room rental, the supervisor denied it. The agency still had no case aide and the parent served a vital role in keeping the child calm. The Ombudsman found the denial of the funding request to be clearly unreasonable.</p>	<p>The Ombudsman contacted the supervisor who stated the funding was denied because the supervisor believed it was not an appropriate use of agency funds (despite being present in the meeting during which the agreement was made) as the parent had previously not been in compliance with services and the agency was preparing to terminate parental rights. The Ombudsman went up the chain to the Deputy Regional Administrator to have the funding request reviewed.</p>	<p>The agency agreed to pay two months' rent for the parent's room. However, two months later the agency still had not released the funds due to bureaucratic complications. The Ombudsman intervened again to ensure the funds were provided.</p>

Assisting the Agency in Avoiding Errors and Conducting Better Practice

Examples

Investigative Finding	Ombudsman Action	Outcome
<p>CPS closed a case after making a founded finding of physical abuse of a 15-year-old non-dependent child against a parent. The closure of the case was based on the parent being charged with assault, and the court's ability to order services and monitor the parent. This was poor practice, given that the parent had been investigated by CPS six times for physical abuse in the last two year, and had received two founded and one inconclusive finding in the last 5 months. Community professionals were expressing concerns about the youth's safety and well-being.</p>	<p>The Ombudsman requested review of the case by an Area Administrator.</p>	<p>The AA decided to reopen the case and offer the family voluntary services. Although the parent initially refused, further investigation by CPS revealed that the youth was at ongoing risk of harm by the parent. CPS filed a dependency petition, the prosecutor obtained a protection order, and the agency began working on placing the youth with the non-abusive parent, who was living out-of-state.</p>
<p>CPS planned to return a 19-day-old medically fragile infant on a hospital hold while being treated for methadone withdrawal, to the parent. Medical professionals were concerned because the parent had a history of drug abuse and had 3 other children at home who were ill with an infectious respiratory virus (RSV). Community professionals felt that CPS was not taking their concerns seriously.</p>	<p>The Ombudsman requested that CPS convene a Child Protection Team meeting to allow community professionals involved with the family to share information and make recommendations regarding the case plan.</p>	<p>CPS convened a CPT meeting and the child was sent home with specific recommendations regarding ongoing medical care and other services and a safety plan to ensure the infant's safety. The CPS case remained open for several months, until the parent relapsed and all four children were placed in out-of-home care.</p>
<p>CPS failed to screen in a referral from a mandated reporter alleging physical abuse of an 11-year-old non-dependent child by the parent. The Ombudsman found that the referral was poorly documented (the referent reported providing a good deal more information than was documented), but even so could have been screened in for investigation based on the allegations as well as the chronic history of similar referrals. However, a new referral from a different mandated reporter had just been screened in for investigation, after the child reported being hit with a belt causing a welt on his back. OFCO reviewed the investigation that was in process, and found that the child had only been seen and interviewed four days after the referral had come in. This is a violation of policy; and by that time, the "red 5-inch welt" described by the referent was a faint mark. CPS was preparing to close the investigation. OFCO determined that the agency should gather more information to better assess the child's need for protection, given the family's history of CPS involvement.</p>	<p>The Ombudsman asked CPS to contact the school counselor, the child's health care clinic, and the family court GAL currently assessing both parents (all of whom had made CPS referrals in the last year). The agency did so, and gathered substantially more information. The investigation resulted in a founded finding (all previous investigations had resulted in unfounded or inconclusive findings). OFCO recommended that the agency require the parent to participate in services or take stronger protective action (e.g. filing a dependency to protect the child).</p>	<p>CPS arranged an FTDM, and the parent signed a voluntary service plan agreeing to attend a parenting class, individual and family counseling for parent and child, regular visits to the health care clinic (for monitoring of ADHD medication), and wraparound services in the home. The school counselor agreed to meet with the child monthly as an additional safety net. The case remained open for monitoring and services for over 8 months.</p>
<p>DCFS failed to remove two adopted youths ages 16 and 17 from their adoptive home where they had lived for the past 10 years, after the youths disclosed years of physical, emotional and verbal abuse by their parents. Despite consistent disclosures by these youth, corroboration of the abuse by an older sibling who had since left home, prior removals of other children from these parents, and a recommendation from DLR/CPS who was investigating the current abuse allegations, DCFS believed the abuse did not meet sufficiency for a legal basis for removal of the youths from the parents. Furthermore, the DCFS/CPS worker inappropriately pressured the youths to remain at home and discouraged them from seeking outside assistance from school personnel.</p>	<p>The Ombudsman contacted the Area Administrator to request a review of the case and in particular the decision not to remove the youths.</p>	<p>DCFS asked the parents to sign a voluntary placement agreement, which they did. The agency provided additional training to the CPS worker. DLR and DCFS collaborated on improving their protocols for conducting joint investigations. Neither of these youths returned to the abusive home. The older youth turned 18 while in voluntary placement, and DCFS filed a dependency petition on the younger youth when the voluntary placement agreement expired.</p>

Preventing Future Mistakes

Examples

Investigative Finding	Ombudsman Action	Outcome
<p>CWS planned to terminate the voluntary placement agreement for a non-dependent 17-year-old youth when the youth turned 18, with no assistance or planning for the youth's immediate future. The youth had been severely beaten by her father two years previously, but the agency had not filed a dependency at that time, opting for a voluntary placement with a relative instead. A few months before the youth's 18th birthday, the relative moved out-of-state. The youth wanted to complete high school (where she had a grade point average of 3.8) and attend college, and had requested foster placement in advance of turning 18. OFCO found the agency's failure to explore all options to assist this non-dependent youth in transitioning to adulthood to be unreasonable, based on the youth's lack of parental or other adult support.</p>	<p>The Ombudsman went up the chain of command as far as the Program Manager for Adolescent Programs at Children's Administration Headquarters to request that the agency aggressively explore what could be done to assist this youth.</p>	<p>CA discovered it had erroneously believed that only dependent youth were eligible for the Foster Care to 21 Program (approved by the legislature in 2006 to assist foster youth in remaining in foster care after turning 18 to complete their education). In fact, youth in foster care under voluntary placement agreements are also eligible. The youth signed herself back into care at age 18 and was accepted into the Foster Care to 21 program.</p>
<p>Two dependent siblings, ages 1 and 2, moved with their foster-adopt parents out-of-state after the court authorized the placement pending ICPC approval. The parent's attorney subsequently argued that the placement was illegal, and the court entered a second, ambiguous order stating that the children should return to Washington but should remain in the foster-adopt placement. DCFS received ICPC approval of the placement from the receiving state, but was given conflicting advice from different AAGs, and told the foster parents the children would have to return to Washington. The children had been in foster care since birth, and had been living in this foster home since the ages of 2 months (the younger child) and 6 months (the older child) respectively. The foster parents wanted to adopt the children if they became legally free.</p>	<p>The Ombudsman confirmed that ICPC approval of the placement had been received from the other state, and contacted the AAG to ensure that the court order would be modified to clearly authorize placement of the children with their foster parents.</p>	<p>The court order was amended and the children's placement was not disrupted. They were subsequently adopted by the foster parents.</p> <p>To avoid these types of errors in the future, the AGO provided the court with a bench book covering ICPC law and regulations, and provided additional training for AAGs and DCFS staff on ICPC issues.</p>
<p>In the course of investigating a complaint regarding CWS's failure to place a dependent child with relatives, the Ombudsman found that there had been exceptionally poor communication between the CWS caseworker and various parties involved, that had contributed to the general confusion, inaccurate information, and ill feeling toward the agency by the relatives and other parties, who felt their viewpoints were not being heard or considered due to the caseworker's communication style.</p>	<p>The Ombudsman contacted the worker's supervisor to discuss these concerns.</p>	<p>The supervisor agreed to provide additional training and oversight to the caseworker with the goal of improving the worker's communication skills.</p>
<p>CWS failed to report injuries sustained by an 18-month-old dependent child in foster care, to the foster home licensor. The child sustained numerous injuries including a black eye, a cut on the nose, and other bumps and bruises. While abuse was not suspected, the level of supervision of the toddler was in question, and the recurring accidental injuries should have been investigated as a licensing complaint.</p>	<p>The Ombudsman requested a file review by the foster care licensing supervisor, to assess whether the injuries should have been reported for investigation either by the Office of Foster Care Licensing or DLR/CPS.</p>	<p>The supervisor found that the injuries should have been documented and reported to the licensor. To avoid future errors, the supervisor discussed the importance of making such referrals with the CWS caseworker and supervisor.</p>

CASE SPECIFIC INVESTIGATION

OFCO receives intermittent requests for investigation of specific cases in which there has been a past action resulting in an undesirable outcome. We report here on an in-depth investigation conducted after receiving such a request directly from the Secretary of DSHS. OFCO made specific recommendations to DSHS based on the findings of its investigation.

Investigative Findings Presented to the Secretary of DSHS

Re: Dependency of *CJ*

Dear Ms. Arnold-Williams:

As you know, the Office of the Family and Children's Ombudsman has completed its review of the *CJ* dependency matter. This review was initiated at your request on March 8, 2006 due to concerns that the Department of Social and Health Services (the Department) may not have provided complete and accurate information to the key entities that have authority for decision making in this case.

Summary of Issues Investigated

Did the Department provide complete and accurate information to key entities that have authority for decision making in this case? Specifically:

A) Did the Department provide the X. County Foster Care Citizen Review Board (FCCRB) with complete and accurate information when the FCCRB considered the issue on 1/25/06 of whether to return *CJ* to maternal relatives?

B) Did the Department advocate for the return of *CJ* to maternal relatives at the court hearing on 3/1/06 and present the court with complete and accurate information upon which to base its decision about placement?

Summary of Conclusion

A) No, the Department did not provide complete and accurate information to key entities that had authority to make decisions or recommendations in this case. In particular, 1) there were inaccuracies and omissions in the Child Welfare Services (CWS) social worker's Individual Service and Safety Plan (ISSP) concerning the child's weight and health; 2) the CWS social worker did not provide critical medical information, which contradicted the assertion that the child was possible failure to thrive, to the FCCRB; and 3) it is not clear from the record whether the social worker clearly presented to the FCCRB the Department's rationale for revising the case plan to return the child to maternal relative.

B) OFCO finds that the Department did advocate for return of *CJ* to maternal relatives at the 3/1/06 court hearing. The AAG cited appropriate case law in arguing for return of the child to maternal relatives. Moreover, the AAG pointed out to the court that there was "nothing definitive from the doctors about whether she was failure to thrive or she was just on her own growth chart."

Evidence Relied Upon

Review of case record (hard file and CAMIS/GUI), interviews of various DSHS personnel, medical documentation, minutes of 11/8/05 J/S Family conference, FCCRB 6-month Review Report of 1/25/06, court recordings (via CD) of hearings on 2/21/06 and 3/1/06, ISSP and updates, GAL report, and various letters and other miscellaneous documentation.

Significant Events

- On 8/4/05, CJ was taken into protective custody and placed in foster care.
- On 8/10/05, CJ was placed with maternal aunt in the home of her maternal grandmother (“maternal relatives”).
- On 11/4/05, CJ was removed from maternal relatives and placed in foster care. The Department later conceded to OFCO that it had based its decision to remove CJ, in part, on erroneous information.
- On 11/8/05, the J/S Family Conference took place. The worksheet from this conference stated, “All Family members want CJ removed from foster care and placed back home with aunt.” Eleven maternal and paternal family members signed this. Plan B was to place with paternal relatives.
- On 11/22/05, CJ was placed with paternal relatives (between removal from maternal relatives and placement with paternal relatives, she resided in foster care).
- On 11/30/05 (about 3 months prior to the 6-month FCCRB review meeting and soon after CJ was placed with paternal relatives), the social worker (SW) documented in service episode record (SER) # 9567568 that she had received a phone call from the [paternal] relative placement. “She said that they went to Dr. B. on 11/29 and CJ weighed 20.6 lbs with clothes on and 19.10 lbs [OFCO clarified with the agency (who consulted with the examining physician) that this meant 19 lbs 10 oz.] with just her diaper.”
- On 1/06, Regional Administrator Randy Hart was asked by Senator Val Stevens to review the Department's decision to remove CJ from maternal relatives and place with paternal relatives. Based on his review, the Department altered its previous position and supported return of CJ to maternal relatives.
- On 1/12/06, SW documented in SER # 9744731, after a Dr's appointment reported by the paternal relative placement, that “CJ weighs 19 lbs 10 oz.” This shows that over the seven weeks in which CJ had resided with paternal relatives, there had not been a weight increase.
- On 1/12/06, SW updated her ISSP. This ISSP was provided to the FCCRB for consideration in its decision about placement of CJ. The social worker documented that “CJ is possible failure to thrive. .[s]ince being placed in paternal relative's home and being placed on a high calorie diet, the child has gained weight at a steady rate and continues to grow.”
- On 1/25/06, the FCCRB conducted a 6-month review of CJ's dependency case to consider whether CJ should be returned to maternal relatives. The FCCRB recommended not moving CJ from paternal relatives, with whom she had resided for approximately 2 months (from 11/22/05). The CWS social worker presented information to the FCCRB. According to the 1/25/06 FCCRB report, the social worker stated, “CJ is doing wonderfully well. Since November 4 she has been put back on Pedia Sure and gained 2 pounds. Her hair is growing and she is filling out. She is taller now. She is appropriately bonded. She is on track and has no delays. An administrative decision has been made to return CJ to the care of her Maternal Aunt and Maternal Grandmother due to the fact that the child resided with them for the first 18 months of her life. The transition will be made over a month. She is bright and happy.” In its recommendation to keep CJ with paternal relatives, the FCCRB stated, in part, “[t]he board is extremely concerned with the plan of the department to return CJ to the care of the maternal relatives. The board does not believe that CJ should be moved again. This move would constitute a 5th placement for the child, which is disruptive and potentially disruptive to CJ's development. CJ needs consistency.”
- On 1/26/06, the dependency case was transferred to a new social worker.

- On 3/1/06, the court held a contested hearing on the issue of CJ's placement. It ruled that CJ should remain with paternal relatives.

Conclusion

The Ombudsman finds that the Department failed to provide complete and accurate information to the decision makers in this case, specifically the FCCRB, with regard to CJ's weight and physical and developmental wellbeing. The social worker's duty and the purpose of an ISSP are to accurately inform the court, other parties, and decision makers about the status and progress of the child.

1) There were inaccuracies, omissions, and misleading information in the ISSP.

The social worker's ISSP was provided to the FCCRB board and to the court in advance of the hearing to determine if placement of CJ should be changed. In the social worker's ISSP update of 1/12/06, she stated, "CJ is possible failure to thrive." This is not a diagnosis that was made by any of the physicians who saw CJ (see discussion below under 2), yet the social worker continued to suggest this diagnosis.

The social worker also stated in the ISSP "[s]ince being placed in paternal relative's home and being placed on a high calorie diet, the child has gained weight at a steady rate and continues to grow." This statement does not accurately reflect medical information that the social worker documented in a 1/12/06 SER (# 9744731), which showed that "CJ weighs 19 lbs 10 oz." This is the same weight as when she was placed with paternal relatives 7 weeks earlier, thus showing no increase in weight.

2) The FCCRB was not provided with information by Dr. B., which contradicted the assertion that CJ was possible failure to thrive. The social worker provided the FCCRB with a copy of her ISSP, which stated CJ was "possible failure to thrive" and had gained weight steadily since being placed with paternal relatives. The assertion of possible failure to thrive was contradicted by the medical documentation of Dr. B. (CJ's primary pediatrician) who examined CJ on 11/29/05. In a letter on this same date, Dr. B. summarized her findings from medical visits with CJ and noted that the child was small for her age, but she had stayed fairly consistently between the third and fifth percentile for weight, based on her length. Dr. B. stated, "[w]e find that many infants who are born small for gestational age [CJ was born premature] never catch up and continue to be very small and below the 'normal parameters' that have been established." She was thoroughly tested by Dr. B. and was not found to have any abnormalities based on the screening tests. She also did not appear to have any delays, physically, emotionally, or socially. This information was not provided to the FCCRB.

3) Although the caseworker articulated the Department's revised case plan to return the child to maternal relatives, it is not clear that the agency's rationale for doing so was clearly presented to the FCCRB. It is unclear whether the FCCRB conveyed to the social worker the agency administration's rationale for placing CJ back with maternal relatives, other than that she had lived with them for the first 18 months of her life. If the social worker elaborated further on the merits of this placement, the FCCRB report does not reflect this. The report documents that the social worker presented CJ's adjustment to the paternal relatives home in positive terms, stating she is "doing wonderfully well. . . is appropriately bonded. She is on track and has no delays. . . She is bright and happy."

Recommendations

It is unclear to what extent the FCCRB relied on representations by the CWS social worker that CJ had improved physically and developmentally to make its decision. However, when the agency does not provide accurate information or omits information that contradicts other information presented, it undermines the ability of decision makers to make the best decisions for children. It also undermines public confidence in the child welfare process. Based on our review of the case file and investigation of this matter, we are recommending three practice changes:

1) The Department should inform the FCCRB and other entities staffing cases, such as Child Protection Teams, of which issues are in dispute and provide these entities with original source documents related to such issues. Information that is verbally presented, which relies on one person's interpretation of written documentation, is susceptible to mischaracterization. Critical information may be accidentally or intentionally omitted or simply presented in such a way that the information is skewed. Participants in decision making or advisory entities should have access to the source documents to review themselves so that they may ask critical and appropriate questions.

2) Policies should be reviewed to ensure that Department records (SERS) and documents (ISSPs) are corrected when inaccurate information has been documented. There needs to be a clear and consistent mechanism for correcting inaccuracies in the record. If the record goes uncorrected, then the misinformation is repeated and is more likely to be relied upon by the court and other entities in making decisions about the child's welfare. Examples of erroneous or incomplete information: 1) the agency persisted in suggesting that CJ was "failure to thrive" even though this had never been medically diagnosed. In fact, there was medical information that contradicted such a conclusion, which was not presented to decision makers; 2) although the Department conceded that the maternal aunt's boyfriend submitted information for a background check (after initially insisting that necessary information had not been submitted to the Department and relying on this as one of the reasons for removing CJ from maternal aunt) there is no evidence that the record was corrected to reflect this.

3) When Children's Administration changes its case plan as a result of review of a case by upper management, management need to attend the subsequent FCCRB meeting or court hearing to present the change in position. It is less effective to rely on the line social worker or even the supervisor to present a significant change in case plan, particularly when that worker/supervisor was responsible for making and/or advocating the prior case plan.

Once again, thank you for contacting our office, and please do not hesitate to contact us again if we can be of assistance to you.

Sincerely,

Mary Meinig
Director Ombudsman

Children's Administration Summary Response

OFCO received a response to its recommendations from the Assistant Secretary for Children's Administration, Cheryl Stephani, in October 2006. The response is summarized here:

Recommendation 1): The Department agreed with the recommendation to inform staffing entities about which issues are in dispute and provide related source documents. The agency reported that this requirement was communicated to all staff in the region in which this case was handled, and CA developed new statewide Child Protection Team policy requiring that source documents be provided to the CPT.

Recommendation 2): The Department agreed with the recommendation to review policies regarding corrections to departmental records, but provided no information as to whether they were reviewed or any changes made.

Recommendation 3): The Department agreed to follow the recommendation to have a representative from upper management present any significant changes in the case plan directed by upper management, directly to the FCCRB or the court.

CHILD FATALITY REVIEW

The Ombudsman reviews all fatalities and near-fatalities of children whose family had an open case with DSHS at the time of death, or within a year prior to death. OFCO released its first child fatality review report in 2005, which described child fatalities that occurred during the 2004 calendar year. Since then, the number of fatalities that OFCO reviews has increased. During its 2007 and 2008 reporting years¹¹, OFCO reviewed over 158 of child fatalities. An in-depth child fatality review report is forthcoming.

2SSB 6206 IMPLEMENTATION

The Ombudsman's reporting duties expanded with the enactment of S22B 6206 which became effective June 2008.

2SSB 6206 requires the Ombudsman to:

Analyze a random sampling of child abuse and neglect referrals made by mandated reporters to the DSHS/CA during 2006 and 2007.

The Ombudsman must report to the Legislature no later than June 30, 2009, on the number and type of referrals, the disposition of the referrals by category of mandated reporter, any patterns established by DSHS in how it handled the referrals, whether the history of fatalities in 2006 and 2007 showed referrals by mandated reporters, and any other information OFCO deems relevant. The Ombudsman may contract to have all or some of the tasks completed by an outside entity.

Issue an annual report to the Legislature on the implementation of child fatality recommendations.

Ombudsman progress:

OFCO entered into an interagency agreement with the Washington State Institute for Public Policy (WSIPP) to utilize its expertise to analyze patterns in mandated reporter referrals. The Ombudsman has facilitated a data sharing agreement between WSIPP and DSHS/CA.

The Ombudsman is in the process of identifying the presence of mandated reporter referrals in the history of child fatalities that occurred during 2006 and 2007 and met DSHS and OFCO's review criteria.

Ombudsman progress:

OFCO is in the preliminary stages of tracking child fatality review recommendations, and plans to issue a report on the status of implementation prior to the 2010 legislative session.

2SSB 6206 requires DSHS to:

Promptly notify the Ombudsman when a report of child abuse or neglect constitutes the third founded report on the same child or family within a twelve-month period. DSHS must also notify OFCO of the disposition of the report.

Promptly notify the Ombudsman in the event of a near-fatality of a child who is in the care of or receiving services from DSHS within the last 12 months

Ombudsman update: The Ombudsman began receiving notification of chronic maltreatment cases in June 2008. DSHS/CA informed OFCO that it would continue to send notification on a monthly basis until an automatic notifier system can be arranged via Famlink. The Ombudsman will provide the Children's Legislative Oversight Committee with an update on findings of the Ombudsman's preliminary review of these cases.

Ombudsman update:

The Ombudsman began receiving automatic notifiers from DSHS/CA regarding critical incidents, near-fatalities, and child fatalities prior to the enactment of 2SSB 6206. The Ombudsman reviews each incident.

¹¹ The Ombudsman's reporting year is September 1 to August 31.

LISTENING TO YOUTH IN GROUP CARE

INTRODUCTION

What happens in our state to youths who cannot remain at home, do not have an able and willing relative with whom they may live, and cannot be successfully managed in foster care? Where do they go? They are often placed in “group care.” Group care is a residential program that cares for youth with complex behavioral and emotional issues that require a more structured and therapeutic level of care than can be provided in a relative or foster home.

In the summer of 2007, the Office of Family and Children’s Ombudsman (OFCO) undertook a study in which the Ombudsman visited 22 group homes across the state to speak directly with 120 youth about their experiences. The purpose of our visits was to elicit from youth their ideas about how to improve group care, and explain to them how to access the Ombudsman as a resource if they needed help. We believed, and still do, that the youth themselves are best positioned to inform public dialogue about what is working and what is not.¹²

We sought to identify within the current group home residential framework what elements seem to be working and which are not. The answers to these fundamental questions may be a springboard to future study of whether the current system as a whole makes good sense and should be retained or whether it should be re-worked in favor of other residential models that have been advanced by child welfare advocates.

SUMMARY

OFCO is statutorily charged with “review[ing] periodically the facilities and procedures of state institutions serving children, and state-licensed facilities or residences.”¹³ Since its inception in 1997, OFCO has visited a variety of state-licensed facilities, such as the Washington School for the Deaf, resulting in system-changing reforms. Additionally, in 2001 OFCO issued a report on what was working best in the foster care system based on input from

Youth Feedback

The best things about living in a group home.

Generally, youth appreciated receiving individualized treatment, good food, feeling safe, and having their basic needs met. They valued fair and caring staff members, opportunities to create friendships with other youth, activities and outings, privacy and independence, and visits with family and friends.

Suggestions to improve the group home experience.

Youth identified six aspects of their group home experience that they would like to see improved:

- Increased safety
- Having basic needs consistently met
- Improved staffing and management
- Increased freedom, contact with family and friends, and privacy
- Increased structure and activities
- Increased nurturing and respect

¹² Children’s Administration and the Braam Oversight Panel recently issued the results of a comprehensive foster youth survey to gather data to assess the effectiveness of and improve services for adolescents in foster care. Results of the 2008 Survey of Washington State Youth in Foster Care, August 2008, are now available at <http://www.dshs.wa.gov/pdf/ca/YouthSurveyDataReport.pdf>

¹³ RCW 43.06A.030(4).

youth.¹⁴ We have recognized over the past few years that the voice of youth was not being heard as greatly or persistently as we would like within our office and this partly inspired our decision to undertake this report.¹⁵ Its goal is to recognize strengths and identify shortcomings within specific group homes and make recommendations for improvement based on the input we received.

There are approximately 127 group care facilities, or group homes, across Washington State. Together, they provide over 500 beds for youth with a wide range of needs. In 2007, the average monthly group care caseload was 965.¹⁶ During our visits, the Ombudsman conducted group discussions, and provided youth with a paper-based questionnaire (“survey”) that included closed and open-ended questions. One hundred twenty youth participated in the group discussions, and 106 responded to the Ombudsman’s survey. Below is a brief summary of youths’ responses, the Ombudsman’s observations and concerns and the action we took as a result of our concerns, and our recommendations to improve youths’ experiences in group care.

OMBUDSMAN CONCERNS

Nearly 30% of youth surveyed do not feel safe in their group home. The Ombudsman responded to youths’ safety concerns by reviewing licensing complaints and referrals made to Child Protective Services (CPS) about the group homes in question. OFCO requested that the Department of Licensed Resources (DLR) review facilities with ongoing problems, and ensure that appropriate corrective action was taken. As of September 2008, two facilities have been closed; one has a stop placement order in effect (i.e. the facility is to accept no further placement of children until issues of concern are resolved); one is receiving a comprehensive review at the Ombudsman’s request; and one is receiving ongoing training and corrective action to address deficiencies. OFCO has continued to monitor these homes over the past year since this survey was completed.

Youths’ basic physical, social, and emotional needs are not being met consistently: 16% reported physical needs are not met and 28% reported emotional needs are not met. The Ombudsman relayed the information to DLR and verified that the youths’ physical needs were subsequently addressed. OFCO has also continued to monitor group homes where specific licensing complaints were alleged.

Many youth are not provided with adequate information, such as how to contact their attorneys and CASAs, and have little to no choice about where they are placed (37% reported receiving no information about the group home prior to moving in) or who provides them with services (46% reported having no choice).¹⁷ The Ombudsman provided these youth with information about how to contact individuals who could help them, including their respective attorneys, CASAs, and social workers.

Almost 25% of youth reported interracial tension. The Ombudsman recommends group home programs to promote cross-cultural understanding.

¹⁴ Foster Care. What young people in the system say is working. OFCO Appreciative Interview Report. January 2001. Copies may be accessed at http://www.governor.wa.gov/ofco/reports/ofco_200101.pdf

¹⁵ The Ombudsman’s full Group Care report is available online at <http://www.governor.wa.gov/ofco/reports/default.asp>.

¹⁶ Note that this number excludes children that are placed in Crisis Residential Centers (CRCs). The average monthly caseload for CRCs for 2007 was 136. Washington State Office of Financial Management, 2007 Washington State Data Book, Community Social Service Workload Indicators, ONLINE. Available: <http://www.ofm.wa.gov/databook/human/st03.asp>

¹⁷ Most youth were unaware of the new state law passed in 2007 that, under certain circumstances, allows legally free youth ages 12 and older to petition the court to reinstate previously terminated parental rights of a parent. Several youth believed this might apply to them.

OMBUDSMAN RECOMMENDATIONS

The Children’s Administration and other stakeholders in the child welfare system should:

- **Prioritize youths’ need for basic essentials** such as food, clothing, personal hygiene items, and basic cleanliness and maintenance of facilities.
- **Improve safety and quality of care** by reducing the minimum “social service”¹⁸ staffing ratio for group care facilities from 1:25 to 1:15, and revising the minimum qualifications for group home “child care”¹⁹ staff in alignment with the Council on Accreditation (COA) standards, and ensuring that staff (and caseworkers) receive training regarding the rights of youth in group care, such as the right to receive and make private phone calls.
- **Empower youth by engaging them** in all decision making regarding changes in their case plans and placement, in a timely manner, by distributing to them a publication²⁰ that describes their legal rights and the dependency process, and by ensuring that dependent youth have an attorney or CASA/GAL and know how to contact them.
- **Ensure that each group home is continually supervised** by an on-call, professional social service staff member available on a 24-hour basis, in alignment with the COA standard.
- **Reauthorize the “Foster Care to 21” program**, if evaluation data from the Washington State Institute for Public Policy (WSIPP) confirms that this program is making a positive difference in preparing youth for their early adulthood and future.²¹

Individual group homes should:

- **Actively facilitate contact** between youth and their outside sources of support.
- **Develop and implement a consistent process** for providing youth with information in a format they can understand when they first arrive at a group home or enter into group care.
- **Balance youths’ needs** for independence with their need for supervision to provide the least restrictive environment for each youth where possible.
- **Ensure that the group home’s phone policy is consistent with the legal rights of youth** under Washington State law.
- **Actively solicit youth suggestions** for improvement of daily routines, rules, structure, and activities.
- **Consider introducing educational programs** for both residents and staff members to promote cross-cultural understanding.

¹⁸ “Social service” staff is defined as a clinician, program manager, case manager, consultant, or other staff person who is an employee of the agency or hired to develop and implement the child’s individual service and treatment plans.

¹⁹ “Child care” staff members provide direct care, supervision, and behavior management for children and must have a high school diploma/GED as well as experience and skills in working with children.

²⁰ The Mockingbird Society has recently issued a pamphlet designed to inform youth about their rights. Mockingbird Society is a non-profit organization based in Seattle committed to reforming public policy and law to better support foster youth and caregivers. See <http://www.mockingbirdsociety.org>.

²¹ WSIPP carries out non-partisan research as directed by the Washington State Legislature. Pursuant to HB 2687 enacted in 2008, WSIPP will issue a preliminary report to the Legislature on the success of youth transitioning out of foster care by September 1, 2008 and a final report by December 31, 2008. See <http://www.wsipp.wa.gov>.

CONCLUSION

Group care in Washington State is a study in contrasts. Our contact with youth highlighted sharp differences in the quality of group care across the state that did not appear to correlate to particular regions of the state, size of home, or even to how physically pleasing the setting was. Instead, differences were related quite simply to the ability of the group home to enhance connections with the foster youth: connection to staff; connection to friends and families; connection to other residents; connection to professionals who provide them support such as their social worker, lawyer, or CASA/GAL; and finally, connection to their future. **Without connection, youth felt marginalized and vulnerable.**

The good news is that the youth were very articulate and insightful about what encourages connection: they need to have their basic physical needs met; they need fair staff looking out for them; they need to have their privacy respected; they need opportunities to create friendships with other youth, and to engage in activities and outings; they need to have contact with their families, lawyers, CASA/GALs, and social workers. They valued structure and routine because this helped them to know what was ahead, and helped to manage their expectations. They preferred being placed within their community so that they could more easily have contact with friends and family. Youth who did not have these things communicated fear, powerlessness, and loss of self-esteem.

RECOMMENDATIONS TO IMPROVE THE SYSTEM

MAINTAINING THE FAMILY CONNECTION

RECOMMENDATION: Increase Long-Term Placements of Dependent Children with Relatives

Background

In 1999, the Washington State Legislature declared that: “children who cannot be with their parents, guardians, or legal custodians are best cared for, whenever possible and appropriate by family members with whom they have a relationship. This is particularly important when a child cannot be in the care of a parent, guardian, or legal custodian as a result of a court intervention.”²² Relatives can and should provide a vital support network for children who have been removed from the care of their parents.

The growing phenomenon of relative care is made clear by the numbers. According to DSHS, as of January 2008, there were over 35,000 children being raised by relatives.²³ The majority of these children are cared for by grandparents.²⁴ According to DSHS, “[t]he number of children placed into out-of-home care has continually increased since Fiscal Year 1999 and in the most recent reporting period [FY 2007], the [Children’s] Administration [CA] saw the greatest number of children placed [10, 411] into out-of-home care since data tracking began.”²⁵ In November and December 2008, the percent of children placed by DSHS in relative care compared to total out-of-home care ranged from a low of approximately 30% in Region 6²⁶ to a high of nearly 42% in Region 5, with an average relative placement rate of approximately 38%.²⁷

OFCO finds that despite the Legislature and the Department of Social and Health Services (DSHS), Division of Children and Family Services (DCFS), making significant strides in developing tools to facilitate relative placement and contact between children and their relatives, relatives are still coming to OFCO with complaints of a system that does not give them an adequate voice in the legal process. Relatives desire greater support to maintain placements, and they want recourse if they disagree with the actions of DCFS. As in previous years, OFCO received complaints most frequently from parents, grandparents and other relatives of children whose family is involved with DSHS. Since 2005, complaints from relatives have consistently accounted for about one-third of all complaints.

²² See <http://search.leg.wa.gov/pub/textsearch/ViewRoot.asp?Action=Html&Item=3&X=1112101447&p=1>

²³ This figure includes both children within the child welfare system who are under the supervision of DSHS and children living with relatives through private arrangements.

²⁴ <http://www.aasa.dshs.wa.gov/about/factsheets/kinship%20navigators%20fact%20sheet%2012-07.doc>

²⁵ 2007 CA Performance Report at p.21 <http://www.dshs.wa.gov/pdf/ca/07Report4Permanency1.pdf>

²⁶ Region 6 includes Vancouver, southwestern Washington, and the Olympic Peninsula.

²⁷ November 2008 data provided by Randy Hart, Director of Field Operations, DSHS, CA, Headquarters via e mail to Linda Mason Wilgis on November 14, 2008. Region 5 includes Tacoma, Bremerton, and the surrounding area.

Complaints in this category typically involve one of the following scenarios:

1. DCFS did not allow or hindered contact between relatives and children;²⁸
2. DCFS failed to place the child with a relative rather than in foster care,²⁹ or placed the child with a less suitable relative when a more suitable one was available;
3. DCFS did not adequately support a relative placement with appropriate services and/or case management; and
4. DCFS inappropriately removed a child from the care of a relative.³⁰

State and Federal law prioritize placement of children with relatives. When DCFS removes a child from the home³¹ due to abandonment, abuse, or neglect, and seeks court approval for placement of a child out-of-the home, the court must give preference to placement of the child with a relative.³² RCW 13.34.130 (1) (b) provides:

Unless there is reasonable cause to believe that the health, safety, or welfare of the child would be jeopardized or that efforts to reunite the parent and child will be hindered, such child shall be placed with a person who is: (A) Related to the child as defined in RCW 74.15.020(2)(a) with whom the child has a relationship and is comfortable; and (B) willing and available to care for the child.³³

Children may be placed with certain relatives without requiring the relative to be a licensed foster parent.³⁴ However, a relative may choose to pursue foster care licensing. Placement of a child with a relative who is not a licensed foster parent is commonly known as a kinship care placement.

There is momentum building across the country among legislators, child welfare policy makers, judges, and child welfare agency workers to formally recognize the importance of relatives in the lives of dependent children. State laws, policies, and social work practice have undergone transformation to reflect this cultural shift in awareness. Relatives, whose primary role in the past has been to help care for children through private arrangements with families as a means of avoiding state intervention, are now being increasingly utilized by child welfare agencies for placement after state intervention has been deemed necessary.³⁵

²⁸ Out of 659 total complaints received by the Ombudsman in 2008, relatives complained of the agency not providing appropriate contact between a child and family in 43 complaints. In 2007, out of 615 complaints, this was an issue in 41 complaints.

²⁹ Out of 659 total complaints received by the Ombudsman in 2008, relatives complained of the agency not placing the child with a relative in 68 complaints (more than 10% of all complaints received). In 2007, out of 615 complaints, this was an issue in 54 complaints.

³⁰ Out of 659 total complaints received by the Ombudsman in 2008, relatives complained of the unnecessary removal of a child from relative care in 28 complaints. In 2007, out of 615 complaints, this was an issue in 9 complaints.

³¹ The priority to place children with relatives was established in 1999 with the enactment of SB 5210.

³² RCW 13.34.130(2); RCW 13.34.060.

³³ RCW 13.34.130; see also WAC 388-25-0445 which lists the factors the agency considers when selecting a relative placement. It includes: "(b) The relative has a potential relationship with the child."

³⁴ RCW 74.15.020(2).

³⁵ Washington State asserts legal control, custody, and control of the child through the dependency process, set forth under chapter 13.34 RCW.

Promising Developments

New Federal Law – Fostering Connections to Success and Increasing Adoptions Act

This year, the U.S. Congress passed the Fostering Connections to Success and Increasing Adoptions Act (hereafter referred to as the “Fostering Connections to Success Act” or “the Act”),³⁶ a major new initiative that provides financial assistance to grandparents and other kinship caregivers who provide permanent homes for children through legal guardianship.³⁷ Dependency guardianships³⁸ have been disfavored in recent years by the agency because guardianships were not considered a permanent plan for a child for federal reimbursement purposes. This new Federal law removes that barrier and allows States that choose to provide assistance to kin, such as grandparents when they become legal guardians of a child, to access Federal monies. This new law helps ensure that children for whom guardianship is the most appropriate permanent plan are able to remain with family regardless of financial resources. One requirement of the Federal law is that potential relative guardians must have cared for the child as foster parents for at least six months prior to the guardianship. The Legislature and the agency should consider whether WA state law needs to be amended to reflect this requirement.

The Act also promotes kinship navigator programs by approving \$15 million per year for Family Connection Grants to promote kinship navigator programs and other efforts designed to connect and help relatives serving as caregivers. The Fostering Connections to Success Act makes crucial strides towards improving out-of-home care for children and families.

Key State Legislative Initiatives on Kinship Care

Building on the statutory framework that prioritizes placement of children with relatives, the Legislature over the past several years has passed several initiatives to increase and support kinship care, including:

- Directing the Washington State Institute for Public Policy (WSIPP)³⁹ to study the prevalence and needs of relative care providers and compare services and policies of Washington state with other states that have a high rate of kinship care placements in lieu of foster care placements;⁴⁰
- Authorizing a Kinship Care Workgroup to develop and prioritize recommendations based on the WSIPP report (OFCO participated in this workgroup, which developed 23 recommendations);⁴¹
- Requiring DSHS to implement a more effective relative search process, which included development of a statewide standardized protocol for relative searches;⁴²
- Creating financial support programs for relative caregivers;⁴³

³⁶ Fostering Connections to Success and Increasing Adoptions Act of 2008, Public Law 110-351, signed into law Oct. 7, 2008.

³⁷ Financial assistance is provided through federal reimbursement to states that choose to provide assistance to kin, such as grandparents, when they become legal guardians of children.

³⁸ The relevant provisions of WA state law are RCW 13.34.230-36.

³⁹ WSIPP is the research arm of the Washington state Legislature and was established in 1983 to conduct research on issues of importance to the Legislature. <http://www.wsipp.wa.gov.vlr>

⁴⁰ Engrossed Substitute Senate Bill 6153, Section 608(5), Chapter 7, Laws of 2001 directed WSIPP to identify possible changes in services and policies that are likely to increase appropriate kinship care placements. WSIPP found that the key barriers to successful kinship placements were inadequate funding, legal barriers, bureaucratic barriers, the need for better access to social services, and gaps in information available to kinship providers about services, policies and laws related to kinship care. A copy of WSIPP’s 2002 report entitled, “Kinship Care in Washington State: Prevalence, Policy, and Needs” is available at <http://www.wsipp.wa.gov/rptfiles/KinshipCareWA.pdf>.

⁴¹ Substitute House Bill 1397, Chapter 144(2), Laws of 2002. A copy of the November 2002 Kinship Care Workgroup Report to the Washington State Legislature is available at <http://www.dshs.wa.gov/word/ea/kinship/KinshipCareReport.doc>

⁴²Substitute House Bill HB 1233.

- Creating Regional Kinship Care Coalitions;⁴⁴
- Creating and expanding the Kinship Navigator Program to assist relatives with navigating the child welfare system to find services and other resources;⁴⁵
- Broadening the definition of “relative”, which had the effect of allowing more kin to care for children without being subjected to foster care licensing requirements;⁴⁶
- Allowing relatives to consent to medical⁴⁷ and mental health treatment for children in their care without a parent’s signature; and
- Authorizing a Kinship Oversight Committee to oversee kinship care activities in Washington State.⁴⁸

DSHS Policy Changes to Support Relative Placement

In the wake of these legislative initiatives, DSHS has adopted policy changes to further encourage relative placement.⁴⁹ Some of the key agency directives, policy and practice changes follow:

- **DCFS Review of Unlicensed Caregivers and Guardianship Cases**

In 2008, DCFS completed a **review of all placements with unlicensed caregivers and open guardianship cases**. This review was requested in the Fall of 2007 by CA management due to the discovery that background checks had not been completed on the homes of some unlicensed caregivers in one region. The Ombudsman had contacted the agency in August 2007 with concerns after OFCO reviewed several child fatalities and injuries and found these had occurred in homes where the agency had not completed background checks on relative caregivers. We learned at that time that a statewide review was just being initiated.

The purpose of the review was to determine if necessary home studies and background checks had been completed and documented.⁵⁰ The agency examined 3,295 cases to verify whether home studies and background checks were needed and if needed whether they were completed. DCFS then directed staff to

⁴³ In 2004, the Kinship Caregivers Support Program (KCSP), which is designed to provide financial assistance for relatives not involved in the child welfare system, was created with an initial appropriation of \$500,000. It helps provide funding for essentials such as food, clothing, transportation, and school activities.

⁴⁴ As of 2007, Regional Kinship Care Coalitions have been formed in King, Snohomish, Pierce, Clark and Yakima counties to coordinate services between service providers. See: <http://www1.dshs.wa.gov/pdf/ea/kinship/WashingtonStateKinshipCareAccomplishments.pdf>

⁴⁵In 2007, funding was increased for the Kinship Navigator program (a public and private partnership) so that there are currently a total of 7.5 navigator positions. These are located on both the Eastern and Western side of the state. You may access more information on the kinship navigator program at:

<http://www.aasa.dshs.wa.gov/about/factsheets/kinship%20navigators%20fact%20sheet%202012-07.doc>. The DSHS Kinship care website is: <http://www.dshs.wa.gov/kinshipcare/>.

⁴⁶House Bill 1377, enacted in 2007, expanded relative placement options by broadening the definition of “relatives”. Relatives include blood and half-blood relatives; first cousins; second cousins; nephews and nieces; grandparents; stepparents; and stepbrothers and stepsisters; and relatives of half-siblings of the child. RCW 74.15.020(2). For a summary of the bill, see <http://apps.leg.wa.gov/billinfo/summary.aspx?bill=1377>.

⁴⁷ Substitute House Bill 1281.

⁴⁸ The statewide Kinship Oversight Committee was established by the Legislature in 2003 with the enactment of Substitute House Bill 1233. The life of the Committee was extended to 2010 in 2005 by SHB 1280. RCW 74.13.261. To access the legislative history of SSB 1280 see <http://dlr.leg.wa.gov/billsummary/default.aspx?year=2005&bill=1280>

⁴⁹ To access information on programs to assist relatives, see “Washington A State Fact Sheet for Grandparents and Other Relatives Raising Children” at http://assets.aarp.org/rgcenter/general/kinship_care_2006_wa.pdf

⁵⁰ Some of the children had been placed in homes prior to changes in policy requiring more thorough home studies.

complete a home study or background check when one was required but had not yet been completed.⁵¹ According to DSHS CA:

- Region 1 identified 181 cases that needed further work. Of those, 177 cases needed home studies completed;
- Region 2 identified 142 cases that needed home studies and 206 cases that needed background checks;
- Region 3 identified 107 cases that required home studies and 27 cases that required background checks;
- Region 4 identified 32 cases requiring a home study which are now [as of September 2008] in process and 12 caregivers with criminal conviction requiring a waiver or administrative approval⁵²;
- Region 5 identified 171 cases requiring home studies of which 106 were pending completion. Five cases with a pending background check were found.
- Region 6 identified 134 cases which needed home studies and 46 background checks which had not been completed.⁵³

The caregiver case review resulted in numerous home studies and background checks being done for the first time, or being completed in instances where they were unfinished. This process led to further scrutiny of homes by DCFS and the removal of children from some long-term placements after the agency concluded they were not in safe placements.

The Ombudsman recommends that the agency conduct an annual case review to ensure that children are not placed in any homes that have not undergone a sufficient home study or background check. Based on the results of its case review, we then expect DCFS to take appropriate action to ensure children are placed in safe homes.

- **Improvements in Identifying Relatives & Completing Relative Home Studies**

In 2006 and 2007, DSHS adopted changes to its home study policy and put current background check requirements into place. This created a more thorough, unified and expedited process for initiation and completion of relative home studies, which are intended to evaluate the suitability of relatives for long term

⁵¹ September 19, 2008 Memorandum from Randy Hart, Interim Director of Field Operations, Children's Administration to Cheryl Stephani, Assistant Secretary, Children's Administration re: REVIEW OF UNLICENSED CAREGIVERS AND GUARDIANSHIP CASES.

⁵² When a disqualifying crime or negative action is found in the course of conducting a background check, CA may give administrative approval or waiver to allow a child to be placed with an individual with a disqualifying crime or negative action if the social worker determines that the child's health and safety will not be jeopardized by the individual and designated management personnel within DSHS grants the waiver or gives administrative approval. The type of approval needed depends on the severity of the criminal conviction. For example, a "permanent disqualifying crime" would require an administrative waiver by the DSHS Secretary whereas a negative action such as a suspension of a license would require administrative approval by a Regional Administrator or Division of Licensed Resources Administrator.

⁵³ September 19, 2008 Memorandum from Randy Hart, Interim Director of Field Operations, Children's Administration to Cheryl Stephani, Assistant Secretary, Children's Administration re: REVIEW OF UNLICENSED CAREGIVERS AND GUARDIANSHIP CASES

placement or adoption.⁵⁴ When the agency locates a potential relative placement resource, the social worker is required to complete a criminal history/background check on the relative and assess their suitability prior to placing the child in the home, unless it is an emergent placement.⁵⁵ If the placement is done on an emergent basis, the social worker is to initiate the background check immediately after placement.

DSHS policy provides that the social worker will work with the family to identify possible placement options and absent good cause, will follow the wishes of the parent regarding placement of the child.⁵⁶ The social worker is to consider both in-state and if appropriate, out of state placement options.

Prior to these policy and practice changes, initial relative home studies were often cursory and focused more exclusively on obvious safety issues. They typically did not address the long term suitability of relatives to care for children permanently. As one Region 3 DSHS administrator observed, “We didn’t always pick the right relative for placement. We didn’t always assess their ability to manage the child or to create appropriate boundaries with the parent.”⁵⁷

DSHS Policy now provides that **within 72 hours of placement of a child with a relative**, the CA social worker will initiate the “Relative Placement” process.⁵⁸ There are four phases to this process and the final written home study is **to be completed within 120 days of out of home placement**. If a relative is identified later in the placement process, they complete a Unified Family Home Study, which is also used for cases subject to an Interstate Compact on the Placement of Children (“ICPC”).⁵⁹ The relative home study lays the groundwork for later foster care licensing or adoption of the child by the relative.

OFCO contacted DCFS Administrators in a variety of the regions served by DSHS to help gauge what the agency thinks are hurdles to placement with relatives and permanency for children, and ingredients for success. Over the last year, each of the 6 regions served by DSHS was allotted additional FTEs for relative support. DSHS, CA has left it up to the discretion of individual regions to determine how best to allocate their resources and develop programs that will support relative placements. According to John March, Region 4, DCFS Area Administrator, Adoptions/Permanency section, “some of the biggest barriers to implementing permanent plans has been early assessments of relative placements, timely completion of relative or adoptive home studies, supporting early permanency for children placed in relative care, and staying on top of these cases so permanency can be achieved safely.”⁶⁰

In early 2008, Region 4 created the kinship support unit to support permanency for children placed with relatives; and the unit became fully operational in August 2008. Of the seven offices in the region, six field offices are assigned at least one kinship support social worker whose main function is to complete relative home studies for all relative placements using the unified home study format, support permanency efforts and provide other case management supports. If adoption becomes the permanent plan, then a request is

⁵⁴ Children’s Administration (CA) Practices and Procedures Guide, section 45274.

⁵⁵ CA Practices and Procedures Guide, section 46273 (c).

⁵⁶ RCW 13.34.260.

⁵⁷ November 12, 2008 telephone call from Linda Mason Wilgis to Region 3, DCFS personnel.

⁵⁸ Section 45274 of the CA Practices and Procedures Guide sets forth the process social workers are to use to identify relatives (which is the first phase of the relative placement process), and initiate a relative home study. These include use of: 1. The Relative Placement Checklist (DSHS 15-280); 2. The Relative Intake form (DSHS 10-392); and 3. The Placement Agreement form (DSHS 12-281). More broadly, the provisions under section 4527 addresses different aspects of relative placement, including choosing relatives. This may be accessed at http://www.dshs.wa.gov/ca/pubs/mnl_pnpg/chapter4_4520.asp#4527.

⁵⁹ The ICPC exists in state law throughout all 50 states. It was developed in 1974 and its purpose is to establish uniform legal and administrative procedures governing children placed across state lines. Washington State’s ICPC is codified at RCW 26.34.010.

⁶⁰ November and December 2008 telephone and e-mail communication between John March, Region 4, DCFS Area Administrator, Adoptions/Permanency section and Linda Mason Wilgis, Ombudsman, OFCO.

made to an adoption home study social worker to simply update the unified home study for that purpose. The kinship workers help navigate the third party custody process when that is the identified permanent plan. Mr. March also employs a “relative search specialist” who uses a specialized federal computer program “ACCURINT” to link individuals to a family tree. This federal computer program also allows certain workers to do a national search of criminal history on prospective relative placements which helps to expedite the home study process. The relative search position went into effect in August 2008. These new initiatives in Region 4 appear to be off to a promising start.

Additionally, with the implementation of FamLink, DSHS’ new computerized database which is just coming online, home studies will be completed within the system. This will create an automated, rather than paper-based, document and will make it easier for the agency to monitor completion of home studies and to include ticklers to staff to remind them of steps that still need to be completed to finish a home study.

Ultimately the success of relative placement starts with identifying relatives at the front end of the dependency process. This hinges on the cooperation of the parents and early efforts by agency social workers to follow up on leads about potential relatives who could help care for a child. Washington State law⁶¹ provides that at the shelter care hearing⁶² the court will inquire into what efforts have been made to place the child with relatives. Individual judges and commissioners have the discretion to ask parents for information to assist in identifying relatives. However, in other states this is taken a step further and parents are notified of specific consequences if they do not identify relatives for placement and provide names, addresses and other contact information within a short specified period of time.⁶³

- **Expansion of Family Team Decision Making**

In recent years, DSHS has incorporated into its decision making process a variety of “shared planning meetings and staffings” to support the safety, permanency, and well-being of children. Among these are Family Team Decision-Making Meetings (FTDMs) which are designed to increase family and community involvement in a case.⁶⁴ FTDMs draw from a large community of participants and may include relatives, family friends, service providers, community professionals, and the DCFS social worker and supervisor. FTDMs occur when a placement decision needs to be made.

While the Ombudsman supports the agency’s efforts to incorporate families into decision making, OFCO is concerned about the number of caregivers who report they are not being invited, or encouraged to attend shared planning meetings. In 2007, the Braam panel commissioned a comprehensive survey of caregivers to gather information about their experiences to ensure that caregivers are receiving adequate support and training from DSHS. In the 2007 Survey of Foster Parents and Caregivers in Washington State, 40% of caregivers interviewed reported that they rarely or never received timely notification of shared case planning meetings at least five days in advance.⁶⁵ In the follow up survey results released in 2008, there was a slight

⁶¹RCW 13.34.065(4).

⁶² A shelter care hearing must be held within 72 hours. The court determines the need for shelter care (temporary out-of-home placement of the child) based on the health, welfare, and safety of the child. RCW 13.34.065(4).

⁶³ For example, Colorado requires parents to provide within 15 days the names and addresses of relatives with whom the child may be placed. Parents are advised that if the parent fails to identify these relatives in a timely manner, the child may be placed permanently outside of the home of the child’s relatives and that the child may risk life-long damage to his or her emotional well-being if the child becomes attached to one caregiver and is later removed from the caregiver’s home. Colo. Rev. Stat. 19-3-403(3.6(a)(I)). The law also authorizes the court to order the child welfare agency to make reasonable and timely efforts to contact such identified relatives within 90 days of the hearing unless there is a showing of good cause not to contact the relative. For a discussion of Colorado law and other selected state kinship efforts, see: <http://www.ncsl.org/programs/cyf/kinshipenact.htm>

⁶⁴ <http://www1.dshs.wa.gov/pdf/Publications/22-1171.pdf>

⁶⁵September 2007 “Benchmark Report for the 2007 Survey of Foster Parents and Caregivers in Washington State” may be accessed at: http://www.braampanel.org/ParentSurvey07_Benchmark.pdf

improvement, with 37% reporting they never or rarely received notification of shared planning meetings at least five days in advance.⁶⁶

- **Relative Visitation**

In OFCO's 2005 Annual Report,⁶⁷ we recommended that DSHS provide ongoing contact between dependent children and their relatives when that relative has an established relationship with the child. We noted that state law at that time did not create an explicit right for relatives to have contact with these children, even when the contact was mutually desired. Visitation was largely left to the discretion of the agency and the court.⁶⁸

In 2008, the state Legislature passed SSB 6306 which provided a procedure for relatives to petition juvenile court to obtain visitation rights with children.⁶⁹ OFCO testified in support of the intent of SSB 6306 because we recognize that by providing relatives a mechanism for securing visits, they can be a source of love, strength and support to children whose ties to their parents have been severed. Under the new law, a dependent child's relative may petition juvenile court for visitation if:

- The child has been found dependent;
- Parental rights of both parents have been terminated;
- The child is in the custody of DSHS or a private child placing agency; and
- The child has not been adopted and is not in a pre-adoptive home or other permanent placement when the petition is filed.

Visitation may be granted if these criteria are met and the court finds it is in the best interest of the child⁷⁰ and that visits would not present a risk to the health, welfare, or safety of the child.

OFCO is encouraged by this new law. It signifies an important step forward by recognizing the importance of maintaining relationships between children and their relatives even when children may no longer have a legal relationship with their parents. However, as discussed in our Recommendations section below, we believe the dependency laws should further encourage relatives to play a vital role in the life of these children by encouraging visits long before termination occurs. Indeed, OFCO is concerned that if a relative has not had ongoing contact with a child prior to termination, the relative's chances for having contact after termination are diminished.

Rationale for OFCO Recommendations

⁶⁶ September 2008 "Braam Outcomes for the 2008 Survey of Foster Parents and Caregivers in Washington State" may be accessed at: http://www.braampanel.org/ParentSurvey08_Outcome.pdf

⁶⁷ The 2004-05 OFCO Annual Report may be accessed at: http://www.governor.wa.gov/ofco/reports/ofco_2005_annual.pdf

⁶⁸ Despite the lack of an explicit right, DSHS policy provided that: "[the] child's social worker will discuss the monitoring of the child's contact with parents and relatives with the out-of-home care provider and ensure that the child's right to privacy regarding private telephone calls and uncensored mail is maintained."

⁶⁹ This was enacted into law and codified at RCW 13.34.385.

⁷⁰ In determining "best interest", the court must consider at a minimum: a) The love, affection, and strength of the relationship between the child and the relative; b) The length and quality of the prior relationship between the child and the relative; c) Any criminal convictions for or founded history of abuse or neglect of a child by the relative; d) Whether the visitation will present a risk to the child's health, welfare, or safety; e) The child's reasonable preference, if the court considers the child to be of sufficient age to express a preference; and f) Any other factor relevant to the child's best interest. RCW 13.34.385(3).

While there are some promising programs within DSHS, many of the improvements have not been implemented state-wide or are simply too new to gauge their effectiveness. This means that some regions of the state are faring better than others. Because many of these are fledgling programs, it will take some time for the Ombudsman to see the benefits of these programs translating into reduced complaints to OFCO by relatives.

The Ombudsman also finds that social work practice too often does not live up to the laws and policies on the books. Unfortunately, there can be a strange disconnect between the intent of laws and policies to encourage relative involvement and/or placement and the practice of agency workers. OFCO hears from relatives who complain that the agency never considered them as a placement resource for children, or that they were never notified of, or included in, important decision-making meetings about the case plan for the child despite repeated efforts to contact the agency and be involved.

A Relative Excluded from Involvement

A grandparent contacted OFCO after discovering that her grandchild had been placed in foster care three months previously following the arrest of one of his parents. The grandparent heard about this via a news report about the parent's long-term prison sentence. The child's other parent was no longer alive, and the grandparent had since been cut off from contact with the family. The grandparent immediately contacted DCFS upon hearing the news, and was told that the child had been placed with a distant relative on the other side of the family. The grandparent wanted to have contact with the child and be considered for placement, but the agency did not offer either of those options. Upon contacting the agency, OFCO found no clear rationale as to why the grandparent had not been contacted when the child came into care (other relatives who had the grandparent's contact information had been contacted) and why this relative was not now being included in planning for this child's future. Following OFCO intervention, the agency arranged for the grandparent to attend a Family Team Decision Making meeting, and began the process of considering the grandparent for permanent placement of the child.

A Relative Passed Over for Placement

A grandparent contacted OFCO concerned about DCFS's decision to place an infant grandchild in foster care rather than with family. Both the infant and the parent had tested positive for drugs at the child's birth, and DCFS arranged for them to enter a drug treatment program together as soon as an opening became available. In the interim, the parent entered into a voluntary placement agreement for the baby to be cared for by the grandparent. When a bed became available, the grandparent expressed concern about safety risks to the child given the parent's history of high-risk behaviors and quitting treatment. The agency assured the grandparent that should the parent choose to leave the program, the baby would not be released to the parent's care.

A few days later, the parent left the treatment program with the two-week old infant. The parent relapsed and exposed the child to an extremely hazardous situation. Once again, the grandparent immediately sought to care for the baby. Due to the grandparent's statements of concern about both the parent's and the agency's failure to ensure the child's safety while under their supervision, the grandparent was viewed by the agency as "disruptive and confrontive" (the agency used this description in its documentation) and unsupportive of reunification. The baby was placed in foster care.

The grandparent reported to OFCO that when the family requested visits with the baby, they were told that the relatives had no rights with regard to this child. Visits were denied, but since the grandparent had requested placement, the agency requested that the grandparent undergo a psychological evaluation and a home study. The home study approved the grandparent for placement, as did the psychological evaluation. The psychologist recommended family therapy for the grandparent and parent to address issues that would arise in the course of this placement. The agency planned to recommend to the court that the therapy proceed "successfully" for at least one month before it would consider placing the infant with the relative, and expressed concerns about disrupting the 3-month-long placement of the child with the foster parents.

OFCO intervened at this juncture to ensure that the Department accurately presented all of the assessments to the court, which would make the final decision, and requested that visits between the relative and the child begin immediately. This was accomplished. Nonetheless, more than two months passed before visits were arranged, and more than five months passed before the baby was placed with the grandparent.

Even once the agency places a child with relatives, relative caregivers communicate to OFCO ongoing hurdles and frustrations created by DSHS. They cite the agency's failure to provide them with copies of the agency's Individual Service and Safety Plan ("ISSP") and notice of court hearings about the child. When they are informed about a hearing, they may not be told that they have the right to submit a caregiver's report to court or that it should be filed and distributed. Relatives also complain that they do not receive from the agency adequate services to help stabilize and maintain placements of children with challenging behaviors, developmental delays, or special medical needs.

Willing and Able Relative Thwarted in Caring for Children

A grandparent contacted OFCO after becoming frustrated with the bureaucracy involved in her attempts to provide care for her two grandchildren, ages 1 and 3, who had been removed after their parent was arrested for manufacturing methamphetamine. She requested placement of the children immediately, but the agency needed to do the necessary background checks and relative home study, so the children were placed in foster care.

It took over two months for the children to be placed with their grandparent. In the interim, they became ill from exposure to other sick children in the foster home. Once the children were in her care, the grandparent made numerous requests to the CPS worker for paperwork and other necessary arrangements to enable her to seek medical care and other needed services for the children. The CPS worker was unresponsive. As soon as the case was transferred to CWS, the grandparent reported that the level of service she received was so superior it was “like night and day”.

Relatives report that their advocacy for the children in their care is often misinterpreted. They state they are accused of failing to cooperate with the case plan or of undermining reunification efforts with parents when they are seeking to access services, protect the child, or make sure the permanent plan is moving forward. OFCO has reviewed and investigated a number of cases in which the vocal and tenacious efforts of relatives to secure more services or to express concerns about the permanent plan for the child have led to removal of the child from the relative’s home. This has happened, to heart-breaking effect, even in cases where the child has been in a relative’s care for several years.

Relative Receives Little Support

The relative caregivers of a 3-year-old dependent child, with developmental delays, contacted OFCO after becoming frustrated with DCFS’s lack of response to their repeated requests for specialized equipment recommended by the child’s health care providers. The agency had also failed to approve the child’s attendance at a preschool program that could address the child’s special needs, which had also been recommended by the child’s providers. The child had been born drug-affected and had been in the relatives’ care since birth. The relatives wanted to adopt the child if the child became legally free.

OFCO found that CWS communicated poorly with the relative caregivers and unfairly questioned their representation of the child’s significant needs and their intention to adopt the child. OFCO requested that the funding requests be given priority attention and be fairly considered. After OFCO intervention, CWS approved the requests for the specialized equipment and the preschool program. CWS also prioritized permanency planning for this child and, cooperated with the adoption home study specialist who approved the home study. The child became legally free less than a year later.

The Ombudsman has also reviewed many cases in which children have been removed from relative care when there is no evidence of abuse or neglect of the child by the relative. Even after the relative has been cleared by a CPS investigation that concludes the allegations were unfounded or inconclusive, these children may not be returned to the relative caregiver:

A Relative is Threatened with Removal of Child

A relative contacted OFCO after DCFS threatened to remove a 2-year-old dependent child from the relative's care. A new agency had recently been assigned to arrange and supervise visits between the parent and the child. The new agency's poor communication with the relative and the child's day care provider, where the child was picked up for visits, caused the relative and the daycare to be confused and concerned about the child's safety. These concerns were appropriately raised by both parties with DCFS, and OFCO found that rather than addressing the poor communication by the new supervising agency, DCFS threatened to remove the child if the relative did not begin cooperating.

OFCO verified with DCFS that the relative had been fully cooperative with parental visits until the new private agency was assigned to the case. OFCO recommended that DCFS work to ensure that the relative and the day care center were fully informed about visitation arrangements. The problems were resolved, and DCFS stopped threatening to remove the child.

Unreasonable Removal from Relative Care

A grandparent contacted OFCO after her two dependent grandchildren, ages 7 and 8, were removed from the grandparents' care. The children had lived with the grandparents or with their parents on the grandparents' property, much of their lives, but were officially placed with the grandparents by CPS ten months previously due to concerns of abuse and neglect by one of the parents. The precipitating event for the children's removal from the grandparents was a CPS referral alleging that the 7-year old had ridden a motorized dirt bike on the family farm unsupervised, and that the children were having unsupervised contact with the other parent, who lived on the property. The grandparent had recently been told by CWS to supervise the children on their bikes at all times, as the older child had had an accident a year previously.

The agency removed the children from the grandparent and placed them in a 20-bed group receiving home two hours' drive away from the grandparents' home while CPS investigated the allegations of neglect. In the course of the investigation, the grandparent sought to reassure CPS that the child was wearing a helmet while riding the motorbike and that the grandparent accompanied the child in the car when the child was riding the motorbike outside of the yard. The agency conceded that it could not substantiate the claims that the children were having unsupervised contact with one of the parents and, in fact, there was evidence to refute this. The findings were inconclusive for neglect (lack of supervision).

Despite the inconclusive finding, the agency did not return the children to the grandparent's care. OFCO's investigation concluded that the neglect allegations were insufficient to warrant the children's removal. There were no credible, immediate safety concerns to justify the trauma to the children caused by removing them from their primary caregivers and there was not sufficient justification for continuing to keep them out of the home of their grandparent. OFCO intervened by requesting review of this decision by CA Headquarters. Headquarters reached the same conclusion and almost two months later, the children were returned to their grandparent's care.

Recommendations:

- **Stabilize and maintain relative placements through greater scrutiny of agency decisions to remove children, and by improving communication & access to services**
 - **Prohibit removal of children from relatives unless CPS has received a credible referral alleging abuse or neglect that presents an imminent risk of harm or the relative has violated a court order.**

The Ombudsman is concerned by the agency's removal of children from relative placements in situations where there has been no abuse or neglect and no finding that the relative has clearly violated a court order. Sometimes, the agency has removed children from long term (2 or more years) placements without sufficient cause. This has been devastating to relatives and children alike and many of these decisions have appeared arbitrary and capricious.

- **Improve access to services by expanding the Kinship Navigator Program**

Relatives complain to the Ombudsman that they have difficulty accessing services for the children in their care, especially respite care and counseling. They also face hurdles receiving authorization and payment for specialized equipment to assist special needs children, even when the need has been substantiated and documented by other professionals. Unfortunately, by the time a relative contacts OFCO, the situation may have reached a crisis level and the placement is in jeopardy. Either the relative feels "burned out" by not having enough agency support to maintain the placement, or the agency has decided that the relative has exaggerated the child's needs and is simply ill equipped to care for the child.

The Kinship Care Navigator Program, a concept which arose out of recommendations made by the WSIPP Kinship Care Report and by the Kinship Workgroup, goes to the heart of this issue. It provides a vital service to relatives by providing information about how to navigate the social service system and access information about services, laws, policies, and procedures. According to DSHS:

In fiscal year 2007, the two Kinship Navigator Program sites served 728 grandparents and other relatives who were caring for 1901 children with a total of 2083 navigation/ assistance services. Seventy-two percent of those served were grandparents and also over sixty years or older. Forty-two percent of the relatives served were Black/African American, 49% were White and 9% were Native American. Eighteen percent of those served were of Hispanic/Latino ethnic origin.⁷¹

Since the formation of the two initial pilot sites in Seattle and Yakima, 4.5 additional navigators have been created for a total of 7.5 navigators. The current navigator sites serve both Eastern and Western Washington and are located within the Area Agencies on Aging (AAA) within DSHS.

The Ombudsman supports the goal of eventually having at least one Navigator in every AAA geographic area. Each county in the state of Washington is served by an AAA office, with some AAA offices serving multiple counties.⁷² Towards this goal, we believe it is essential to not only maintain funding for existing navigators but to provide additional funding for new navigator positions.⁷³ The availability of Federal dollars for this program through the newly enacted Fostering Connections to Success Act should be explored.

⁷¹ <http://www.aasa.dshs.wa.gov/about/factsheets/kinship%20navigators%20fact%20sheet%2012-07.doc>

⁷² For a list of Washington Area Agencies on Aging and the counties they serve, see http://www.carewashington.org/list10_wa_Aging_Services_senior_centers.htm

⁷³ The Children's Home Society Advocacy group is requesting in 2009, funding for an additional 2.5 – 3.5 Navigators: \$85,000/Navigator x 3.5 = \$297, 500 x 2 years = \$595,000 + \$40,000 for administration at the state level = \$635,000.

- **Develop and implement clear strategies to improve communication with relatives so that they feel valued and are clear on respective roles of agency and relatives in dependency proceedings**

Many of the problems seen by the Ombudsman relate to poor communication and to caregivers and the agency not fully appreciating the role that each entity brings to the dependency process. Relative caregivers report that they do not feel the agency respects their role in caring for dependent children. Feelings of disrespect are fueled by poor communication or lack of communication altogether between the agency and the caregiver. This can lead to the agency and caregivers assuming the worst of motives in each other and a further deterioration of the relationship.

There is natural tension between the differing roles of DSHS and caregivers. In many of the cases the Ombudsman investigates, the agency is intolerant of relatives or other caregivers who demand time of the agency by questioning agency practice, or advocating for the child. This is particularly so when the direction of advocacy runs counter to what the agency believes is in the child's best interest or is not considered practical and available given the constraints of time, energy, and money. In one case reviewed by the Ombudsman, this even led DCFS, Child Welfare Services to make a CPS referral alleging that the caregivers (in this case, a foster care provider, rather than a relative) who had consistently provided excellent care for a now almost 3 year old dependent child, were in violation of nurturing/care licensing requirements because they did not agree with the agency's decision to remove the child from their care and send the child out of state to relatives the child had never met. The foster parents had consulted with professionals about the impact this would have on the child and sought to have this information presented to the court. Although the allegations in the referral were found to be invalid, it was enormously stressful for the caregivers to be subjected to a CPS investigation while they were simultaneously coping with the loss of a child they had hoped to adopt.

Relatives may view the agency's required monthly health and safety checks of the child in their home as an "intrusion" into their home and family life. They are offended by the agency questioning their ability to care for a child they may have spent years raising and they dislike what they view as agency intolerance of their family customs and practices. Relatives must be clear that the agency has a duty to monitor the health and safety of a child in out-of-home placement. By necessity, this means in home visits with the child, interviewing the child outside the presence of the caregiver, and sometimes asking probing questions if it seems necessary based on the child's behavior, the condition of the home, or reports by third parties that raise concerns.

Sometimes the agency's efforts to comply with their statutory duty to safeguard dependent children can feel heavy-handed. The following service episode record (SER)⁷⁴ from a case OFCO investigated illustrates an attitude of the agency social worker that was considered offensive by relatives. They viewed the agency as having an overly proprietary attitude toward their family's child:

Spoke with [relative] regarding her criminal history. Told her that the children are the SW's children. SW is looking for someone who the SW can trust and meet the needs of children and follow the court orders and set the boundary with the parents. The SW may contact her employer for her reputation of caring for children. The SW would also do a home visit to her place herself. [The relative] stated that SW had visited her place already. The SW told her that [she] is a covering SW while the assigned SW is on vocation [sic]. The assigned SW wanted to do one more home visit. [The relative] is upset and called the SW's supervisor to complain.

(italics added.)

⁷⁴ Service episode records document the DCFS social workers work on the case, including contact with parents, caregivers, and service providers.

Poor communication can be alleviated with common courtesy such as returning phone calls and e-mails on a timely basis. The agency needs to remember to give the caregiver reasonable notice of hearings⁷⁵ and staffings and assure them that their input to the agency and the court is valuable. DCFS can also facilitate providing the court and parties with copies of the caregiver's report.

Workers need to be responsive to caregiver requests for appropriate services and funding so that frustration levels do not build. The agency should use regular health and safety checks of the child as an opportunity to not only check on the child's well being, but to establish a relationship of trust and communication with the caregiver long before a problem arises, so that the caregiver feels free to raise questions or concerns.

RCW 13.34.130(6) provides that any placement with relatives is contingent upon cooperation by the relative with the agency case plan, compliance with court orders and any other conditions imposed by the court related to the care and supervision of the child including contact between the parent and child and sibling contacts. If the relative does not comply with the case plan or court order, the agency may remove the child from the relative's home, subject to review by the court. Relatives need to be well informed by the agency about the importance of complying with court orders and cooperating with the case plan. On the other hand, when relatives advocate for the child in their care, this should not be readily mistaken for lack of cooperation with the case plan.

- **Improve notice and opportunity to be heard for relative caregivers**
 - **Provide adequate notice of shared planning meetings and hearings**
 - **Provide relatives with a minimum of 5 days written notice prior to a child being removed from their home and ensure that the notice explains the reasons for removal of the child**

Relatives should be provided with a minimum of 5 days written notice prior to the removal of a child from their home, just as the agency provides foster parents.⁷⁶ RCW 74.13.300(1) requires that: "Whenever a child has been **placed in a foster family home** by the department or a child-placing agency and the child has thereafter resided in the home for at least ninety consecutive days, the department or child-placing agency **shall notify the foster family at least five days prior** to moving the child to another placement" (emphasis added.) The goal of this provision is to minimize disruption to the child in changing foster care placements.⁷⁷ The only exception to this requirement is if: (a) A court order has been entered requiring an immediate change in placement; (b) The child is being returned home; (c) The child's safety is in jeopardy; or (d) The child is residing in a receiving home or a group home.⁷⁸ It is inexplicable that current law does not provide for such notice, when it requires that placement with relatives be prioritized by child welfare agencies.

⁷⁵ In the September 2007 "Benchmark Report for the 2007 Survey of Foster Parents and Caregivers in Washington State," 24% of caregivers reported that the agency rarely or never notified them about court hearings for the child, in a timely way, within 10 working days prior to court hearings; and 37% reported that the agency rarely or never advised the caregiver that they had an opportunity to be heard at these hearings. See pp. 16 - 17 of the report at http://www.braampanel.org/ParentSurvey07_Benchmark.pdf. In the 2008 Survey, which asked caregivers about notification in 2007, 25% of caregivers reported rarely or never receiving 10 day notice prior to court hearings; and 36% reported rarely or never being advised by the agency about their opportunity to be heard. See pp. 18 - 19 of the 2008 Survey report available at: http://www.braampanel.org/ParentSurvey08_Outcome.pdf

⁷⁶ RCW 74.13.300(1).

⁷⁷ RCW 74.13.300(3).

⁷⁸ RCW 74.13.300(1)(a) – (d).

Relatives should not have to engage in guesswork to figure out why a child is being removed from their care. Unless it would compromise a CPS or law enforcement investigation, the agency should provide the relative with a clear, written explanation as to why a child is being removed from their home and be able to substantiate this.

- **Provide relatives with the right to an administrative review process when children are removed from their care**

Relatives are not currently provided an administrative review if they wish to contest the agency's decision to remove a child from their care. In general, a commonly held principle of law is to grant individuals who have been deprived of important rights, due process by which to contest such a loss. For example, a child care or foster care provider who has a license denied, revoked, suspended, or modified has the right to challenge the agency's decision and have the decision reviewed in a hearing before an Administrative Law Judge.⁷⁹ It stands to reason that relatives who have had a child placed in their care for 6 months or longer should have the right to request a timely review of the agency's decision. This could be accommodated either through an internal agency grievance process and/or by providing relatives with the right to an administrative hearing if the matter cannot be resolved by the agency's internal review of the matter.

- **Allow relatives who have an established relationship to play a meaningful role in the lives of dependent children**
 - **Expand the reach of newly enacted law to allow relatives who have an established relationship with a dependent child placed out of the home to petition the court for visitation when visits are mutually desired by the child and relative.**

Newly enacted RCW 13.34.385 provides relatives with the right to petition juvenile court for reasonable visitation with a child whose parents' rights have been terminated. This law became effective in June of this year, 2008, so it is too soon to tell to what extent it will effectively address what has been a common complaint -- the lack of contact between relatives and children in the foster care system. Some relatives feel as if they have wrongly being punished for the deficiencies of the parents by having their relationship with these children severed as well.

The new law does not address visitation between relatives and dependent children whose parents' rights have not been terminated. The Legislature should give consideration to extending the reach of this new law so that relatives are provided a legal procedure to petition juvenile court for unsupervised visitation with dependent children who have been placed out of the home, but whose parents' rights have not been terminated. This would be appropriate when the child is placed out of the home, the relative has had an ongoing relationship with the child, contact is mutually desired, and it would be in the best interest of the child.⁸⁰

- **Authorize all persons who have cared for a child within the last 6 months prior to a review hearing to provide a report to the court.**

The Adoption and Safe Families Act (ASFA), passed by Congress in 1997,⁸¹ provides that caregivers (relatives and foster parents) must be provided notice of, and the opportunity to be heard in, any review or hearing to be held with respect to the child. **Current** caregivers in Washington may provide the court with a caregiver's report. The agency and the courts need to consistently recognize that caregivers can be a source of invaluable first hand information about a child. The Ombudsman believes it would be useful to allow not only current

⁷⁹ RCW 74.14.130(2); RCW 43.20A.205; WAC 388-148-0105.

⁸⁰ This would not affect a parent's rights to raise objections to the visitation at a hearing on the petition.

⁸¹ The Adoption and Safe Families Act of 1997, Pub.L. No 105-89, 111 Stat. 2115, amending 42 U.S.C. §§671-675.

caregivers, but all caregivers who have provided care to the child within 6 months of a review hearing to provide a report to the court, unless the child has been removed from that caregiver because of abuse or neglect by the caregiver.

- **Clarify ambiguity in the law governing relative placement preference**
 - **Ensure that language in statute and governing regulations and policies is consistent as to “relationship” between child and relative.**

RCW 13.34.160 plainly states a preference to place a child with a relative **“with whom the child has a relationship and is comfortable.”**⁸² The Washington Administrative Code (WAC) implementing the law states in pertinent part, “The department reviews and determines the following when selecting a relative placement: (b) The relative has **a potential relationship with the child.**”⁸³ The practical effect of this language is to broaden the preference for relative placement so that even if a child has never met a relative and has no relationship with that relative, the agency will prioritize this placement over a non-relative caregiver. This may occur even in instances where the child has been living in a non-relative placement for a lengthy period of time (well over a year). The variation in the language between statute and regulation has been brought to the attention of the Ombudsman by many citizens who have contested placement moves for children. This discrepancy needs to be resolved by the Legislature and the agency so as to avoid confusion.

Conclusion

The goal of these recommendations is to avoid the prolonged uncertainty and inherent instability that seems to characterize too many placements of dependent children. This has a detrimental effect on the psychological well being of the children in care and leads to the loss of family members who would like to be a resource for these children.

⁸² RCW13.34.160(1)(b).

⁸³ WAC 388-25-0445 (emphasis added.). see also CA Practices and Procedures Guide, section 4527 at http://www.dshs.wa.gov/ca/pubs/mnl_pnpg/chapter4_4520.asp#4527

LIVE UP TO THE PROMISE OF GREATER PERMANENCE FOR CHILDREN

Recommendation: Comply with Permanency Timeframes in the Adoption and Safe Families Act (ASFA) of 1997

Background

In 1997, Congress enacted the Adoption and Safe Families Act¹⁰⁰ (“ASFA”) in response to growing concerns about the length of time children were remaining in foster care. This law reformed the child welfare system to prioritize child safety, permanence, and well-being over family preservation. Its intent was to increase the likelihood and the speed with which children in the child welfare system attain a permanent home. One of the key provisions of ASFA is the requirement that state child welfare agencies file a petition to terminate parental rights (or to support a petition filed by a third party) when a child has been in foster care for 15 out of the most recent 22 months.¹⁰¹

Multiple Agency Snafus Result in Delayed Permanence for Young Child

The Division of Children and Family and Services (DCFS), Child Welfare Services (CWS) unreasonably delayed permanence for a now 5 year old dependent child. The child was taken into protective custody and placed in out-of-home care at less than a year of age due to severe neglect, lack of supervision, and suspected physical abuse. The agency and/or court returned this dependent child to the care of the parent three times after the removal: the first time, for 7 weeks; the second time, for 1 month; and the third time, for 10 ½ months. Each time, the child had to be taken back into protective custody because the parent continued to violate court orders (e.g. not informing the agency of the parent and child’s whereabouts when the parent changed residences; allowing the child to have contact with inappropriate and unauthorized individuals); and would not comply with court ordered services to address mental health and other issues.

The same foster parents continued to accept the child back into their home. They wished to adopt the child if the permanency plan was changed to adoption. Months turned into years as CWS delayed terminating parental rights. OFCO found gaps in the agency’s documentation of its work on the case and delays in conducting regular health and safety checks on the child. The caseworker acknowledged to OFCO that the worker was overwhelmed, was working under an excessive caseload of close to 40 children, and could not keep up with the responsibilities of the case.

The parent continued to violate court orders, including the terms of visitation. Parent-child visits continued despite evidence of trauma to the child manifested by emotional outbursts, nightmares, and other concerning behaviors following visits. Visits were eventually curtailed when the guardian ad litem filed a motion which the court granted. The foster parents helped secure therapy for the child to address the emotional upheaval and uncertainty in the child’s life. The agency declined to fund this therapy but eventually agreed to after much perseverance by the foster parents and service provider.

The Ombudsman contacted the Area Administrator and requested a review of the case as well as the high caseloads in that DCFS office. **The child’s permanency plan was changed to adoption**, and CWS sent a referral to the Attorney General requesting that a petition for termination of parental rights be filed.

Even with the enactment of this ground breaking law more than a decade ago, the Ombudsman finds there is an institutionalized practice of delayed permanence for children in the child welfare system throughout the State of Washington. Each year, OFCO receives a growing number of complaints related to permanency.¹⁰² As in previous years, the **welfare and permanency of dependent children remained our third-highest category of complaints.**¹⁰³ Among these complaints, issues that involved **inappropriate permanency plans or delays in permanency saw the sharpest increase – an increase of 62% since 2006.**¹⁰⁴

We find that practice in the State of Washington is not living up to the promise and intent of ASFA articulated by the U. S. Department of Health and Human Services (“DHHS”). DHHS is the Federal agency responsible for providing guidance to States in implementing ASFA and integrating it into their child welfare system. DHHS instructed States that the following “key principles . . . must be considered in order to implement the law”:

- **The safety of children is the paramount concern that must guide all child welfare services.**
- **Foster care is a temporary setting and not a place for children to grow up.**
- **Permanency planning efforts for children should begin as soon as a child enters foster care and should be expedited by the provision of services to families.**
- **The child welfare system must focus on results and accountability.**
- **Innovative approaches are needed to achieve the goals of safety, permanency and well-being.**¹⁰⁵

Moreover, practice in our State does not adequately reflect the priorities of State law which declares: “The right of a child to basic nurturing includes the right to a safe, stable, and permanent home and a speedy resolution of any proceeding under this chapter.”¹⁰⁶

Rationale

In preparing for this section of the annual report, we talked to a wide variety of stakeholders to gather their thoughts and opinions about what is creating impediments to permanence and what seems to be working in areas of the State that are managing to move cases toward a permanent plan on a timelier basis.¹⁰⁷ Perhaps more than other areas investigated by OFCO, the issue of permanence seems to fall victim to shortcomings that cut across multiple systems: the child welfare agency, the courts, representation by attorneys (defense and

¹⁰² For purposes of data calculation, OFCO groups together complaints related to health, well being, and permanency. This category includes issues of: inappropriate change of child’s placement, inadequate transition to new placement; failure to provide child with medical, mental health, educational or other services, or inadequate service plan; inappropriate permanency plan or unreasonable delay in achieving permanency; failure to provide appropriate adoption support services, other adoption issues; inappropriate placement/inadequate services to children in institutions and facilities.

¹⁰³ These issues increased even more sharply (by 46% since 2006) than child safety and family separation issues. OFCO received 299 complaints out of 1170 complaints over the two year period of 2007 and 2008.

¹⁰⁴ These accounted for 29 complaints in 2006; 33 in 2007; and 47 in 2008.

¹⁰⁵ These principles were set forth in a “Program Instruction” issued on January 8, 1998 by the U.S. Department of Health and Human Services, Administration of Children, Youth, and Families. Its purpose is to inform States of new legislation and provide guidance on implementing the new law. See http://www.acf.hhs.gov/programs/cb/laws_policies/policy/pi9802.htm

¹⁰⁶ RCW13.34.020.

¹⁰⁷ In October, November and December 2008, Linda Mason Wilgis, Ombudsman, interviewed a variety of DSHS, Children’s Administration administrators and supervisors; a court administrator; Assistant Attorneys General; and a Parents Representation Managing Attorney collectively representing Regions 1, 3, 4, and 6. It is important to note that this was not meant to be a comprehensive survey, but rather to gather a cross section of perspectives from the Eastern and Western sides of the State.

Assistant Attorney General) and guardians ad litem. This much is clear from OFCO's interviews and investigation of specific cases: the problem is complex, it is multi-systemic, and different regions have different strengths and shortcomings. Nonetheless, certain lessons emerged from these conversations when we were able to find common problems identified and conversely, certain common threads of success. Here is what we learned:

Problems

Inadequate Court Resources and Attorney Support

In many regions of the State there are too few judicial resources to handle the volume of dependency and termination cases. Courtroom space is scarce and the judges or commissioners to hear the cases are even scarcer. This leads to delays in setting hearings to address contested issues and in setting cases for termination trial. Additionally, some DCFS offices have complained of inadequate attorney support within the Office of the Attorney General, resulting in delays in one jurisdiction of up to a year between DCFS making a referral to the AGO requesting that a termination petition be filed, and the actual filing of that petition by the AGO.¹⁰⁸ At times, supervisors expressed bafflement over the prioritization for termination petitions being filed, stating that some referrals would sit for long periods of times, while others that had only recently been submitted to the AGO were promptly filed. This suggested to the Ombudsman that some DCFS offices need better communication with their AGO and a better system for keeping track of referrals for termination.¹⁰⁹

A significant change implemented by ASFA was a shift in the time frame for the permanency planning hearing from 18 months to 12 months.¹¹⁰ It is difficult to achieve these timeframes if there are not sufficient courtrooms or human capital.

Judges are Focused on the Interests of the Parents Rather than the Best Interest of the Child

Assistant Attorneys General and DCFS staff have described the legal pendulum as swinging away from the child's best interest to the interests of the parent. They have complained of judges who accept the testimony of parents with drug/alcohol problems and mental health issues even when it directly contradicts the testimony of neutral professionals, social workers, and CASA/GALS.

¹⁰⁸ This particular jurisdiction reported that this situation had improved over the last several months.

¹⁰⁹ It should be noted that several DCFS offices reported excellent relationships with their AGO and stated that they are kept regularly informed about the status of referrals for terminations and that their AAGs are very responsive to their needs.

¹¹⁰ ASFA, sec. 302.

Now 6-Year-Old Child Still Lacks Permanence After Life in Out-of-Home Care

Investigative finding:

CWS delayed permanency with regard to a 4-year-old dependent child who had been in out-of-home care in a relative placement since birth. Although the Ombudsman found that this was the result of multiple factors not clearly or solely attributable to CWS, CWS inappropriately changed the child's permanency plan to reunification with the parent from its former primary plan of adoption. Although the parent had completed some services, and some service providers had recommended reunification, other professionals believed that the parent had not adequately corrected parental deficiencies, and that the child's more than four-year (life-long) placement with the relatives had resulted in a primary attachment that would be too traumatic to disrupt.

The parent was believed to have relapsed into drug use, was not cooperating with the visitation transition plan, and was living with a convicted felon whom she was allowing to have contact with the child despite a court order prohibiting this individual to have contact with children. Moreover, the Ombudsman found that there had been poor communication between the AGO and the agency, which had affected the strength of advocacy for the agency in dependency court and a failure to provide all of the relevant information. There had been 8 different caseworkers assigned to the case in four years, resulting in a lack of continuity of case planning and management. Although a termination petition had been submitted to the AGO well over a year previously, no termination trial date had been set.

Ombudsman Action:

The Ombudsman contacted the Area Administrator and requested a review of the decision to change the permanency plan to return home. This review, as well as a review of the case by the community Child Protection Team resulted in the agency seeking a contested review hearing requesting that the permanency plan be revised to adoption rather than return home.

Outcome:

Over CWS's objections, the court retained the plan of return home and ordered that the child be transitioned to the parent, with whom the 4-year-old child had never lived. The court also refused to order that the parent produce urinalyses as evidence of sobriety.

Six months later, the case was heard by another judge after the original judge withdrew from the case. The new court returned the child to the relative placement after finding that the parent was in violation of court orders and not providing a safe and appropriate home environment for the child.

The child is now 6 years old, has lived with the relatives for all but six months of his life, and is still not legally free.

The Ombudsman has investigated a number of cases in which the court has returned children to the care of parents without requiring independent verification that the parent is remaining clean and sober. This has occurred even in cases where the parent has a long and clearly substantiated history of drug or alcohol abuse. The Ombudsman has also reviewed cases where the custodial parent is allowing the child to have contact with an individual who is court-ordered not to have contact with the child due to criminal history, including sex offenses against children. The agency has presented evidence to the court from more than one source substantiating that the parent is allowing contact. Yet, the court has accepted the parent's denial of this fact. On more than one occasion, children have narrowly avoided catastrophic consequences after their return to the parent.¹¹¹ The law is clear that when the rights of the parent conflict with the best interests of the child,

¹¹¹In one memorable case, two young children were returned to a parent who lived in an apartment complex in which a shoot-out occurred. During the police investigation, law enforcement established that the person whom the children

the best interests of the child prevail.¹¹² These decisions run counter to the priority in the law -- which is that **the safety of our children must come first.**

Child welfare practitioners are also dismayed when the court provides parents with repeated opportunities to comply with services after the child has been removed from the home for two, three, or even four years, without substantial progress by the parent. Some jurisdictions report going back in front of the same Judge two and three times, with each delay giving the parent another six months in which to attempt to comply with court-ordered services. Unfortunately, in some of the situations investigated by the Ombudsman, it appears that the court's decision to return the child to a parent has been driven by the court's impatience with the agency over delays in moving the case toward permanence, rather than by a clear finding that the parent has corrected the parental deficiency that led to the original removal.

Parties also describe certain Judges as being highly reluctant to terminate parental rights even when the State has demonstrated the elements of the termination statute by clear, cogent, and convincing evidence.¹¹³ When the Ombudsman countered that the agency had the right to appeal, they cited the length of time it took for the appeal process to run its course¹¹⁴ and indicated that in many of those cases it was easier to re-file the termination petition in the hope of drawing a different judge to hear the termination.¹¹⁵ These judicial practices have had the effect of delaying permanence and resolution of termination cases when it was unwarranted.

Placement Disruptions Cause Delay

DCFS is too willing to remove children from long term, stable placements. Even the discovery of a relative should not be a basis to remove a child from an approved, pre-adoptive placement when that child has been in the home for 15 months or longer. The agency needs to identify prospective relatives at the earliest date, and make every effort to place children with viable relatives at the outset.

We believe it is misguided for the agency to minimize the traumatizing effect of such placement moves. We have been told many times by the agency that although the child (and the family from whom the child is removed) may go through some grieving, the child will be just fine because the foster parent has done so well in making the child feel secure and loved in their current stable placement.

Failure to Appoint Counsel or a CASA/Guardian ad Litem for the Child

The Ombudsman finds that certain children in the dependency system continue to go unrepresented by a guardian ad litem or attorney despite Federal law which provides for such representation.¹¹⁶ Washington State law requires the court to appoint a guardian ad litem (GAL) for a dependent child unless the court finds for "good cause"¹¹⁷ that appointment is not necessary. If the child is represented by independent counsel in the proceedings, the duty to appoint a guardian ad litem is deemed satisfied.¹¹⁸ The degree of representation for children in Washington State varies tremendously from county-to-county because of the practice of having counties fund their own court proceedings. Some counties, particularly in the more rural areas, do not have

were not supposed to have contact with was in the apartment of the parent at the time and that this person may in fact have been the target of the shootout. The young children were thrown to the ground to avoid being hit by bullets that were shot into the apartment complex.

¹¹²RCW 13.3 et. seq.

¹¹³ RCW 13.34.180-190.

¹¹⁴ According to one AAG, it can take 18 months in Division 1, which covers Region 4.

¹¹⁵ Apparently this is in spite of Washington State's accelerated review procedures for dependency and termination appeals.

¹¹⁶ Child Abuse Prevention and Treatment Act (CAPTA), 42 U.S.C. §5101 et seq., which was enacted in 1974.

¹¹⁷ The good cause exception has been used broadly by Washington courts so that the "good cause" relied upon may not relate to the particular needs of the child, but instead to shortfalls in funding and availability in GALs.

¹¹⁸ RCW 13.34.100(1).

the resources to ensure that a child has some form of representation in court even when it comes to the most important of decisions.

In a 2007 report by First Star, the child advocacy group awarded our State an “F” for its poor performance¹¹⁹ on ensuring that children receive representation on matters before the court related to services, placement, and permanence.¹²⁰ Later in the year, the Washington State Supreme Court Commission on Children in Foster Care adopting principles calling for legal representation of all adolescents in foster care. Their recommendation was based on input from the Children’s Representation Workgroup, a broad cross section of child welfare stakeholders, who met over the course of several months and deliberated over the ingredients for meaningful and effective children’s representation.¹²¹ Legislative proposals were introduced, but not enacted, in 2008 to put into law some of these recommendations. The Ombudsman hopes and expects that this issue will be re-visited in the 2009 Legislative session.

If adolescents are provided an attorney who can advocate for them in the legal process, this helps to ensure that they are in a home that meets their needs and keeps them safe. These components facilitate long term stability and permanency. Attorneys can also advocate for adolescents to return to their biological parents when appropriate. Without legal counsel for adolescents, dependency cases can become like a rudderless ship that needs outside control and direction to right itself. Children must have a voice in court and someone to help them navigate the legal system.¹²²

Duplicative Services for Parents are Court Ordered

The Ombudsman finds that delayed permanence occurs as a result of duplicative services being ordered as to parents, particularly psychological evaluations. We believe this creates an unnecessary expenditure of time and money. Unless there is a compelling reason to have another evaluation of the parent, the court should not be granting motions or ordering on its own, duplicative services. It can take six to nine months in many jurisdictions to agree upon an evaluator, schedule the evaluation, and receive the results. Based on our review of the case record in these cases, we seldom have found a compelling reason to re-evaluate the parent. Re-evaluation should be used sparingly and only where there is a sufficient showing of a change of circumstance or other factors justifying a new evaluation.

Under ASFA, **reunification efforts are meant to be time-limited**. Services need to be offered intensively at the front-end of the dependency process and it is essential that these services be accessible, meaningful, and well targeted to the parental shortcomings. Reunification efforts are intended to be time limited so that permanency may be achieved sooner. Facilitating visitation between parents and children is a critical component of this. State law provides that visitation should not be limited unless it would adversely affect the

¹¹⁹ Washington State was one of 15 states that received a failing grade. The grades were based on assessing the law of the respective states, not practices. See “A child’s Right to Counsel, First Star’s National Report Card on Legal Representation for Children”, available at <http://cdm266901.cdmhost.com/cgi-bin/showfile.exe?CISOROOT=/p266901coll4&CISOPTR=564&filename=565.pdf#search=%22Star's%22>

¹²⁰ See May 4, 2007 article in the Seattle Post Intelligencer, entitled “Foster Care: Fix the F Grade” at http://seattlepi.nwsource.com/opinion/314406_kidlegaled.html; see also April 24, 2007 CBS news report entitled, “Advocacy Group: Abused Kids Need Lawyers” available at <http://www.cbsnews.com/stories/2007/04/24/politics/main2720070.shtml>

¹²¹ The Children’s Representation Workgroup formulated recommendations about appropriate children’s representation to the Washington State Supreme Court Commission on Children in Foster Care. OFCO was appointed to and participated in this workgroup.

¹²² Even in cases where parental rights have been terminated, the child can languish in the foster care system. An attorney or GAL who remains on the case even after termination of parental rights can be enormously beneficial to ensure the permanent plan is finalized on a timely basis.

health, safety, or welfare of the child.¹²³ Nonetheless, the Ombudsman continues to see cases where visits are not provided to parents due to the unavailability of visitation supervisors and OFCO has had mixed success in procuring make-up visits for parents.

DCFS Seldom Utilizes “Aggravated Circumstances” to Expedite Termination

Child protection workers, and attorneys from the defense bar and the Office of the Attorney General were united in their perspective that the fast tracking procedures provided for by ASFA and state law are seldom used to expedite selected cases with aggravated circumstances. Aggravated circumstances make it unlikely that services will bring about return of the child to the parent in the near future. Consequently, ASFA provides that States are not required to make “reasonable efforts” to reunify when the parent has subjected the child to “aggravated circumstances”¹²⁴ as defined by state law¹²⁵ or engaged in other acts set out by the Federal law, such as murder or having parental rights to a sibling terminated involuntarily.¹²⁶

Washington law includes as “aggravated circumstances”: rape of the child by a parent; conviction for criminal mistreatment of the child; assault of the child; a murder conviction related to murder of the child’s other parent, sibling, or another child; a finding by the court that a parent is a sexually violent predator; and failure of the parent to complete treatment, which has led to a prior termination of parental rights to another child.¹²⁷ This list may seem comprehensive. However, our State takes a more narrow view of aggravated circumstances than would be permissible under Federal law.¹²⁸ For example, ASFA provides that “chronic abuse” may be considered an aggravated circumstance,¹²⁹ but State law does not explicitly provide for this as a basis to expedite a termination.

We believe that one of the key reasons aggravated circumstances are seldom relied upon is that the Washington legislature modified the law many years ago to provide that “**Notwithstanding the existence of aggravated circumstances, reasonable efforts may be required** if the court or department determines it is in the best interests of the child.”¹³⁰ There is a concern that if the agency proceeds to a termination trial and it has not offered services to a parent, even when that parent has a particularly heinous history that constitutes an “aggravated circumstance,” that the case could be reversed on appeal for failure to make reasonable efforts.

The current discretion granted to the court to require reasonable efforts in aggravated circumstances cases has the effect of severely curtailing the usefulness of aggravated circumstances as a basis to expedite terminations. This was not the intent of Congress in enacting ASFA. ASFA carefully carved out certain categories of cases where the parent’s history makes it extremely unlikely that services could have a rehabilitative effect. In those limited circumstances, it was deemed appropriate to provide States with the ability to bypass the time and expense of offering services where it would be futile.

¹²³ RCW 13.34.136(2)(b)(ii).

¹²⁴ ASFA provides that States may include in their definition of “aggravated circumstances” abandonment, torture, chronic abuse, and sexual abuse. ASFA also lists as “aggravated circumstances”: the parent has committed murder or voluntary manslaughter of the child or a sibling (or aided murder or voluntary manslaughter), the child or a sibling is the victim of serious physical abuse by the parent, or when a parent’s rights have been involuntarily terminated as to the child’s sibling. ASFA. Sec. 101(a).

¹²⁵ ASFA, sec. 101(a); see RCW 13.34.132(4) for a list of aggravated circumstances.

¹²⁶ ASFA, sec. 101(a). Washington State includes “involuntary termination” in its list of aggravated circumstances.

¹²⁷ RCW 13.34.132(4).

¹²⁸ RCW 13.3.132.

¹²⁹ ASFA, sec. 101(a).

¹³⁰ RCW 13.34.132(4).

Promising Developments

In the process of preparing for this section of the annual report, the Ombudsman was struck by the number of sound recommendations that have been developed by various child welfare agencies, court systems, and non-profit entities to address a multitude of child welfare issues, including delayed permanence. It's difficult to know whether to be encouraged by this, or disheartened. On the one hand, it is heartening that people care enough about improving the lives of children to develop worthwhile ideas for reform. On the other hand, it is discouraging to take stock of a system that is still failing too many children despite so many worthwhile ideas. It begs the question about whether there is sufficient coordination between stakeholders so as to not duplicate efforts and bring these ideas to fruition.¹³¹ While there are a number of promising developments across the state, the following are a few that the Ombudsman is encouraged by based on feedback from participants, and observers of the juvenile justice system.

The Court Improvement Training Academy

In 2007, the Court Improvement Training Academy (CITA) got underway to help train judges, lawyers, and other professionals involved in the juvenile court dependency process. CITA is funded by a grant of federal Court Improvement Program money administered by the Washington State Administrative Office of the Courts. CITA describes itself as creating “learning opportunities [that] are centered around a philosophy which blends innovative interdisciplinary research and practical solutions to everyday problems faced in child welfare law.”¹³²

CITA has convened “Tables of 10,” a county-by-county training approach that brings together 10 leaders in the child welfare field from a particular county. To date, Tables of 10 have gathered in: Stevens and Ferry; Lewis, Kitsap, and Skagit Counties. Individuals for the Tables of 10 are drawn from the judiciary, legal bar, child welfare agency, CASA/GAL program, and community of professionals who provide services to dependent children. The group focuses on “results based outcomes” and they are asked to “choose a single data point to work on improving in the county and develop objective goals and implementation strategies as part of the program.”¹³³

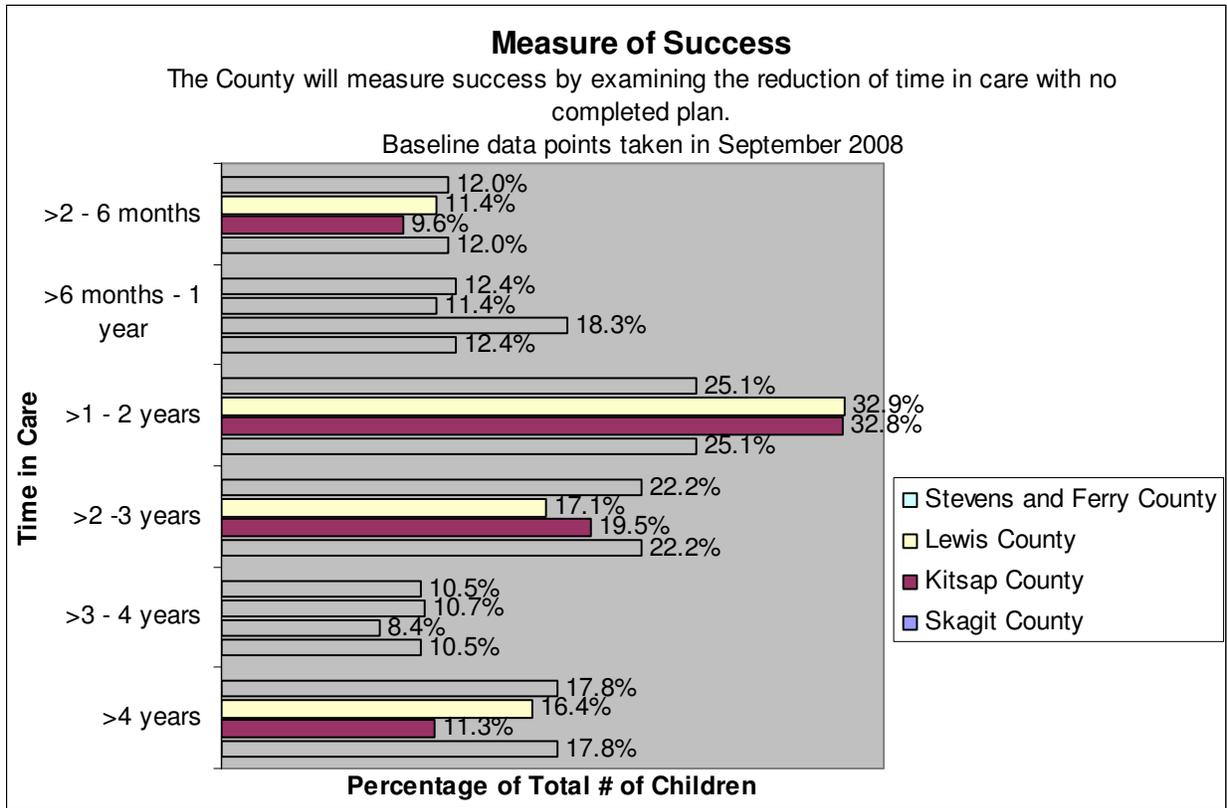
These counties selected as a “measure of success,” reducing the time in care for children with no completed plan.¹³⁴ They have self-reported their data on children in care and it should be noted that this data is not official and is for purposes of Tables of 10 training and improvement of their child welfare system:

¹³¹Ongoing work by the Center for Children and Youth Justice (CCYJ) is relevant to this issue. CCYJ is developing a “comprehensive database of 1,957 recommendations from 256 reports issued over the past 10 years issued by government panels, nonprofit organizations, task forces, etc. regarding the child welfare system.” See <http://www.ccyj.org/uploads/publications/CCYJ%20fact%20sheet.pdf>

¹³² <http://www.uwcita.org/index.html> <http://www.uwcita.org/index.html>

¹³³ <http://www.uwcita.org/CITAv1008/tablesoften.html>

¹³⁴CITA provides each “Table of 10” with quarterly training. <http://www.uwcita.org>



Source: <http://www.uwcita.org/index.html>

This data reinforces the Ombudsman’s concerns about children not having a permanent home soon enough. According to these counties, anywhere from approximately 61% to 81% of children have been in the system for more than a year without a completed plan; 36% to 51% have been in the system for more than 2 years without a completed plan. The Ombudsman commends these counties for taking an important step toward addressing the problem, which is to recognize that indeed there is delayed permanence for children and that this is unacceptable.

The Washington State Supreme Court Commission on Children in Foster Care

The Children’s Representation Workgroup, which was convened by the Washington State Supreme Court Commission on Children in Foster Care, is continuing its efforts to provide recommendations to the Commission on proposed legislation that would provide for legal representation of children age 12 and older. See additional discussion in this section of report under *Problems: Failure to Appoint Counsel or a CASA/Guardian ad Litem for the Child*.

Improved Parent Representation through the Office of Public Defense

The Office of Public Defense’s (OPD’s) Parent Representation Program is designed to improve defense representation of parents in dependency and termination cases.¹³⁵ The program is in place in 25 counties at this time. It has reduced the caseloads of defense attorneys so that they are at a manageable level, established improved standards of practice, and provided parents with greater access to support services, such as defense social workers, and access to funding for other services geared toward reunification of parents and children.

¹³⁵ <http://www.opd.wa.gov/>

Supporting Early Connections Pilot Project

Supporting Early Connections is a pilot project in Region 4 (Kent) that is funded by the Stuart Foundation¹³⁶ with other entities including DSHS and the Seattle-based Center for Children and Youth Justice (“CCYJ”).¹³⁷ It is geared toward reunification of young parents and children, ages 0 to 2, by providing early intervention mental health services for infants, toddlers and their parents. This project is modeled after a program in Dade County, Florida which reports a 100% success rate with reunifications over a three year period. The lesson here is to replicate effective practice models. This one is particularly encouraging because if effects change within the existing system and DCFS is able to fund the project through the child’s Federally funded medical coupons.

Improved Regional Practices to Expedite Permanency

There are a number of examples of positive practice by selected DCFS offices across the state. Some of the practices that were identified by top agency Administrators as helping them to reduce delays were:

- The development of kinship units to identify and locate relatives for placement and complete relative home studies;¹³⁸
- Regular communication and collaboration between units within DCFS to set up and coordinate services; and file termination petitions;¹³⁹
- Consistently reminding the court of the timeframes of the case in relation to ASFA deadlines;
- Personalizing the case by providing photographs of the child with the agency’s Individual Service and Safety Plan (ISSP) presented to the court;
- Engaging in monthly meetings with Judges, AAGs, defense attorneys, and CASA/GALs; and
- Participating in the Court Improvement Training Academy’s Table of 10 to identify clear goals and break down barriers to communication among stakeholders with diverging points of view.

Monitoring Compliance with ASFA

In the wake of ASFA enactment, the Federal DHHS published regulations implementing the new law. It created new measures for monitoring state child welfare programs under ASFA. Title IV-E eligibility and the Child and Family Services Review (CFSR)¹⁴⁰ were set up to help gauge compliance with ASFA. These reviews focused on practice improvements and performance-based outcomes for children and families. This marked the first time the child welfare system had been reviewed based on performance outcomes. All 50 states have now completed an initial CFSR review.¹⁴¹

DHHS compares the data gathered from a CFSR review against a set of national standards that establish a high level of performance. The state and Federal government team up to establish a Performance

¹³⁶ For an October 31, 2008 & November 4, 2008 presentation of the Supporting Early Connections Project, see http://earlychildhoodpolicy.com/yahoo_site_admin/assets/docs/Attachment_101_CCYJ_SEC_Project_2008.303122139.pdf

¹³⁷ CCYJ is a non-profit organization that was founded in 2006 by the Honorable Bobbe J. Bridge, former Washington State Supreme Court Justice, to promote juvenile justice and child welfare reform. <http://www.ccyj.org/>

¹³⁸ According to John March, Region 4, DCFS Area Administrator, Adoptions/Permanency section this went into effect over the last year.

¹³⁹ Becky Smith, Area Administrator for Region 6, emphasized the need for open and active communication, and the importance of personalizing cases so that judges and other parties are vividly reminded that decisions affect the life of a child.

¹⁴⁰ http://www1.dshs.wa.gov/pdf/ca/cfsr_ovrvw.pdf

¹⁴¹ The CFSR review gathers data from state programs by examining a sampling of case records from selected counties, and interviewing children and families and court personnel and other representatives of the child welfare system “to analyze how the child welfare system responds to help both the child and the family.” http://www1.dshs.wa.gov/pdf/ca/cfsr_ovrvw.pdf

Improvement Plan (PIP) to address those areas that do not meet the national standards. Every two years, state programs are reviewed again to monitor improvements and compliance.

In 2003, DHHS completed its first CFSR review of Washington's program. It concluded that Washington was not operating in substantial conformity in seven outcome areas (Safety 1 and 2; Permanency 1 and 2; and Well-Being 1, 2, and 3) and three of the seven systemic areas (Case Review System, Staff Training, and Service Array).¹⁴²

Following this initial review, Washington developed a PIP to address the areas of non-conformity. The PIP was contained in "Kids Come First Phase II" and was approved by DHHS.¹⁴³ DHHS concluded in November 2006, that: "Washington has successfully completed the PIP for six of the seven outcome areas (Safety 1 and 2; Permanency 2; and Well-Being 1, 2, and 3) and the three Systemic Factors (Case Review System, Staff Training, and Service Array). Associated penalties for those six outcomes and three systemic factors that successfully achieved the performance improvement goals have been rescinded."¹⁴⁴ The next CFSR on-site review is now scheduled for 2009. In view of the cases being reviewed by the Ombudsman, we eagerly await the results of this Federal review.

Delayed Permanence Affects Families on All Different Levels

The tragedy is that delayed permanence may mean the loss of a permanent home altogether. The Ombudsman has investigated several cases in which foster parents eventually abandoned their hopes of adopting the child they had cared for long-term. Many of these families had put important aspects of their lives on hold while they waited for a final resolution of the case. For example, more than one family had turned down or delayed job promotions which would have required them to move to another state because they did not want to leave their foster child behind and were led to believe that termination was just around the corner. These were foster homes with a record of stellar care. After delays of one to three years in length, they were painfully and finally reconciled to the fact that the delay in permanence could go on indefinitely and they were finally forced to leave behind their foster children for the sake of the family as a whole.

In the following case, like so many others, when the pre-adoptive family finally moved away, it had a profound effect on the child who was 4 ½ at the time and had severe learning disabilities. This child had been with the family from age 1 to 2 and was returned to them again by the agency from age 2 ½ to 4 ½. In an e-mail from the new foster parent to the social worker, the foster parent said:

[The child still blows kisses to "[his former foster] mommy, [foster daddy], and foster sister] every night before [the child] goes to sleep. He asks for prayer[s] for [the former foster mother] to come back to take him to [the State where they are now living] every week in Church. When he heard we were going to Seattle for the parenting evaluation (I told him it was for a meeting) he assumed we were going to the airport to send him to [the State where his former foster parents live] and wanted to know why no suitcases. He wanted to take his things along. He miss[es] [them]. In his mind they are his family.

This child is now 5. He was removed from his biological parents at birth, a termination petition was filed over 2 years ago, and this child is still not legally free.

¹⁴²The review team gathered data from King, Clark, and Grant/Adams counties.

<http://www1.dshs.wa.gov/pdf/ca/ApprovalHHS.pdf>

¹⁴³ CA sends DHHS quarterly status reports on the PIP.

¹⁴⁴ November 21, 2006 Letter from Susan Orr, Ph.D., Associate commissioner, Children's Bureau, Administration for Children and Families, Department of Health and Human Services to Robin Arnold-Williams, Secretary, State of Washington, Department of Social and Health Services. Accessed on 10/7/08. See <http://www1.dshs.wa.gov/pdf/ca/ApprovalHHS.pdf>

The delay in permanence also has the effect of wearing down otherwise optimistic, and resilient care providers. The following excerpt is from a couple who had a foster child placed in their care at 4 weeks of age; the child is now over 3 years old; the child was only recently declared legally free and the couple is still waiting to adopt:

Only when we invoked our 'Right to be Heard' pursuant to RCW 13.34, at a hearing in September, 2008 was our [foster child] made legally free (which again, we only learned was available to us through our own research and not from any of the social workers), because finally the Court heard the impact and stopgap to permanency for this child that DSHS created in this case. However, despite that milestone, we were then told by the social worker that a decision had been made at DSHS to delay our moving forward with adoption until [the child's] sibling's issues were resolved because their case files are together. Although they are in separate homes and will be adopted by different families, we were told that there is a back log in having time and personnel to separate out the files. This is totally unacceptable to us, especially given that it has taken over 3+ years to even get to the point that our [foster child] is legally free.

These experiences are disillusioning for care providers. As the following excerpt shows, many caregivers arrive at the painful decision that they can no longer care for foster children in a system that is so fraught with delay and uncertainty:

Our story unfortunately is not unique. While we know many upstanding couples and families who have inquired of us and/or considered being a foster parent, we cannot in good conscience, based on our experience with DSHS, recommend this undertaking.

In the following case, a foster family was devastated by the agency's decision to remove a 2 year old foster child from their pre-adoptive home to place with relatives out-of-state that the child had never met:

We long ago decided not to explore international adoptions because so many children in Washington need a safe and loving home. But our experiences with DCFS have compelled us to transfer our license to a private agency. It is our hope that in doing so we - and the children we take into our home - will be better protected from the incompetency and insensitivity of Division staff. [We] have been told that the state desperately needs competent foster parents. But is it any wonder that more adults do not assume this role? Not only are foster parents asked to undertake a mighty responsibility of caring for neglected and abused children but our supposed partner in this endeavor seems to lack the skills, empathy, and initiative to provide the necessary guidance and assistance. How can DCFS attract and retain competent caregivers when it seems more concerned with protecting the status quo of the organization and its policies than the interests of the child? The local newspaper occasionally reports the horrors of child abuse and lack of supervision provided to these homes. How much more common are the poorly conceived and executed care plans that do not rise to the level of abuse or neglect but still contain the potential for lasting emotional and psychological damage. [Our foster child] has many loving adults involved in [the child's] case. [We] are distressed to consider the hundreds or thousands of other children in the foster care system that are without this type of support and are shuffled along without much thought or compassion.

Caregivers need to have confidence that their input is considered and that the agency is making well-considered permanency decision. DCFS uses "shared planning meetings" to "share information, plan and make decisions to support the safety, permanency and well-being of [dependent] child[ren]."¹⁴⁵ Prognostic staffings are one type of shared planning meeting used by the agency "to develop and assess permanent plans

¹⁴⁵ For information on Shared Planning Meetings and Staffings, see http://www1.dshs.wa.gov/pdf/ms/forms/15_260.pdf

for the child. A Permanency or Prognostic Staffing can be held at any time during the course of a dependency case; but must be held prior to a Permanency Review Hearing.”¹⁴⁶

Although the Ombudsman supports the concept of prognostic staffings, OFCO has participated in more than one prognostic staffing in which it appeared that the agency was only going through the motions as opposed to truly engaging families, the true purpose of these staffings. Citizens across the State have complained of this as well. Instead of using the staffing to genuinely develop and assess a permanent plan, it was clear the agency had already made its decision, was not open to diverging perspectives, and was using the meeting to deliver its decision to participants and get them to acquiesce. The following excerpt was from a letter from a caregiver who participated in one such prognostic staffing:

[We] . . . understand that reasonable people may disagree. But when a process does not include any authentic consideration and discussion of differing opinions then the credibility of that decision is highly suspect. It is our view that DCFS applied a “one size fits all” approach to [this child’s] placement. The Division sought the easiest, most expedient path, applying their typical policies and practices without considering the “messiness” of [this child’s] situation. It did not matter to DCFS that [the child] had never met the placement relatives or that the biological parents did not even know them. It did not matter that [the child] would be moved 2500 miles from the only caregivers [the child] had known or that [the child] had closely bonded with [the pre-adoptive foster parents]. The very advocates appointed by the court and funded by the state to ensure consideration of [the child’s] best interests were ignored. DCFS simply followed their rather narrow interpretation of the statutes ignoring those phrases in the RCW’s that reference ‘best interest of the child’ or that placement be with a relative ‘with whom the child has a relationship and is comfortable’ (RCW 13.34.130).

Recommendations

- **Implement consistent and improved state-wide tracking and performance measures to ensure compliance with the Adoption and Safe Families Act**
 - Direct DSHS to coordinate with the Office of the Attorney General (AGO) and the court system to implement a clear and consistent state-wide tracking system so that all three entities are consistently informed of critical milestones for each dependency case within each required ASFA timeframe, especially the date by which the child has been in foster care for 15 out of the last 22 months; the date of referral and filing of the termination petition; and documentation of a compelling reason if this timeframe is not met.
- **Encourage fast-tracking termination of parental rights in cases with “aggravated circumstances.”**
 - Remove from state law the discretion of the court to require reasonable efforts in cases with aggravated circumstances, except in those cases where the sole aggravated circumstance is “prior termination of parental rights to another child.”

The rationale for not including prior terminations is that it may continue to be appropriate for the court to have the discretion to require the agency to make reasonable efforts in cases which involve a young parent with great potential to change despite having rights to a prior child involuntarily terminated.

¹⁴⁶See: http://www1.dshs.wa.gov/pdf/ms/forms/15_260.pdf

- **Avoid consideration of alternate placements, even if a relative, where child has been in a safe, stable, nurturing pre-adoptive placement for 15 months or longer.**
- **Appoint attorneys for children 12 and older and retain CASA/GALs on cases involving legally free children until the permanent plan, such as the adoption decree, has been finalized and entered with the court.**
- **Require that all dependency cases in which a duplicative service is being ordered as to a parent be supported by a clear judicial finding on the record to support ordering such service.**
- **Bolster court and agency training on “reasonable efforts” so that services are front-loaded in the system and road-blocks to participation are eliminated.**

Conclusion

DCFS is not adequately meeting ASFA’s mandate of permanence for children; specifically, the requirement that the State petition the court for termination when a child has been in foster care for 15 out of the most recent 22 months.¹⁴⁷ Many child welfare experts regard timely permanence for children as the true litmus test of a successful child welfare system. Indeed, in the Department of Social and Health Services, Children’s Administration’s (CA) Annual Performance Report 2007, CA stated that its goal is to: “[p]rovide stable, nurturing, and permanent placements as quickly as possible for children who are placed into out-of-home care.”¹⁴⁸ Yet, the Ombudsman finds that despite the articulation of this goal and laws on the books designed to bring about timely permanence and a speedy resolution of cases, Washington’s dependent children are suffering from system-imposed uncertainty and upheaval. The need for timeliness and certainty is especially important when these children are already suffering from the traumatic loss of their parents.

¹⁴⁷ ASFA, sec. 103.

¹⁴⁸ Part 4: Part 4: Permanency of “The Children's Administration Annual Performance Report 2007.” Available at <http://www1.dshs.wa.gov/pdf/ca/07Report4Permanency1.pdf>

IMPROVING THE CHILD WELFARE SYSTEM THROUGH PEER REVIEW AND OUTSIDE ACCREDITATION

RECOMMENDATION: Reinstate the COA Accreditation Process and Make Achieving – and Maintaining – these Standards a Priority.

Background

In 2001, the state of Washington enacted law¹⁴⁹ directing Children’s Administration (CA) to undertake accreditation by the Council on Accreditation (COA)¹⁵⁰, an independent, non-profit, internationally recognized accreditor of human service organizations. The goal was for CA to complete accreditation by July 2006. The legislature recognized that holding the agency to nationally recognized standards would facilitate the organizational change needed to improve outcomes for children: “The legislature finds that accreditation of children’s services by an independent entity can significantly improve the quality of services provided to children and families. Accreditation involves an ongoing commitment to meeting nationally recognized standards of practice in child welfare and holds organizations accountable for achieving improved outcomes for children.”¹⁵¹

The law required CA to report to the legislature its progress toward accreditation on an annual basis and as of July 2006, the accreditation process had not been completed. According to CA, by 2008, “43 of Children’s Administration’s 46 field offices and headquarters had passed the various steps for accreditation. . . .”¹⁵² In the 2008 legislative session, Republican Senator Dale Brandland sponsored legislation¹⁵³ to require COA to achieve full accreditation by the end of this year. This bill did not make it to the desk of the Governor.

On February 15, 2008, COA notified CA that the accreditation process had been put on hold.¹⁵⁴ COA President and CEO Richard Klarberg noted in his letter that, “(COA) reserves the discretion at any time to place an agency’s accreditation process on hold when conditions exist that raise a serious concern about stakeholder health or safety or the credibility of COA’s accreditation process.” While COA noted the progress that CA had made since it initiated the accreditation process in September 2001, it stated that there remained “a significant number of foundational standards relating to stakeholder health and safety that have not been implemented, including but not limited to timely visits to foster homes; caseload size; staff credentials; adequate kinship home studies; stakeholder participation in the CQI [Continuous Quality Improvement] processes; and risk management reviews. Moreover, the Department has failed to adopt policies relative to the implementation of these standards.” COA referenced multiple requests to CA beginning on December 7, 2007 in which COA requested a specific timeframe for implementing required standards and noted that CA had still not provided them with “any communication addressing our request.”¹⁵⁵ COA stated that it still had not received this from the agency and it provided CA until February 29, 2008, to submit a schedule.

CA responded to COA on February 15, 2008.¹⁵⁶ In her letter, Ms. Stephani expressed concerns that COA was being influenced by outside pressure in the form of Braam plaintiffs who were seeking enforcement of the

¹⁴⁹ Second Substitute House bill (2SHB) 1249; see also Final H. Bill Rep on 2SHB 1249. Accessed at: <http://apps.leg.wa.gov/documents/billdocs/2001-02/Pdf/Bill%20Reports/House/1249-S2.FBR.pdf>.

¹⁵⁰ <http://www.coanet.org/front3/index.cfm>

¹⁵¹ 2SHB 1249. Chapter 265, Laws of 2001. Accessed at: <http://apps.leg.wa.gov/documents/billdocs/2001-02/Pdf/Bills/Session%20Law%202001/1249-S2.SL.pdf>

¹⁵² http://www1.dshs.wa.gov/CA/about/imp_Accred.asp

¹⁵³ Senate Bill 6766.

¹⁵⁴ The February 15, 2008 letter from COA to CA may be accessed at <http://www.dshs.wa.gov/pdf/ca/COAletter.pdf>

¹⁵⁵ Id.

¹⁵⁶ February 15, 2008 letter from CA to COA may be accessed at <http://www.dshs.wa.gov/pdf/ca/CAResponse.pdf>.

settlement from the court. She went on to present an optimistic picture, stating that “As of June 2007, all CA and HQ [Headquarters] offices have completed initial accreditation site visits; As of January 2008, 44 offices and HQ have received notice from COA that they have met COA accreditation requirements; . . . [and that] CA was on track to reach the goal of statewide accreditation by spring of 2008.” COA responded that it would reconsider its decision if it received from the agency a written plan with proposed completion dates for specific standards. COA identified caseload size, supervisor credentials, monthly visits to children in care, and comprehensive family assessments as the four major areas needing immediate attention. Mr. Klarberg went on to say that, “The refusal of the Department to submit a plan. . . will call into question the genuineness of its commitment both to the full implementation of COA’s standards and to the adoption of our philosophy of best practice.”¹⁵⁷

COA eventually concluded that CA was not being responsive to its request.¹⁵⁸ On May 16, 2008, COA again sent CA a letter asking the agency to fulfill a list of conditions as a basis for continuing the accreditation process.¹⁵⁹ In May 2008, CA decided to halt the COA accreditation process.¹⁶⁰ This incited an outpouring of editorials, news articles, and letters from child advocates, policy makers, and service providers who expressed dismay at CA’s decision to end the accreditation process. It was hard for stakeholders to understand why the agency would pull out of the process after an investment toward accreditation of seven years and \$1.2 million taxpayer dollars.

OFCO reviewed correspondence between CA and COA and talked with COA staff and CA about the process leading up to accreditation being halted and CA’s decision not to pursue it any longer. A different perspective emerges from each entity: CA states that it was faced with certain conditions and timelines with which the agency did not believe were realistic for it to comply. It cited the competing demands of other priorities such as Braam compliance and review by the Federal government. It also noted that some of the conditions required by COA were out of the agency’s control because additional appropriations by the legislature and approval by the Governor were needed to fund workers and programs to meet these conditions.

COA, on the other hand, described an agency that was not willing to work with COA to meet standards. COA described the accreditation process as a fluid process in which COA works on a **collaborative basis** to help **facilitate improvements**. It was willing to provide CA with more time to meet the standards, but CA’s failure to comply with basic requests for concrete indicators of progress (for example, how many supervisors had obtained or were in the process of obtaining Masters degrees in Social Work or a related field, since the agency began accreditation) led COA to conclude that the agency was not making good faith efforts toward reaching accreditation in a timely manner.

Prior to the announcement of the agency’s decision to stop accreditation efforts, CA Assistant Secretary Cheryl Stephani extolled the virtues of COA accreditation on many occasions. In a January 2008 letter to the Ombudsman, she stated that, “COA standards are widely accepted in the field of child welfare, and are selected through a rigorous process based on literature review and field experience, and have evolved to become increasingly outcome-focused and evidence-based.” Ms. Stephani reaffirmed the agency’s commitment to reach accreditation as recently as March 2008 to the Braam panel: “CA has long been committed to working with the COA to meet the accreditation standard in all of its offices.”

¹⁵⁷ March 6, 2008 letter from COA to CA may be accessed at http://www.dshs.wa.gov/pdf/ca/COA%20Response_03_06_08.pdf

¹⁵⁸ April 8, 2008 letter to CA from COA may be accessed at <http://www.dshs.wa.gov/pdf/ca/COAResponseApril08.pdf>

¹⁵⁹ May 16, 2008 letter from COA to CA may be accessed at http://www.dshs.wa.gov/pdf/ca/COA_CA_051608.pdf

¹⁶⁰ The following link provides the correspondence between COA and CA and the CA’s explanation of its decision to stop the accreditation process: http://www.dshs.wa.gov/ca/about/imp_Accred.asp

After CA announced its decision to halt accreditation, the Ombudsman was contacted by several DCFS staff who expressed their distress about this decision. They spoke of how proud they had been of the accreditation process, and what it meant to them as an indicator of integrity in Washington’s child welfare system.

As eloquently stated by Doug Lehrman, a former CA Area Administrator who had been the first manager for the statewide accreditation effort, in a letter to Ms. Stephani:

I recognize, as you do, that there are many routes to system improvement. The COA route, though arduous, provided a pathway to quality improvement that held great promise and complemented the improvement strategies mandated by Braam and by the federal review process. I recognize that there are resource limitations that have impinged on the state’s ability to complete this task. I also know that the CA system is better funded now and in better condition to accomplish all of its goals than it was throughout my entire 25 year career in the agency. This was a do-able task and an attainable goal. I am disappointed that the agency and the legislature did not have the will to marshal the resources to. . . .stay the course.

I am especially disappointed that leadership is not committed to the MSW credentialing sufficiently to have made that a priority. . . .The MSW supervisory credential (or equivalent) does make a difference in the quality of services in an office. That was a key determinant of the reason that [a particular office] was sought to be the pilot office on accreditation and a primary reason that the office readily achieved accreditation. . . .[and has been so] well managed throughout the years. . . .

Similarly, the offices in which workload is well managed and controlled, even when work is at high levels, more readily achieved accreditation. Workload management and supervisory/leadership credentialing are important determinants in the success and performance of any child welfare office. . . .The COA standards. . . .directly relate to what is good for children and families in their relationship to a child welfare office and the outcomes produced by that office.¹⁶¹

Rationale

Outside Peer Review Maintains Integrity in the Process & is Linked to Success

There is no substitute for the **value of outside peer review** that COA provides. COA is recognized as the “gold standard” for children and family services. The standards established by COA have been developed with input from top child welfare professionals – researchers, administrators, and social workers in the field. They are based on replication of other successful child welfare programs, social work experience and practical, well tested, evidence based research.¹⁶² The COA process ensures that qualitative and quantitative data show measurable results, provides input into developing plans to mitigate risk factors, and **supports positive outcomes in children and family services over a sustained period of time.**

¹⁶¹ June 16, 2008 letter from Doug Lehrman to Cheryl Stephani.

¹⁶² COA explains that “The standards rest on a platform of on-going guidance of three kinds: information gathered formally, through expert panels and advisor work groups; informal discussion with human service organizations about how the standards are implemented in a range of circumstances; and reviews of published research and professional literature.” <http://www.coastandards.org/standards.php?navView=private>

COA Standards are Consistent with the Braam Professional Standards

The Braam Panel, as called for in the Settlement Agreement, developed professional standards in March 2007 by which social workers and administrators would be measured in carrying out their work.¹⁶³ These standards set the bar for enforcement proceedings. The Panel based these standards on Council on Accreditation (COA) standards, because it recognized that CA was pursuing COA accreditation and that the standards have evolved from lessons professionals have learned from experience in the field and well documented research. The Panel stated, “The selected COA standards are well-aligned with the [Settlement] Agreement’s goals, outcomes and benchmarks, but are preferred as standards because they have been developed by a diverse professional body and are solidly based on and developed through practice and expertise.”

Accreditation Process Makes Reduction of Caseloads a Priority

High case loads lead to social worker burn out and sloppy work, with insufficient supervisory oversight of children in care. In OFCO’s 2005 Annual Report, we discussed at length the unfortunate consequences of high case/workload: “Our investigations reveal that high caseloads result in incomplete abuse and neglect investigations, inconsistent monitoring of the safety and welfare of children, poor follow through on offering services to families, and delayed permanence for children. We have also found excessive caseloads to be a contributory factor in several of the high profile child fatalities over the past several years that we have either independently reviewed or have knowledge of from reviewing DSHS’ reviews of these cases.” Our findings in 2005 remain as relevant today.

High case loads continue to be a significant factor in child fatalities. When OFCO learns of a death or serious injury,¹⁶⁴ the Ombudsman routinely checks the caseload of the assigned social worker and supervisor. We do this because, as noted, high caseloads lead to unacceptable work quality despite the best intentions of workers. 2008 has the unfortunate distinction of so far having the greatest number of child fatalities since OFCO began recording this data. CA’s retreat from accreditation coincided with the May 2008 death of three-year old Michael Kekoa Ravenell caused by mother’s boyfriend. OFCO reviewed the circumstances of this death and concluded that Child Protective Services (CPS) missed crucial warning signs and failed to act on the others it recognized. OFCO found that the assigned CPS social worker was carrying a caseload of 33 cases -- an impossible number of investigations to handle while carrying out the agency’s mission to protect children. We also found that the supervisor, burdened with a backlog of 69 cases, had failed to conduct required monthly case reviews or review the worker’s safety assessment and safety plan.

The Ombudsman identified other significant practice failures in this case that could be reasonably attributed to high caseload. For example, CPS failed to conduct a criminal history check of the mother’s boyfriend which would have revealed that he had injured his own 23-month-old son in 2003 for failing to pick up his toys and that in 2004, he pled guilty to two counts of third degree child assault. A simple background check of this man on the agency’s CAMIS database would have shown whether the perpetrator had a CPS history and presented a grave danger to the child. Would the CPS worker or supervisor had checked the criminal background of this man if they were less burdened by a heavy caseload? We will never know for certain, but we think the duty to perform adequate background checks would have been less likely to slip through the cracks.

¹⁶³ Braam professional standards may be accessed at <http://www.braampanel.org/ProfStandards0307.doc>

¹⁶⁴ OFCO receives notice of child deaths or critical incidents known to DSHS from the automated critical incident notifier via e-mail. This comes from the CA Administrative Incident Reporting System (AIRS). It provides the date of the critical incident and sufficient identifying information so that the Ombudsman is able to conduct further research on the child via DSHS records, law enforcement reports, medical records, and autopsy reports to create a profile of the fatality. OFCO records this profile in its database. It includes information such as the circumstances of the death, age, gender, and race.

The Ombudsman recognizes that accreditation alone will not protect Washington's children. However, abandoning recognized professional standards puts their lives in danger. As long as caseloads are excessive, the temptation will be to blame this factor alone as the cause of agency negligence. Standards focus attention on the other poor casework and management practices that contribute to the loss of lives. CA must be directed back to careful, well-managed practice to keep children safe and ensure their wellbeing. To do this, we believe the agency must reinstate the COA accreditation process and make achieving - and maintaining - these standards a priority.

DSHS RESPONSE TO 2006 RECOMMENDATIONS

The Ombudsman is statutorily charged with “identifying system issues and responses for the Governor and Legislature to act upon” to improve the state child protection and welfare system.

In its 2006 Annual Report, the Ombudsman recommended detailed responses to the following systemic issues:

1. Native American children are over-represented in the child welfare system and experience significant delays in permanence. Complaints related to compliance with the Indian Child Welfare Act (ICWA) are on the rise.
2. The system is failing children with developmental disabilities and mental health issues.
3. Overwhelming caseloads leave vulnerable children and families at risk.

The Ombudsman’s recommendations and DSHS’ subsequent responses are provided, verbatim, in the table below. DSHS Secretary, Robin Arnold-Williams, issued her first response on January 24, 2008. On October 28, 2008, the Ombudsman requested a status update regarding several of the pending initiatives noted in the January 2008 response. Secretary Arnold-Williams provided the Ombudsman with an update on November 14, 2008.

Systemic Issue 1: Delays in permanence for Native American children and compliance with the Indian Child Welfare Act

OFCO RECOMMENDATION 1	Increase Communication Among Stakeholders Regular meetings should be established between tribal representatives, judges, tribal prosecutors, tribal welfare agency staff, care providers, the Attorney General’s office, CASA/GALs, and Children’s Administration to discuss procedures, issues, communication, and other issues of mutual concern.
DSHS RESPONSE	<p>“Currently CA has monthly Tribal/State meetings with Tribal ICW directors and workers and regional CA staff. Telephone conference capability is provided for all of these meetings.</p> <p>IPAC meets on a quarterly basis in Olympia. IPAC delegates and DSHS officials meet to discuss policy, planning, and program development on a government to government basis.</p> <p>Quarterly 7.01 meetings are held in the regions with Tribes and Recognized Indian Organizations to address individual and local issues and collaboration on service delivery processes.</p> <p>CA maintains a Tribal listserv to communicate between meetings. Through the listserv agendas, meetings notes, articles of interest, and notifications are shared with Tribal ICW, State ICW, and concerned partners.</p>

	CA sponsors an annual ICW Summit.”
STATUS UPDATE REQUESTED	No update requested.
STATUS UPDATE PROVIDED BY DSHS	N/A
OFCO RECOMMENDATION 2	<p>Identify Gaps in Resources and Services</p> <p>DCFS shall conduct a comprehensive survey of resources and services available in Native communities to satisfy the requirement under ICWA that “active efforts have been made to provide remedial services and rehabilitative programs designated to prevent the breakup of the Indian Family.”</p> <p>In the process of identifying resources, DCFS should also determine gaps in the system. Once these are identified, state and Federal resources need to be directed toward filling these gaps so that appropriate services are available in Native communities to serve Native children and families. Public funding for rehabilitative services such as substance abuse treatment and mental health counseling services need to be increased.</p>
DSHS RESPONSE	<p>“In May 2007, a formal consultation session was convened with Tribal Leaders and the Secretary of DSHS and Assistant Secretary of CA.</p> <p>CA is encouraging and assisting Tribes to review their current Agreements to help address the disparity in service delivery.</p> <p>CA is collaborating with the National Office for the Alliance of Children and Families in the deployment of Federal legislation to make Title IV-E and ILS available directly for Tribes.</p> <p>Currently there are 4 Tribes accessing IV-E as pass-through from CA. CA is working with 3 additional Tribes in developing an IV-E agreement. CA provides training and technical assistance to all Tribes requesting these services.”</p>
STATUS UPDATE REQUESTED	Outcome of the May 2007 formal consultation session between tribal leaders and DSHS regarding service delivery.
STATUS UPDATE PROVIDED	<p><u>“Outcome of the May 2007 formal consultation session between tribal leaders and DSHS:</u></p> <p>The consultation resulted in agreement on two major areas:</p> <ol style="list-style-type: none"> 1. Funding Distribution <ul style="list-style-type: none"> • The funding distribution will utilize the February 2007 Bureau of Indian Affairs (BIA) population figures for new funding only. • The funding formula will be 30/70; 30 percent base will be equally distributed to all existing contracts and the 70 percent will be applied to the Tribal Government contracts based on population. 2. Local ICW Agreement Template <ul style="list-style-type: none"> • A template was adopted that can be individualized to meet each Tribe’s unique needs for accessing services for their children and families.

	<p><u>CA's IV-E Agreements with the Tribes</u></p> <p>CA currently has four Tribal/State IV-E agreements. Those agreements are in place with the Quinault Nation, the Lummi Tribe, and the Port Gamble S'Klallam Tribe and the Makah Tribe. CA continues outreach to those Tribes that express interest in learning more about IV-E agreements.</p> <p>CA has presented at the Indian Child Welfare (ICW) Conference on a per request basis. In addition, CA has meetings scheduled in November on the east side of the state to discuss IV-E and in February 2009 on the west side of the state. These agreements may change with the passage of the federal Fostering Connection to Success and Increasing Adoption Act of 2008, which gives Tribes the opportunity to directly operate their own IV-E programs beginning in October 2009. CA will continue to be available for consultation with Tribes regarding IV-E.</p> <p><u>Funding:</u></p> <p>DSHS submitted a Decision package to the Governor's Office for funding to support tribal capacity building through additional funding. Given the current status of state budget projections, it is unknown whether this will be included in the Governor's budget. If proposed in the Governor's budget, the legislature would need to appropriate additional funding."</p>
<p>OFCO RECOMMENDATION 3</p>	<p>Avoid Long-Term Placement Disruption</p> <p>The following steps should be implemented to minimize situations in which DCFS must choose between the loss of a long-term, committed, and stable foster home and the loss of an opportunity to place a child in a prospective Native home:</p> <ol style="list-style-type: none"> 1. Active inquiry at the front end into a child's Indian status at the time of initial out-of-home placement. 2. Active recruitment and retention of Native foster homes with training and financial resources to support this goal. 3. Improved representation of Indian children through appointment of an attorney and/or a GAL to represent the child's best interest in all child welfare, proceedings, whether in state or tribal court. 4. Avoid placement of Indian children in non-Native homes except for short term placements or respite care, and communicate this at the front end to foster parents so as to manage expectations.
<p>OFCO RECOMMENDATION 4</p>	<p>Clarify Applicability of Permanency Timeframes</p> <p>Establish a workgroup to consider permanency timeframes, in particular, the extent to which the timeframes under the Adoption and Safe Families Act (ASFA) apply to ICWA children. The workgroup shall recommend a policy for adoption by Children's Administration to guide the agency and provide greater clarity on the issue of permanence for Indian children.</p>
<p>OFCO RECOMMENDATION 5</p>	<p>Be an Active Player</p> <p>Require DSHS CA through training, improved policies and procedures and a shift in the culture of the agency, to remain actively engaged in all dependency cases whenever the agency continues to provide child welfare services, regardless of the entity deciding the case.</p>
<p>DSHS RESPONSE</p>	<p>"During the 2006 WA state Legislative session, CA supported the change</p>

Addresses OFCO recommendations 3, 4, and 5 above.

in state RCW allowing WA State Tribes to license foster homes on or near their reservation boundaries under their own Tribal standards. Previously under state code, Tribes were only able to license on the reservation. This legislative change brought Washington State code into alignment with Federal code. To date, one Tribe, Port Gamble S’Klallam, has exercised this right. Currently CA is working with one other Tribe at their request to replicate this process.

CA respects the authority of Tribes to govern their own courts and child welfare programs reflecting their cultural values. We work with Tribes to develop permanency for their dependent children within the guidelines of Federal regulations and Tribal codes and customs

CA does not have the authority to direct, undermine, or challenge Tribal authority when they exercise their sovereign status as a Federally Recognized Tribal Government. We value our government to government relationship to work together for the safety, wellbeing, and permanence of all of our children.”

STATUS UPDATE REQUESTED	No update requested.
STATUS UPDATE PROVIDED	N/A
OFCO RECOMMENDATION 6	<p>Implement a Weighted Caseload Implementation of a weighted caseload which recognizes that Indian child welfare cases due to notification requirement, legal complexities, cultural considerations, and a higher burden of proof under the law, are more labor intensive and time consuming.</p>
DSHS RESPONSE	<p>“The work load study recently completed for the CA provides a comprehensive review of the work done and the time spent by CA staff. CA will utilize the results of the survey to develop and implement strategies to support appropriate workloads.”</p>
STATUS UPDATE REQUESTED	Status of whether Indian child welfare caseloads are weighted.
STATUS UPDATE PROVIDED	<p><i>“Indian Child Welfare (ICW) Weighted Caseloads</i> Children’s Administration began weighting each ICW case as 1.3 cases to reflect the additional workload of ICW cases in September 2008. This case weighting standard has now been incorporated in calculation of caseloads reported to the Braam Panel.”</p>

Systemic Issue 2: System Fractures Are Failing Children With Special Needs

<p>OFCO RECOMMENDATION 1</p>	<p>Establish a Protocol to Expedite Placement Require DSHS to establish a protocol between the Division of Children and Family Services (DCFS), the Division of Developmental Disabilities (DDD), and the Mental Health Division (MHD) to simplify and expedite access to service and placement of children with mental health needs and/or developmental disabilities that can no longer be managed at home.</p>
<p>DSHS RESPONSE</p>	<p>“DSHS convened a cross agency work group to create cross system protocols. It is expected that the protocols will be completed by mid-2008.”</p>
<p>STATUS UPDATE REQUESTED</p>	<p>Status of the cross system protocols between the Division of Children and Family Services, the Division Developmental Disabilities, and the Mental Health Division.</p>
<p>STATUS UPDATE PROVIDED BY DSHS</p>	<p><u>“DDD and CA Collaboration</u> CA and DDD have been collaborating under an Interagency Agreement since 2002. That agreement is being revised and updated and should be completed by mid-2009. CA and DDD do have a process in place to serve DDD eligible children who require out of home placement but do not have abuse and neglect issues. CA contributes state funds to assist DDD in paying for costs related to food, clothing, and shelter. DDD provides case management and placement services for these children.</p> <p><u>MHD and CA Collaboration</u> CA and MHD have drafted Coordination Guidelines to simplify and expedite access to services and placement of children with mental health needs who can no longer be managed at home. These draft guidelines are currently being reviewed to identify any regional considerations and are expected to be finalized by mid-2009.”</p>
<p>OFCO RECOMMENDATION 2</p>	<p>Convene a Task Force to Develop a More Effective Response to Requests for Services from Adoptive Parents</p> <p>Children’s Administration should convene this task force to address the special needs of formerly dependant children who require additional adoption support services.</p> <p>A system of services to meet the needs of these families should include crisis intervention and wraparound services, as well as a protocol for collaboration between CA and other DSHS division (such as DDD and MHD) in order to quickly access and coordinate needed services and/or placement.</p>
<p>DSHS RESPONSE</p>	<p>“A number of studies and reports have identified the service needs of adoptive parents.</p> <p>Currently there is a King County work group meeting to address this issue.</p>

Convening another task force would not be productive at this time. These reports and studies agree that:

- Adoptive parents need more training and preparation before adoption
- Adoptive parents need help navigating the system and accessing services
- Adoptive parents and children need improved access to mental health services

Several initiatives are underway to address these needs.

A cross agency team is implementing HB 1088 (the redesign of children’s mental health system). This will include a redefinition of access to care standards with a view to providing greater access to services to all children and families. It also includes the implementation of 4 wrap around pilot programs.

The Mental Health Transformation Project has a focus on mental health prevention. There is a special focus on children birth to 5 years. The goal is to improve the coordination and add services to support mental health.

CA is reviewing models for providing post-adoption information and referral services for adoptive parents.

CA published and distributed to all adoptive families receiving adoption support a booklet which outlines post-adoption services.

CA conducted a survey of post-adoptive families in 2007. The results indicated a need for information and referral services and opportunities such as a listserv so that adoptive families can communicate with each other.

CA’s caregiver training programs are open to all adoptive parents. CA is reviewing its training programs with a view to providing more training that meets the specific needs of adoptive parents.”

<p>STATUS UPDATE REQUESTED</p>	<p>Status of the work of the King County work group to improve training for adoptive parents and access to services, and whether recommendations made by the workgroup have been implemented by DSHS.</p>
<p>STATUS UPDATE PROVIDED BY DSHS</p>	<p>“Region 4 has implemented a two-hour pre-Foster-Adopt Program Information session. These sessions occur twice a month and are required prior to a family submitting an application to be a foster-adoptive family in Region 4.</p> <p>Region 4 has also developed a support group, which meets on the third Thursday of each month. This support group offers discussion/training on various adoption related topics that have been requested by the attendees.</p>

	<p>Statewide there are several support groups available to adoptive families. The voluntary listserv has offered a way for families to connect with other adoptive families, discuss issues and ask questions of adoption specialist. The listserv provides a venue for adoptive families to share information on support groups' services and to raise awareness.</p> <p>The foster care newsletter "Caregiver Connection" features a section on adoption issues. The "Caregiver Connection" is mailed to all licensed caregivers, unlicensed caregivers, and to adoptive families who have chosen to receive the newsletter. It is available on the Internet.</p> <p>CA, in collaboration with Partners for Our Children, applied for a federal Adoption Opportunities grant in May 2008 with a component focused on preparation and ongoing support for adoptive families. Unfortunately, Washington was not selected."</p>
<p>OFCO RECOMMENDATION 3</p>	<p>Eliminate Waiting Lists for Children who qualify for Long-Term Inpatient Care in a Children's Long-Term Inpatient (CLIP) Facility</p> <p>Provide better wraparound services up front to children to meet their mental health needs so as to reduce the number of children and adolescents in need of CLIP placement.</p> <p>Direct DSHS to inventory supplemental wraparound services and therapeutic foster and group home placement options; identify children currently on a CLIP waitlist and provide these children with intensive therapeutic placement and supplemental wraparound services until either the child's clinical situation has improved to a degree that CLIP placement is no longer necessary or placement in a CLIP facility is available.</p>
<p>DSHS RESPONSE</p>	<p>"There are ongoing efforts to develop the availability of effective resources for community-based intensive mental health services. These efforts parallel the recommendation of the Office of the Family and Children's Ombudsman.</p> <p>Expanding the Availability of the Wraparound Process</p> <ul style="list-style-type: none"> • Recent implementation of legislation (SSHB 1088) includes expanding four new and existing Wraparound sites based on the National Wraparound Institute research based high fidelity model. • The DSHS Mental Health Division (MHD) is supporting Regional Support Networks' applications for SAMHSA System of Care grants to look at integrated means of addressing children and youth's needs. <p>Intensive Community based Services</p> <ul style="list-style-type: none"> • MHD is currently piloting Multi-Systemic Therapy (MST) an intensive, in-home evidence-based practice for youth in Thurston-Mason RSN.

	<ul style="list-style-type: none"> • While MHD does not have the direct ability to provide out-of-home placement for youth, MHD is piloting Multi-Dimensional Treatment Foster Care (MTFC) in Kitsap County, an evidence-based practice which provides a specialty trained foster family and intensive work with the youth and guardian/family. • Community stakeholder and Tribal forums are being conducted to inform MHD’s formation of the next biennial requests for new services. <p>‘High intensity services’ is a team-based modality offered through the RSNs which may support ...supplemental wraparound services.”</p>
<p>STATUS UPDATE REQUESTED</p>	<p>Status on the implementation of the wraparound pilot program for children with serious emotional or behavioral disturbances authorized by HB 1088.</p> <p>Whether CLIP waitlists have been reduced, what the current waitlist is for CLIP treatment and whether appropriations were sought and received for additional CLIP beds.</p>
<p>STATUS UPDATE PROVIDED BY DSHS</p>	<p><u>“Wraparound Pilot</u></p> <ul style="list-style-type: none"> • MHD implemented three “High Fidelity Wraparound” pilot sites in April 2008.” • Pilot sites are located in Grays Harbor, Skagit, and Cowlitz counties. • Since July 1, 2008, 18 children and youth with severe emotional and behavioral disturbances have been referred and have wraparound teams. • Enrollment is not restricted to children/youth meeting the state’s access to care standards. • The pilot sites have close ties with cross-system partners including: CA, JRA, DDD, NAMI Washington, DASA, schools, local primary medical practitioners, and mental health providers. <p><u>CLIP Waitlist</u></p> <p>Since January 2008, the current average number of children and youth waiting for CLIP, based on a monthly snapshot, is 23. This is up so far (in 2008) from 2007 and 2006 when the average was 18.</p> <p>While we continue to monitor and track these trends with the length of time waiting prior to admission, wait times have not reduced in the past three quarters.</p> <p>The following factors influence wait times:</p> <ul style="list-style-type: none"> • The volume of referrals; • Intensive community mental health service alternatives to enable more diversions from CLIP; and • “Step-down” (safe, intensive community or residential) services to help address length of stay by enabling an earlier discharge for those who could manage a less secure environment but still need high levels of support and structure.

CLIP Appropriations

Appropriations have been sought. DSHS submitted a Decision Package to the Governor's Office which includes:

- Funding for 12 additional beds specifically targeted to children ages 5-11.
- Funding for implementation of one site (10 "beds") of Multidimensional Treatment Foster Care for children ages 7-12 which carries the prospect of diverting eligible children from long-term inpatient care or allowing earlier discharges.
- Given the current status of state budget projections, it is unknown whether this will be included in the Governor's budget. If proposed in the Governor's budget, the legislature would need to appropriate additional funding.

Additional Efforts:

- A cross-system meeting held in August 2008 with the Regional Support Networks' Children's Care Coordinators and Children's Administration Regional Representatives to address system issues impacting CLIP length stay and the waiting list.
- The Mental Health Division convened the Intensive Children's Mental Health Services workgroup contracting with national consultants, Tri-West Group to facilitate a time-limited stakeholder group to study capacity for intensive community-based services. Other states models were researched. The group identified and prioritized interventions and grouped these into purchasing scenarios. This lays groundwork for future planning with DSHS leadership and legislators.
- An MOU was signed with the Squamish Tribe to allow direct application the CLIP Administration for tribal children and youth without going through the RSN.

Systemic Issue 3: Caseloads are unmanageable and leave vulnerable children and families at risk

**OFCO
RECOMMENDATION 1**

Urgently implement recommendations previously made by the Ombudsman, the Joint Task Force on Child Safety, and a number of child fatality reviews, to address a workload crisis widely reported by caseworkers and supervisors across the state

This recommendation was originally issued in the Ombudsman's 2004-05 Annual Report. See excerpted text Below.

Reduce Caseloads of Caseworkers and Supervisors

Direct DSHS to develop and submit a proposal to the state legislature that would create a method for reducing caseloads and keeping them at a level that is consistent with standards established by the Child Welfare League of America (CWLA) or the Council on Accreditation of Services for Families and Children (COA).

DSHS RESPONSE

January 31, 2007

“CA has received funding for FY 2007 to hire additional caseworkers, first-line supervisors, and clerical support FTE’s. These new staff are being hired and put into service according to the FTE phase-in provided in the budget allocation.

In addition, the Governor’s 2007-09 budget includes funding for an additional 71 case worker and supervisor FTE’s. If the additional resources identified in the governor’s budget request are provided to CA, we should be close to achieving the COA caseload standard of 1 caseworker to 18 cased by the end of FY 2008.

CA is in the process of achieving accreditation through the Council on Accreditation. This includes meeting the COA social worker caseload standard and supervisor-to-staff ratio standard. We believe the COA standards are widely accepted in the field of child welfare, and are selected through a rigorous process based on literature review and field experience, and have evolved to become increasingly outcome-focused and evidence-based.

CA has contracted with Walter McDonald and Associated to undertake a prospective workload study. The study will be done in collaboration with the American Humane Society. They have considerable experience in this area and have conducted similar workload studies for California and New York. This study will focus on the current and projected expectation of caseworkers and supervisors. The study will be conducted in February 2007 and the results will be available in June 2007. The study will provide objective data upon which to determine staffing requirements.”

STATUS UPDATE REQUESTED

Status of strategies that are being developed as a result of the workload study to support appropriate workloads.

STATUS UPDATE PROVIDED BY DSHS

“Workload Study
CA Management, Union Management Coordinating Committee (UMCC) and Washington Federation of State Employees (WSFSE) representatives have held 11 full-day meetings to discuss workload issues. This work includes analyzing data, examining policy and processes, and making recommendations to reduce workload. The results of the workload study report are being used the UMCC meetings to identify possible workload efficiencies and changes. To date UMCC has:

- Reviewed work of the Regional and Policy Workgroups and discussed implications for the UMCC work
- Reviewed current tasks performed by social workers,
- Identified tasks that could be done by non-case carrying staff or through contracts, and
- Reviewed the task list from the workload study to validate that identified tasks would save time if moved from social worker workload.

Final recommendations of the UMCC will be included in a report to the Legislature in November 2008.

Funding:

With the support of the Governor and Legislature, CA received:

- Funding in the 2006 Supplemental and the 2007-09 budget to phase-in an additional 284 new staff, by the end of December 2008, for monthly visits of children; and Funding in the 2008 Supplemental to accelerate the hiring of monthly visit staff so that all staff are hired by May 2008 rather than December 2008.

Other initiatives that have been recently funded to help reduce workload and strengthen the continued commitment for the safety and well-being of children include:

- Funding of FamLink which will support good Social Work practice;
- Funding to establish Centers for Foster Care Health Services. The Centers will provide care coordination services and gather, organize, and maintain individual health histories for nearly 2,000 children in foster care;
- Funding to contract for twenty-two chemical dependency specialist who will provide services in each field office; and,
- Funding of additional resources for relative placements and support services for birth and foster parents.”

2008 LEGISLATIVE ACTIVITIES¹⁶⁵

The Ombudsman facilitates improvements in the child welfare and protection system by identifying system-wide issues and recommending responses in its annual report to the Governor, Legislature, agency officials and the public. Many of the Ombudsman's findings and recommendations are the basis for legislative initiatives to improve the system.

The Ombudsman also reviews, analyzes, and comments on bills proposed each legislative session. During the 2008 session, the Ombudsman provided significant input to Legislators through written and oral testimony on numerous bills, which are summarized below.¹⁶⁶

LEGISLATION PASSED INTO LAW¹⁶⁷

2SSB 6206: Concerning agency reviews and reports regarding child abuse, neglect, and near fatalities. (*Effective June 12, 2008*)

This new law provides additional accountability measures for DSHS/CA and expands the Ombudsman's duties. 2SSB 6206 reflects the Ombudsman's recommendations that DSHS should pay closer attention to reports of child abuse and neglect from mandated reporters, scrutinize multiple reports of child abuse or neglect on the same child or family, and ensure that recommendations resulting from child fatality reviews are implemented effectively to improve the system.

2SSB 6206 requires the Ombudsman to:

- **Analyze a random sampling of child abuse and neglect referrals made by mandated reporters** to the DSHS/CA during 2006 and 2007. The Ombudsman must report to the Legislature no later than June 30, 2009, on the number and type of referrals, the disposition of the referrals by category of mandated reporter, any patterns established by DSHS in how it handled the referrals, whether the history of fatalities in 2006 and 2007 showed referrals by mandated reporters, and any other information OFCO deems relevant. The Ombudsman may contract to have all or some of the tasks completed by an outside entity.
- **Issue an annual report to the Legislature on the implementation of child fatality recommendations.**

2SSB 6206 requires DSHS to:

- **Promptly notify the Ombudsman** when a report of child abuse or neglect constitutes the third founded report on the same child or family within a twelve-month period. DSHS must also notify OFCO of the disposition of the report. (*Originally provided in SB 6209, which was not enacted.*)

¹⁶⁵ The Ombudsman's activities during the 2007 legislative session are summarized in its 2006 Annual Report. The 2006 Annual Report is available online at <http://www.governor.wa.gov/ofco/reports>.

¹⁶⁶ The Ombudsman's legislative testimony is available online at <http://www.governor.wa.gov/ofco/legislation>.

¹⁶⁷ More information on specific bills and accompanying legislative reports may be accessed at <http://www.leg.wa.gov/legislation>.

- **Promptly notify the Ombudsman in the event of a near-fatality** of a child who is in the care of or receiving services from DSHS within the last 12 months.
- Assemble a Child Fatality Review (CFR) comprised of individuals who have not been involved in the child's case, if the child fatality occurs as the result of apparent abuse by the child's parent or caretaker.
- At the conclusion of the CFR, DSHS must issue a report on the results of the review within 180 days of the death of the child. The Governor may extend the due date.
- DSHS must distribute the report to the appropriate legislative committees and must also create a public web site where all CFR reports are to be posted and maintained.

SB 6306: Providing an additional procedure for visitation rights for relatives of dependent children.
(Effective June 12, 2008)

This legislation reflects the Ombudsman's recommendation to provide relatives who have an established relationship with a child, in which the relatives and child wish to continue, with ongoing contact after the child has been removed from parental care pursuant to a dependency action.¹⁶⁸ SB 6306 allows a dependent child's relative, other than a parent, to petition the juvenile court in a dependency matter for reasonable visitation with the child under specific circumstances. (See page 46 for a description of the provisions of this new law.)

LEGISLATION INTRODUCED BUT NOT ENACTED

The Ombudsman testified in support of the intent behind the following bills that were not enacted during the 2008 legislative session:

HB 2760: Establishing children's rights in dependency matters.

HB 2846: Establishing a process for entering voluntary out-of-home placement agreements for adoptive children in crisis.

HB 3061: Creating a department to elevate the importance of child well-being as an essential outcome of an effective child welfare system.

HB 3187: Establishing systems to support families who have adopted children from foster care.

SB 6207: Requiring notification of a child's guardian ad litem of allegations of abuse or neglect. *(The entirety of this bill was incorporated into 2SSB 6206.)*

SB 6209: Requiring notification of the Office of the Family and Children's Ombudsman in cases involving multiple reports of child abuse or neglect. *(Although this bill was not enacted, its provisions are substantially similar to those in 2SSB 6206.)*

¹⁶⁸ This recommendation was issued in the Ombudsman's 2004-05 Annual Report, which is available online at <http://www.governor.wa.gov/ofco/reports>.

BRAAM UPDATE

BRAAM V. STATE OF WASHINGTON HELD THAT FOSTER CHILDREN HAVE A CONSTITUTIONAL RIGHT TO SAFETY

In December 2003, the Washington Supreme Court held, “that foster children have a constitutional substantive due process right to be free from unreasonable risk of harm and a right to reasonable safety. To be reasonably safe, the State, as custodian and caretaker of foster children, must provide conditions free of unreasonable risk of danger, harm or pain, and must include adequate services to meet the basic needs of the child.”¹⁶⁹ The court held that the standard to be applied in determining whether substantive due process rights have been violated is that applied by the U.S. Supreme Court in *Youngberg v. Romeo* - did the state’s conduct fall substantially short of the exercise of professional judgment, standards, or practices.¹⁷⁰

Goals of 2004 Settlement Agreement in *Braam v. State of Washington*

On July 31, 2004 the plaintiffs¹⁷¹ and the state of Washington¹⁷² in *Braam v. State of Washington*¹⁷³ reached a settlement agreement (the “Settlement Agreement”) consenting to the following specific, measurable and enforceable goals for children in the custody of DCFS:

- Providing each child with a safe and stable placement;
- Providing better mental health assessment & treatment;
- Improving foster parent training and information;
- Providing safe and appropriate placements;
- Placing siblings together unless a compelling reason not to; and
- Improving the quality & accessibility of services to adolescents.¹⁷⁵

The Settlement Agreement established an oversight panel, known as the Braam Panel (the “Panel”¹⁷⁶), to monitor progress toward these goals.

Panel found Lack of Compliance by State

¹⁶⁹ *Braam v. State of Washington*, 150 Wn.2d 689, 700, 81 P.3d 851 (2003) (class action suit brought by current and former foster children who sought damages for harm suffered as a result of multiple placements while in the custody of DCFS).

¹⁷⁰ *Braam v. State of Washington*, 150 Wn.2d 689, 703-04, 81 P.3d 851 (2003), relying on *Youngberg v. Romeo*, 457 U.S. 307, 324, 102 S. Ct. 2452 (1982).

¹⁷¹ Plaintiffs have developed a website that describes the history of the *Braam* case and current progress and developments. It may be accessed at <http://www.braamkids.org/501.html>

¹⁷² The State of Washington, Children’s Administration describes the Braam settlement and CA’s efforts at compliance at http://www.dsbs.wa.gov/ca/about/imp_settlement.asp

¹⁷³ *Braam v. State of Washington*, 150 Wn.2d 689, 712, 81 P.3d 851 (2003) (class action suit brought by current and former foster children who sought damages for harm suffered as a result of multiple placements while in the custody of DCFS).

¹⁷⁵ *Braam v. State of Washington* Final Settlement, July 31, 2004, available at: <http://www.braampanel.org/SettlementAgreement.pdf>

¹⁷⁶ See <http://www.braampanel.org/>

The Panel exercised its authority to issue an Implementation Plan, which defined specific and enforceable measures of performance for DSHS. Performance is gauged by the agency's compliance with action steps, benchmarks, and outcomes developed by the Panel.¹⁷⁷ The Settlement Agreement requires the Panel to issue Monitoring (progress) Reports regarding the settlement every six months.¹⁷⁸ In March 2006, the Panel released its first monitoring report. It concluded that the agency had not completed 32 out of 45¹⁷⁹ "action steps" that were to be completed by the end of 2005.¹⁸⁰

The Panel, as called for in the Settlement Agreement, developed professional standards in March 2007 by which the practice of social workers and administrators would be measured in carrying out their work. These were to be used in enforcement proceedings and were based on Council on Accreditation (COA) standards.¹⁸¹

On January 22, 2007, the Department released comprehensive statistics showing the agency's level of compliance with annual benchmarks set by the Panel in the Braam Implementation Plan.¹⁸² The data showed that the Department failed to reach all measurable statistical benchmarks that it was required to meet by June 30, 2006, in the following areas:

- **Foster homes** - Increasing the number of beds available to children in care;
- **Placement stability** - Decreasing the number of youth experiencing less than three placements in their first few years in care;
- **Kinship care** - Increasing the number of kinship care providers;
- **Sibling separation** - Increasing the number of siblings placed together;
- **Health care** - Increasing the timeliness of health screening, assessment and services;
- **Runaways** - Reducing runaway events and time as a runaway; and
- **Foster parent training** - Increasing the in-service training to foster caregivers.

In April 2007, the Braam panel released its Monitoring Report which for the first time released benchmark data. The benchmark data revealed that DSHS had failed to reach required benchmarks in all six areas¹⁸³ of the Settlement Agreement.¹⁸⁴ Furthermore, the agency acknowledged to the Panel that it had "not yet provided the Panel with sufficient information to enable the Panel to accurately track compliance with the benchmark as required under the settlement agreement..."¹⁸⁵ The Panel treated absent data as not meeting benchmarks in those areas. As of December 2007, the Panel had rejected three consecutive compliance plans from the agency on caseloads, 30 day visits, and emergency respite care.

¹⁷⁷On July 3, 2008, the Panel issued a Revised Braam Settlement Implementation Plan.
<http://www.braampanel.org/ImpPlanREVJuly08.pdf>

¹⁷⁸ Monitoring reports were issued by the Panel on March 2006; September 20, 2006; April 17, 2007; October 4, 2007; and October 2008. "The Implementation Plan is released simultaneously to the parties and the public. In the case of Monitoring Reports, the parties have agreed that CA and the plaintiffs will receive preliminary reports and be given time to comment before the documents are released to the public. Panel reports released for public distribution will be posted on the website; individuals and organizations can sign up to receive email alerts when new material is posted." These documents may be accessed at <http://www.braampanel.org/reports.asp>

¹⁷⁹ This constitutes a rate of incompleteness over 70%.

¹⁸⁰ <http://www.braampanel.org/MonRptMar28.doc>

¹⁸¹ Braam professional standards may be accessed at <http://www.braampanel.org/ProfStandards0307.doc>. Part of the Panel's rationale in selecting COA standards was based on the fact the CA was then pursuing COA accreditation. As OFCO discussed earlier in this report, that is no longer the case.

¹⁸² You may access the Department's most recent Braam Performance Report: FY 05 –FY07 with May 08 Update at http://ca.dshs.wa.gov/intranet/uploadedFiles/StateReportFY07_v2.doc

¹⁸³ Placement stability, mental health, foster parent training, unsafe/inappropriate placements; sibling separation, and adolescents.

¹⁸⁴ <http://www.braampanel.org/MonRptApr07.doc>

¹⁸⁵ <http://www.braampanel.org/MonRptApr07.doc> at p. 44.

Over the past year, OFCO continued to attend the quarterly meetings of the Panel, review the progress reports of the Panel, and monitor Children's Administrations' duty to deliver family and children's services to ensure children's health and safety and preserve families.

Plaintiffs Returned to Court in 2008 to Seek Enforcement of Settlement

In our prior Annual Report issued in December 2007, the Ombudsman reported on the intent of plaintiffs to return to court in the months ahead to seek enforcement of the *Braam* Settlement Agreement. As anticipated, on January 18, 2008, the plaintiffs filed a Motion to Enforce the Settlement Agreement reached in July 2004 with regard to four key areas: safety,¹⁸⁶ caseload sizes,¹⁸⁷ sibling contact,¹⁸⁸ and child health and education screenings (falls under mental health area).¹⁸⁹ The plaintiff's motion was based on findings made by the Panel that the Department was not in compliance with the Settlement Agreement.¹⁹⁰

Judge Agreed with Plaintiffs that Department had not Complied with Settlement Agreement

On June 30, 2008, Whatcom County Superior Court Judge Charles R. Snyder found that DSHS had violated the Settlement Agreement and on September 24, 2008, the court entered its written order.¹⁹¹ The Judge ruled that DSHS was out of compliance with the Settlement Agreement by not meeting the standards, the benchmarks, or actions plans in the four key areas that were the subject of plaintiff's motion: monthly contact between case workers and foster children, sibling visits, appropriate case load ratios, and Child Health and Education Tracking (CHET) screens. The court found that DSHS "has fallen well short of its obligation to provide sufficient information to accurately track their compliance with outcomes, benchmarks, and actions steps"¹⁹²

The court also found that before the enforcement motion was filed, DSHS had acknowledged its noncompliance in these areas. The agency attributed this partly to a lack of funding or resources. Since that time, the Legislature has provided additional funding in the 2008 supplement budget for the hiring of additional caseworkers, contracts for sibling visits, and the hiring of 12 additional CHET screeners.

The Judge granted the agency until July 30, 2008, to draft detailed compliance plans in the areas of monthly visits, lowering social worker caseloads, and CHET screens.¹⁹³ CA sent proposed compliance plans for the

¹⁸⁶ Plaintiffs asserted that more than 60 percent of foster children were not receiving monthly visits from caseworkers and that the agency failed to keep detailed data on caseworker visits.

<http://braamkids.org/PlaintiffsReleaseReturntoCourt.pdf>

¹⁸⁷ Plaintiffs asserted that the statewide average for foster care caseworkers is 25 cases and noted that professional standards call for 18 cases per worker. <http://braamkids.org/PlaintiffsReleaseReturntoCourt.pdf>

¹⁸⁸ Plaintiffs asserted that although the Settlement Agreement required twice monthly visits between siblings, less than half of siblings were receiving them and that the number of children placed with siblings was actually declining. <http://braamkids.org/PlaintiffsReleaseReturntoCourt.pdf>

¹⁸⁹ Plaintiffs asserted that more than two-thirds of foster children were not receiving required Child Health and Education Track (CHET) screens within the required 30-day time period.

<http://braamkids.org/PlaintiffsReleaseReturntoCourt.pdf>

¹⁹⁰ The Settlement Agreement creates a rebuttable presumption that findings by the Panel are correct. *Braam v. State of Washington* Final Settlement may be accessed at <http://www.braampanel.org/SettlementAgreement.pdf>

¹⁹¹ September 24, 2008 Order on Children's Revised Motion to Enforce Settlement Agreement.

¹⁹² The Court's June 30, 2008 Oral Ruling on Motion to Enforce Settlement, pp 17-18. OFCO has found that the insufficiency of data presented by CA to the Panel and to plaintiffs has been a recurring concern raised by the Panel, plaintiffs, and other stakeholders during the course of the Braam meetings. This has added to the complexity of tracking progress and holding CA accountable for certain performance measures the agency agreed to in the Settlement Agreement.

¹⁹³ The court ruled that if the Panel did not accept the proposed compliance plan in a particular area, CA had an additional 60 days to submit a revised compliance plan that is acceptable to the Panel. Within 90 days of the acceptance

other three benchmarks to the Panel on July 30, 2008.¹⁹⁴ These have undergone revision with input from the Panel and plaintiffs. In the area of sibling visits, the agency had already submitted an approved sibling visit compliance plan prior to the enforcement motion. However, the court required the agency with 90 days from June 30, 2008 “to demonstrate substantial improvement towards compliance”¹⁹⁵ with the sibling visitation plan.

Current Status on Compliance

Monthly visits

The Panel approved CA’s compliance plan and visit policy submitted on August 29, 2008 and noted in its most recent Monitoring Report (October 2008) that CA implemented on September 1, 2008 the policy requiring monthly visits and visits in the first week of placement.¹⁹⁶ OFCO is conducting random checks of cases brought to our attention through our complaint process to determine whether the agency is complying with this mandate. In those cases where we find that CA is not meeting its duty to check on children every month, we are bringing this to the attention of supervisors and requesting that corrective action be taken.

Sibling visits

As already stated, this issue was not one of the benchmark areas in which the Judge required a compliance plan. However, it was raised in plaintiff’s Motion to Enforce the Settlement so we address it here. The Panel found that policies and protocols to develop a framework for visitations between parents, children, and sibling were completed as of September 1, 2008. The Panel replaced the requirement for quarterly reporting with monitoring of related outcomes.¹⁹⁷

Mental Health

The Panel found that data provided by the Department to assess progress as to whether children in out-of-home care 30 days or longer have completed and documented Child Health and Education Track (CHET) screens within 30 days of entering care is inadequate or inappropriate and that therefore the benchmark has not been reached. The Department reports that it is developing a data management tool to allow tracking based on the Panel’s requirements and that this will be reported on in the next monitoring report. Thus, the compliance plan, as ordered by Judge Snyder’s court order, is still in process and has not been approved.¹⁹⁸ As to the required outcome that children in out-of-home care be screened for mental health and substance abuse every 12 months, the Panel found that DSHS failed to meet the FY 07 benchmark and that a compliance plan is still required.¹⁹⁹

Caseload

The Panel approved CA’s October 1, 2008 version of its compliance plan which calls for the submission of a comprehensive, fully-detailed caseload reduction plan by December 31, 2008.²⁰⁰

of a compliance plan, CA must then show substantial progress in that area. Within 9 months of the acceptance of a plan, the Department is required to meet related benchmarks.

¹⁹⁴ <http://www1.dshs.wa.gov/pdf/ca/Panelltr073008.pdf>

¹⁹⁵ September 4, 2008 Order on Children’s Revised Motion to Enforce Settlement Agreement at 8.

¹⁹⁶ Note that the Panel and parties agreed to modification of the language of the original action step requiring visits “once every 30 days” to “every calendar month, with no visit being more than 40 days after the previous visit” to reflect policy changes approved by the Panel <http://www.braampanel.org/MonRptOct08.doc> at p. 14. See also http://www.dshs.wa.gov/ca/about/imp_settlement.asp

¹⁹⁷ <http://www.braampanel.org/MonRptOct08.doc> at p 15.

¹⁹⁸ <http://www.braampanel.org/MonRptOct08.doc> at p 23.

¹⁹⁹ The Panel required that the statewide benchmark of 75% must be met and that no region’s performance may be more than 10 percentage points lower than the statewide benchmark. <http://www.braampanel.org/MonRptOct08.doc> at p 23.

²⁰⁰ <http://www.braampanel.org/MonRptOct08.doc> at p 10.

Conclusion

In the Panel's October 2008 monitoring of the status of CA's compliance with outcomes by area of the Settlement Agreement, the Panel concluded that CA:

- reached the annual benchmark for 6 outcomes (1 for placement stability, 3 for mental health, and 2 for unsafe/inappropriate placements);
- failed to reach the annual benchmark and a compliance plan is required for 14 outcomes (1 in the area of placement stability, 1 in mental health, 3 in foster parent training, 4 with regard to unsafe/inappropriate placements, 3 for sibling separation, and 2 related to adolescents);
- failed to reach the annual benchmark and a compliance plan was approved for 1 outcome in the area of unsafe/inappropriate placements; and
- failed to reach the annual benchmark and compliance planning is in process in 1 outcome for mental health.²⁰¹

2008 Supplemental Budget Responds to Critical Foster Care Issues

The 2008 Supplemental Budget adopted by the legislature and approved by the Governor provided significant additional funding to expedite hiring new social workers to provide monthly visits to all children in CA care.²⁰² CA has begun hiring and training to carry out this mandate. The budget also responded to other issues raised by the Ombudsman and by plaintiffs in enforcement proceedings: money has been appropriated to facilitate twice-monthly visits between siblings who are placed out of the home and live apart from each other, and additional funding was set aside to hire more CHET screeners. Plaintiffs have expressed ongoing concerns that the fourth area of their Motion to Enforce the Settlement Agreement—case load size—has not been addressed with additional funding or other adequate measures. OFCO shares these concerns and as addressed by our recommendations in this report, continues to favor re-engagement of the COA accreditation which would set a clear standard for caseload size.

Meeting Status

The last Panel Meeting was held on December 8 and 9, 2008.²⁰³ At the Panel's request, OFCO delivered a presentation regarding how complaints are processed and investigated, as well as the Ombudsman's role in monitoring and reforming the child welfare system.

²⁰¹ October 1, 2008 Braam Settlement Monitoring Report #5 available at:

<http://www.braampanel.org/MonRptOct08.doc>

²⁰² The Braam Implementation Plan required that by June 30, 2006, 70% of children in foster care were to have monthly visits by case workers. In the 2007 survey of caregivers commissioned by the Braam panel, caregivers reported that only 37.9% of children in care received a private and individual face-to-face visit from the caseworker for each full placement month. Over 60% of all survey respondents reported that the child in their care did not receive a monthly visit from a caseworker and about 17% of survey respondents reported that their foster child did not receive a single visit in all of 2006. See: http://www.braampanel.org/ParentSurvey07_DataApp.pdf at p. 49. The Ombudsman believes that irregular and/or inadequate health and safety checks create missed opportunities for the agency to intervene with children before devastating things happen. Health and safety checks provide a chance for the case worker to observe first hand the environment in which the foster child is living and the interaction between the child and the care provider, and to develop a relationship of trust with the child so that if neglect or abuse is occurring, the child feels comfortable to disclose this to the worker.

²⁰³ Minutes from the Braam meetings are available at <http://www.braampanel.org/minutes.asp>

APPENDIX A

2008 OMBUDSMAN ACTIVITIES

The Ombudsman's 2007 activities were reported in the 2006 annual report.

OMBUDSMAN PRESENTATIONS

“Role of the Ombudsman”

Children’s Justice Conference 2007 & 2008

“Perspectives on Foster Care in Washington State”

World Affairs Council, NGO Delegation from Bangladesh

“New Ombudsman Training”

United States Ombudsman Association Conference, Anchorage, Alaska

“Role of the Ombudsman in State Child Welfare”

Foster Parent Association of Washington State, Mini Conferences

“Family and Children’s Ombudsman”

Public Service Career Fair, Seattle University Law School

“Role of the Ombudsman”

University of Washington, School of Social Work

TRAINING ATTENDED

Bonding Assessment Training
Child Well-being
Children and Families Experiencing Domestic Violence
Children’s Justice Conference
Conducting Subject Interviews
Core Investigator Training
Dialectical Behavior Therapy
Family Engagement Summit
Foster Care Assessment Program Training
Government to Government
Indian Child Welfare Summit
Infants in the Child Welfare System
National Association of Social Worker Teleconference
Personal Service Contracts
Shared Decision Making Training
Symposium on Racial Disproportionally
United States Ombudsman Association
Washington State Ethics

APPENDIX B

OFCO IN THE NEWS

“Woman pleads guilty in starvation deaths of young sons.” – *KOMO TV, Aired October 25, 2007*

- “An independent investigation [by the Office of the Family and Children’s Ombudsman] into the boys’ deaths found state child protection workers ignored or mishandled complaints about Robinson.”

“Mom Who Starved Sons to Death Pleads Guilty to New Charges.” - *Associated Press and Kitsap Sun Staff, Kitsap Sun, October 25, 2007*

- “The children’s deaths caused a furor at the time, as the Child Protective Services Caseworkers in Bremerton were accused of mishandling the Robinson case in a report issued by the state Office of the Family and Children’s Ombudsman, according to Sun archives. ... Charges against Robinson were dropped in January and she was referred to Western State Hospital for civil commitment.”

“Union Head Calls for Withdrawal of Human Services Appointee.” -*Ann E. Marimon, Washington Post, February 8, 2007*

- “...At the time, Mary Meinig, Washington state’s ombudsman for families and children, told the Seattle Post-Intelligencer that the ‘ramifications were pretty hard-hitting.’ In an interview last week, Meinig described Ahluwalia as ‘very smart, focused and committed to children’s issues.’”

“Statistics on abuse are difficult to pin down.” –*Shawn Vestal, Spokesman Review, April 1, 2007*

- “...often the circumstances surrounding a neglected child’s death are murky. The Washington Office of the Family and Children’s Ombudsman produced a report that noted in 2004, 87 children died who were ‘in the care of, or receiving child welfare services ... within one year of their death or who died while in state licensed care.’”

“Abused by drugs.” – *Benjamin Shors, Spokesman Review, April 2, 2007*

- “In a review of 87 child fatalities published last year, Washington’s children and families ombudsman found that two-thirds of the children who died came from homes with histories of drug and alcohol abuse.”

“Child welfare system biased, experts claim, disproportionate number of minorities affected.” -*Kevin Graman, Spokesman Review, April 4, 2007*

- “...Fuentes filed a complaint with the Office of the Family and Children’s Ombudsman against the Division of Foster Care Licensing. She said she had been trying since January to gain custody of Lorenzo without success despite passing several background checks and a home study. She also complained of the foster family’s interference in violation of her civil rights and the rules for state licensed foster care.”

“System under scrutiny, Summer’s death may eventually affect Washington law.” –*JoNel Aleccia, Spokesman Review, April 4, 2007*

- “The Spokane 4-year-old, who died March 10 of severe abuse, allegedly at the hands of her father and stepmother, likely, will be the subject of a full fatality report by the Office of the Family and Children’s Ombudsman.”
- In 2004 and 2005, Meinig’s office conducted full reviews of the deaths of Justice and Raiden Robinson, a toddler and an infant found starved and dehydrated in their home, and Siritia Sotelo, a 4-year-old beaten to death by her stepmother. Those reviews led to changes in laws governing Washington’s child welfare system, including the Justice and Raiden Act, which allowed greater ability to intervene in cases of neglect.”
- “We look at where the system had an opportunity, where it missed an opportunity and how do we make sure it doesn’t happen again,’ Meinig said.”

“Deaths often unreviewed.” –*JoNel Aleccia, Spokesman Review, April 13, 2007*

- “In Washington, budget cuts, inconsistent reporting and the lack of statewide coordination have eroded what once was a robust program for monitoring about 750 child deaths each year.”
- “It was a very good system and we could have confidence in what we were looking at,’ said Mary Meinig, director of the Office of the Family and Children’s Ombudsman, which conducts its own reviews. ‘Now we just don’t have that confidence’... ‘We’re missing kids,’ said Meinig.”

“Standard review in Phelps case.” –*JoNel Aleccia, Spokesman Review, April 19, 2007*

- “An executive review is not required to fully understand every child death analyzed by the Children’s Administration, said Mary Meinig, director of the Office of the Family and Children’s Ombudsman. Executive reviews often are high-profile events that include legislators and range of agency representatives.”
- “Still, Meinig said she plans to conduct a separate investigation of Summer Phelps’ death and to come to Spokane as an independent observer of the other agency’s process.
- “How many other eyes were on this child?’ Meinig said Tuesday. ‘Did we know enough to be involved enough to make a referral?’”

“Who speaks for the kids in dependency court?” –*Maureen O’Hagan, Seattle Times, April 25, 2007*

- “Studies have indicated that cases take longer when the child goes unrepresented, according to the state Office of the Family and Children’s Ombudsman.”

“Sirta’s Law’ may help avert future tragedies” –*Diana Hefley, Daily Herald, May 12, 2007*

- “I think this is going to make a difference,” Meinig said. ‘We can’t predict who is capable of hurting a child, but we can look at the system and where there are opportunities to make improvements.”
- “Meinig said the new law may have helped Shayne Abegg. The boy, 4, was found nearly starved to death in March in his father’s south Everett apartment.”

“Helpless at helping our kids.” –*Diane Carman, Denver Post, May 13, 2007*

- “In Washington State, if a doctor notices a child is not thriving, calls social services and sees no action being taken, he or she can call children’s ombudsman Mary Meinig and get results.”
- “Meinig and Alston do not work for state departments of social services, the courts, the schools or the cops. They work for the children and they accept no excuses.”
- In Washington, Meinig’s office acts as ‘neutral fact-finders,’ she said. With no butts to protect except those of the kids, ‘we can identify clearly where the gap in response has occurred, which department failed to make collateral calls and determine what needs to be done right away.’”

“Review delayed in Summer’s Death.” –*JoNel Aleccia, Spokesman Review, May 16, 2007*

- “Mary Meinig is among advocates who worry that such delays dilute the momentum for action that follows egregious deaths such as Summer’s.”
- “‘People want to know what happened and what we need to fix,’ Meinig said. But she and others also acknowledged that balancing the interests of prompt disclosure with the interests of justice is difficult. ‘We want to be timely – and we want to do it right,’ said Meinig.”

“Our Kids: Native American Children” –*Live chat with community expert, Toni Lodge, Spokesman Review, May 17, 2007*

- Q: “Can you discuss obstacle/problems/issues discovered in the Indian Child Welfare system when an Indian Child is killed while in this system? And of the children killed while in foster care; do you have data depicting which minority suffers the greatest losses?”

A: “Indian children had the highest percentage of child deaths of any ethnic group in Washington State. Native people are 2% of the total population and suffered 17% of the child fatalities in 2006, according to [the Office of the Family and Children’s Ombudsman]. Unbelievable and unacceptable. As we are continually exposed to death, trauma, grief and loss, we perpetuate the concept of intergenerational trauma.”

“Report finds similar problems in foster care system” –*Susannah Frame, King 5 News, November 29, 2007*

- “The Ombudsman has dealt with a significant number of complaints involving children with special needs who have been adopted through the foster care system. Parents who have adopted these children... report great difficulty accessing needed services.”
- “The Ombudsman is urging the state to put together a task force to develop an effective response to requests for service from adoptive parents.”

“Report finds complaints growing against DSHS.” –*John Langelier, KXLY4, Aired December 3, 2007*

- “More complaints, more areas of concern and way too much work: In a nutshell that describes the latest report on Washington’s child welfare system.”

“State didn’t do enough to protect starved boy, report says.” –*Diana Hefley, Daily Herald, December 18, 2007*

- “First his parents failed him. Then state social workers let him down. Shayne Abegg, 5 nearly starved to death before someone noticed.”

- “Based on the history of medical and physical neglect, the state should have gone to court to begin the process of removing the children from their parents, according to the DSHS review.... The review team included staff from the Children’s Administration, a pediatrician, sheriff’s detectives and the director of the Family and Children’s Ombudsman.”

“Zarelli targets foster care ills.” *-Kathie Durbin, Columbian, January 10, 2008*

- “Senate Bill 6209 would require DSHS to notify the state Office of the Family and Children’s Ombudsman when it has received a third report of abuse/neglect involving a child, and to inform the ombudsman office of how it dealt with the report.”
- “‘The 2004-05 ombudsman report found 63% of the children who died from abuse or neglect while under state supervision had at least three prior reports in their files,’ Zarelli said. ‘Instead of letting DSHS choose not to investigate a complaint, or deem the complaint unfounded, we need this legislation to put a spotlight on cases where the evidence says a child is at high risk.’”
- “‘Presently, the agency is not required to investigate reports made by these ‘mandatory reporters,’ and Zarelli said the ombudsman has noted that it’s common for them to be disregarded. ‘What’s the point of requiring someone to make a report if we can’t be sure it will be investigated?’ he asked.
- “‘Senate Bill 6206 would expand state law to require investigations of near-fatalities of children under the state’s supervision. It would require legislators to hold public hearings on the finding of fatality and near fatality investigations; require DSHS to post its investigations on a public website; and require the Family and Children’s Ombudsman to issue annual reports on the agency’s progress in implementing recommendations to reduce child fatalities and near-fatalities.’”
- “‘By raising the profile and legislative awareness of near-fatalities as well as deaths, we can increase the chance that corrective action will be taken, and that the agency will be held accountable,’ Zarrelli said.”

“A glut of near-death experiences.” *–Adam Wilson, Olympian Blog, January 18, 2008*

- “File this under sad but true: Asking the Legislature to hold hearings every time a child under state supervision nearly dies would be asking too much. ...Sen. Joe Zarelli, R-Ridgefield, proposed requiring the Department of Social and Health Services to conduct in-depth reviews each [time] there is an unexpected ‘near fatality’ incident with a child under state watch, such as foster care or in-home supervision.”
- “Mary Meinig, the ombudsman in the Office of the Family and Children’s Ombudsman, supported the concept, for rather depressing reasons. ‘Most of these kids are not a fatality because of highly sophisticated medical intervention that saves their lives,’ she said. “We can learn a lot from looking at the system and where the systems had an opportunity to intervene with these families.”

“Foster care bills met with skepticism.” *–Kathie Durbin, Columbian, January 19, 2008*

- “A package of bills introduced by Sen. Joe Zarelli that would hold the state more accountable when it receives reports of abuse or neglect of foster children got an openly skeptical reception from the chairman of the Senate Human Services and Corrections Committee on Friday. ...But the Office of the Family and Children’s Ombudsman, which exercises independent oversight of the Department of

Social and Health Services, said the reforms could provide valuable information to the social workers and even save lives.”

- “...Mary Meinig, director of the ombudsman’s office, said the recommendations resulting from those fatality reviews often get lost. They don’t always get implemented.’ She said Zarelli’s legislation would allow her office to monitor more closely how DSHS acts on the lessons learned when children die or experience life-threatening injuries in state custody.”
- “On the bill requiring notification of the state ombudsman when the state receives the third public complaint of abuse or neglect about an individual child, Hargrove said that could create an overwhelming workload for state workers. ...Receiving that many complaints ‘would be daunting,’ Meinig agreed. ‘But it would also give us some pretty useful information,’ she added. ‘A neighbor calls three times and, bingo, a fatality occurs and it turns out the neighbor was right. We might learn a lot from this. ...One solution to the volume of calls, she said, would be to look at a random selection of calls DSHS receives but chooses not to act on.”

“Bill seeks to keep watch on child abuse.” –*Adam Wilson, Olympian, January 21, 2007*

- “State Sen. Joe Zarelli, R-Ridgefield, proposed three bills last week that would require more reporting by the agency, which needs 1,500 more social workers to keep up with current workload according to a recent report.”
- “The additional reports, many of them to the independent Office of the Family and Children’s Ombudsman, are intended to reduce the worst of the worst cases of abuse and neglect. ‘There’s a lot of proposed demand on our office, but they are all good. They are coming from our recommendations,’ said Mary Meinig, director of the ombudsman’s office.
- “Zarelli also proposed requiring the agency to notify the ombudsman’s office of cases involving multiple reports of child abuse or neglect. An ombudsman’s report found at least three previous reports of abuse where made to the state in 63 percent of the cases that ultimately led to the death of a child. ‘The goal here again is to have the ombudsman have a different set of eyes on it... to try to bring additional oversight into what might be chronic cases,’ Zarelli said.”
- “The ombudsman’s office checks in on thousands of cases each year, but nowhere near 22,000, said Meinig. “That would be daunting. That’s a lot. But it would also give us some valuable information, what do these 22,000 families look like?”

“Deaths of kids raise oversight questions, Relatives are among those seeking independent reviews of DCS cases.” – *Tim Evans, Indianapolis Star, February 18, 2008*

- “In Washington State, lawmakers established an ombudsman office in the mid-1990s after the death of a 3-year-old girl who had just been returned to her parents despite the concerns of some social services workers. Mary Meinig, the state ombudsman, said she is appointed by the governor but is independent and can only be removed for malfeasance. Her post is a Cabinet level position, outranking the head of the child welfare program. Like most ombudsman programs, the office investigates all fatalities or near-fatalities of children who have had any contact with the system within the year before their deaths – in Washington that’s about 110 deaths and near-deaths a year. The office also reviews complaints about the child protection system leveled by children, parents, and others in the community. ‘I think, over the years, we have really created credibility everywhere,’ she said.

- “Having a watchdog is huge . . .,” said Meinig. “There is no doubt that we have intervened in cases where a bias existed” because of conflicts between agency workers and family members.”

“Senate approves Zarelli’s foster care bill.” –*Kathie Durbin, Columbian, February 19, 2008.*

- “Legislation sponsored by state Sen. Joe Zarelli that would require more oversight of children in state-supervised foster care passed the Senate unanimously Monday.”
- “The independent Office of the Family and Children’s Ombudsman would be required to issue an annual report to the legislature describing how recommendations in the fatality and near-fatality reports are being implemented by DSHS caseworkers.”
- “The bill also requires DSHS to promptly notify the ombudsman’s office when a report of child abuse or neglect constitutes the third founded report on the same child or family within a year, and to promptly notify a dependent child’s guardian ad litem when it receives a report that the child being abused or neglected.”
- “Finally, Zarelli’s bill would require the ombudsman’s office to review all child abuse and neglect referrals made in 2006 and 2007 to DSHS by “mandatory reporters – doctors, nurses, child care providers, and professional school personnel, who are required by law to report suspected child abuse or neglect. The ombudsman would have to report to the Legislature by July 2009 on the number and type of referrals, how they were handled, and any apparent patterns in how the department handles referrals.”

“Law requires near-death reviews for children.” –*Kevin Graman, Spokesman Review, March 12, 2008*

- “Senate Bill 6206, which passed unanimously by both houses of the legislature, also requires the Department of Social and Health Services to tell a child’s court-appointed guardian, or guardian ad litem, when a child under state care is reported to have been abused or neglected.”
- “That is an important change in current policy, according to Mary Meinig, director of the Office of the Family and Children’s Ombudsman, who said the policy should already have been in place. . . .The GALs need to know. They are responsible for the child,’ Meinig said. ‘It’s too bad we have to have it legislated.’”
- “The bill also directs Meinig’s office to report annually on how DSHS is implementing recommendations from the child death and near death reviews and requires the ombudsman’s office to analyze reports of child abuse and neglect made by “mandatory reporters.”
- “The ombudsman’s office will look at a random sampling of mandatory reporting and look the “screening decisions” made by the child welfare professionals as to whether the reports were referred for further investigation. ‘The reason for this is DSHS kept having incidents of mandated reporter referrals that had been screened and not investigated,’ Meinig said.”

“Lawmakers take up the fight.” –*Richard Roesler, Spokesman Review, March 30, 2008*

- “Child abuse, neglect and foster care were much on the minds of Washington lawmakers this year, and they approved several changes that advocates long have urged.”
- “Senate Bill 6206 is an attempt to eliminate some ‘blind spots’ in child welfare cases, particularly those involving the death of a child. Under current law, the state must launch a public “child fatality

review” if a state-monitored child dies unexpectedly. SB 6206 tightens up the procedure, banning people involved with the case from being on the review committee and requiring that the reports be published on the internet. It would also require annual reports to the Legislature on whether social workers are making the changes recommended in previous child fatality reviews. The bill is awaiting Gregoire's signature.”

“Making strides, it has been a year of progress since a month long focus on child welfare, yet much work remains.” –Kevin Graman, *Spokesman Review*, March 30, 2008

- “In its most recent annual report, released late last year, the ombudsman’s office found shortcomings in three areas: compliance with the federal Indian Child Welfare Act; long-term treatment for children with mental illnesses; and reducing the workload of caseworkers and supervisors in the Washington Children’s Administration.”
- “In the [reporting] year ending Aug. 31, 2006 the ombudsman’s office, which is charged with overseeing child protection and child welfare services investigated a record 477 complaints. Most of these complaints fell under two categories, ‘failure to protect’ and ‘unnecessary removal’ of children, reflecting the tightrope the Children’s Administration walks in performing its duties.”
- “Since recommending a reduction in caseloads in 2005, the ombudsman’s office has conducted periodic random reviews of the Children’s Administration, consistently finding much higher caseloads in both Child Protective Services and Child Welfare Services units than recommended by the national Council on Accreditation.”
- “Mary Meinig, director of the Office of the Family and Children’s Ombudsman, said these high caseloads are responsible for the ‘severity of morale in the agency and a sense of its staff being overwhelmed and afraid. Meinig’s concerns were confirmed in a study contracted by DSHS that was completed late last year by Walter R. McDonald and Associates in collaboration with American Humane Association.”
- “In its report, the ombudsman’s office also recommended that the state Division of Children and Family Services, the Division of Developmental Disabilities and the Mental Health Division come together to help families with children who can no longer be managed at home... exacerbating these issues, the ombudsman finds that a culture has developed within the agency that frequently shames families who cannot manage special needs children at home,” the report states.

“Foster-care system still struggling.” –Maureen O’Hagan, *Seattle Times*, August 10, 2008

- “Earlier this year, the Office of the Family and Children’s Ombudsman had so many concerns that its director, Mary Meinig, gave her first closed-door legislative briefing. Among other things, she told lawmakers that child fatalities were on the rise and complaint-ridden foster homes were allowed to remain open. Meinig, a neutral, nonpartisan investigator into complaints about the Children’s Administration, later wrote in a memo that it was “imperative” the problems be addressed immediately.”
- “Last February, Meinig, the ombudsman, told key legislators that the number of complaints to her office was ballooning. Some involved children in foster care, and thus came under Braam, but her concerns were broader than that. Most troubling, she said, was that child fatalities were increasing. Eighteen children who were the subject of open child-abuse or –neglect complaints had died in the previous six months. Twelve died in the same period a year earlier.”

- “There were also numerous worrisome incidents that didn’t result in death. One of those, Meinig later said, involved a 12-year-old Pierce County boy who lived with his grandparents. They were suspected of abusing him. Using Stephani’s philosophy of engaging families, workers and relatives came up with a plan: The boy would stay with grandparents, but head to live out back, in a travel trailer with no running water. Police, who arrested the grandparents last summer after the boy said he suffered further abuse, were appalled. ...The agency acknowledged it made an error. But Meinig and others worried that the family –focused policy wasn’t properly understood by workers. In her memo, Meinig wrote that the alleged perpetrators were invited to help decide where abused children should live, and that relatives weren’t being properly scrutinized.”

“Colville’s child and family services under investigation.” *KXLY, Aired August 11, 2008*

- “...complaints are similar, but wide-ranging. State Children and Family Ombudsman Mary Meinig has seen them all. “Safety of children in foster care is one. Removal is another. Removal from parents. Reunification issues. It is a number of issues...”

“This is just the tip of the iceberg.” *–Sophia Aldous, Statesman Examiner, August 13, 2008*

- “A state ombudsman will be in Colville this week as part of a state investigation into the Washington Division of Children and Family Service’s Colville office. The investigation follows a high number of complaints connected to the department.”
- “At the request of the Department of Social and Health Services Secretary Robin Arnold-Williams, ombudsman Mary Meinig will be in Colville meeting with WDCFS staff as well as area groups and individuals concerned about the division practices in Stevens and Ferry counties.”