

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

2010 Annual Report

Mary Meinig, Director Ombudsman
Patrick Dowd, Ombudsman

www.governor.wa.gov/ofco



**STATE OF WASHINGTON
OFFICE OF THE FAMILY AND CHILDREN'S OMBUDSMAN**

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January 2011

To the Residents of Washington State:

I am pleased to submit the 2010 Annual Report of the Office of the Family and Children's Ombudsman. As we enter 2011, the Governor and Legislators have a daunting task of maintaining essential government services and protecting our most vulnerable citizens while establishing a balanced budget at a time of reduced revenues and financial crisis.

Like all state agencies, the Department of Social and Health Services must cope with fewer resources, yet fulfill its mandate to protect children at risk of abuse and neglect and strengthen families. While this is a formidable challenge, it also provides a unique opportunity for partnership between public and private child welfare agencies and redesign how we serve the children and families of Washington State. Examples of these efforts discussed in our report include consolidating performance based contracts for services for children and families through partnership with private agencies and initiatives to eliminate barriers and coordinate services between multiple state agencies serving families.

Our core duties and responsibilities are responding to inquiries and complaints regarding children and families involved with the child welfare system. In 2010 we completed 674 complaint investigations regarding 975 children. The primary issues identified in these complaints were the safety of children and separation and reunification of families. Also discussed in this report are systemic issues identified through our complaint investigations such as effective monitoring of the use of psychotropic medications for children in state care.

Additionally, through our administrative reviews of child fatalities, near fatalities and cases of recurrent maltreatment, we identified common factors which put children at substantial risk of harm and recommend systemic changes to prevent harm. This annual report includes the results of our examination of these case reviews and discusses issues such as screening decisions when Child Protective Services receives a report concerning bruises to a pre-mobile infant. Such reports often precede much more serious harm to the child and provide an opportunity for early intervention.

Finally, I want to express my appreciation to the Governor, the Legislature, the Department of Social and Health Services, private agencies and advocates who are committed to excellence in child welfare outcomes. Most importantly, I thank the parents, youth, relatives, foster parents, professionals and others who brought their concerns to our attention. We take their trust in our office most seriously and it is an honor to serve the citizens of Washington State. 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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REPRESENTATIVE MARY HELEN ROBERTS
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SENATOR VAL STEVENS
21st District

SENATOR DEBBIE REGALA
39th 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.

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

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

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/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.

Ombudsman

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 established by the 1996 Legislature to ensure that government agencies respond appropriately to children in need of state protection, children residing in state care, and children and families under state supervision due to allegations or findings of child abuse or neglect. The office also is intended to promote public awareness about the child protection and welfare system, and to recommend and facilitate broad-based systemic improvements.

This report provides an account of OFCO's complaint investigation activities from September 1, 2009, through August 31, 2010. OFCO's administrative reviews of critical incidents such as child fatalities and near fatalities include cases through December 2010. This report also provides recommendations for statutory and administrative changes designed to improve the quality of state services for children and families.

THE ROLE OF THE OMBUDSMAN

The Ombudsman operates under the Office of the Governor, independent of the Department of Social and Health Services (DSHS). Acting as a neutral and objective fact finder, the Ombudsman provides families and citizens an avenue through which they can obtain an independent and impartial review of the decisions made by DSHS and other state child welfare agencies. The Ombudsman performs its duties by focusing its resources on complaint investigations, complaint intervention and resolution, and system investigations and improvements. The Ombudsman is committed to excellence in child welfare.

INQUIRIES AND COMPLAINT INVESTIGATIONS

OFCO received 1,612 inquiries from families and citizens seeking assistance or information about the child welfare system in 2010. Approximately 42 percent of these contacts were formal complaints requesting an Ombudsman investigation. Between September 1, 2009 and August 31, 2010, OFCO completed 674 complaint investigations regarding 975 children. As in previous years, issues involving the separation and reunification of families and the safety of children living at home or in substitute care were by far the most frequently identified issues in complaints. The majority of completed investigations were standard, non-emergent investigations. Twelve percent of the complaints met OFCO's criteria for an emergent investigation as they involved issues of imminent child safety or well being.

OMBUDSMAN IN ACTION

The annual report describes four main categories of Ombudsman action known as "interventions:" inducing corrective action, facilitating resolution, assisting the agency in avoiding errors and conducting better practice, and preventing future mistakes. Forty-two complaints (six percent) required intervention by the Ombudsman. The vast majority of complaints in which the Ombudsman intervened or assisted resulted in the complaint issue being resolved.

Effective November, 2009, OFCO and DSHS entered into an inter-agency agreement, creating a new protocol for the working relationship between our two agencies and providing greater

transparency in OFCO's work as well as heightened accountability by DSHS. The agreement stipulates that OFCO will provide Children's Administration (CA) with written notice of adverse findings made on a complaint investigation. CA is invited to formally respond to the finding, and may present additional information and request a revision of the finding.

REVIEW OF CRITICAL INCIDENTS

The Ombudsman conducts administrative reviews of cases of recurrent child maltreatment as well as all fatalities and near fatalities of children whose family had an open case with DSHS at the time of death or near fatality, or within a year prior. During this reporting period OFCO conducted 167 administrative reviews of critical incident cases – 64 child fatalities, 25 near fatalities and 78 cases of recurrent maltreatment. Through these reviews, the Ombudsman is able to identify common factors and systemic issues regarding these critical incidents. Issues and recommendations discussed in this section of the annual report include: unsafe sleep environment and child fatalities; prevention of “Shaken Baby Syndrome” or Abusive Head Trauma; CPS referrals reporting babies with bruises; and inadequate CPS investigations.

WORKING TO MAKE A DIFFERENCE

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. This section provides a highlight of those bills on which OFCO provided testimony or those which impact the child welfare system. Legislation discussed in this section addressed topics including: guardianships; youth representation in dependency proceedings; and reports to CPS from law enforcement when a driver is arrested for DUI and children are present in the vehicle.

During this past year there have been several significant court decisions which raise questions about how our child welfare system deals with issues such as parental fitness, placement of a child with a parent residing out of state, CPS child interviews, and the entry of an adoption decree while the order terminating parental rights is under appeal. The Ombudsman analyzes these issues and suggests changes to law or policy for consideration.

SYSTEM IMPROVEMENT EFFORTS

Because of the Ombudsman's independent perspective and knowledge of the child welfare system, the Ombudsman is often invited to participate in efforts to improve outcomes for children and families. During the past year, these efforts include: serving as a member of the *Child Welfare Transformation Design Committee* to in phase I, implement performance based contracts for child welfare services and in phase II, establish pilot projects contracting with private agencies for child welfare case management services; assisted in the development of attorney practice standards, training requirements and caseload standards for attorneys representing children; and participated in collaborative efforts with both public and private agencies to engage fathers in child welfare proceedings.

TERMS AND ACRONYMS

Dependent Child	A child for whom the state is acting as the legal parent.
AIRS	Administrative Incident Reporting System
ARS	Alternative Response System
ARY	At Risk Youth
CA	Children's Administration
CA/N	Child Abuse and Neglect
CDR	Child Death Review
CFR	Child Fatality Review
CHINS	Child in Need of Services
COA	Council on Accreditation of Services for Families and Children
CPS	Child Protective Services
CPT	Child Protection Team
CWS	Child Welfare Services
DCFS	Division of Children and Family Services
DDD	Division of Developmental Disabilities
DOH	Department of Health
DLR	Division of Licensed Resources
DMH	Division of Mental Health
DSHS	Department of Social and Health Services
ECFR	Executive Child Fatality Review
EFSS	Early Family Support Services
FamLink	CA's computerized database introduced in late January 2009
FRS	Family Reconciliation Services
FVS	Family Voluntary Services
ICPC	Interstate Compact for the Placement of Children
OFCO	Office of the Family and Children's Ombudsman
SDM	Structured Decision Making
VSA	Voluntary Service Agreement

KEY FINDINGS AND RECOMMENDATIONS

Require that CPS intake accept for investigation reports of child abuse or neglect alleging bruises to a non-mobile infant. Bruising alone is not indicative of child abuse or neglect and reports to CPS alleging bruises to a non-mobile infant are not necessarily screened in for investigation. Such referrals deserve heightened attention and by accepting these referrals for investigation, CPS has the opportunity to assess risk of maltreatment in the home and if necessary take steps to protect a vulnerable infant.

Improve cross-system collaboration between various departments within DSHS to better serve families. OFCO complaints continue to identify gaps between state systems, such as Children's Administration and the Division of Developmental Disabilities, which are harmful to families and put children at risk.

Identify common causes of delays and take steps to ensure that CPS Investigative Assessments are completed in a timely fashion. CPS' failure to complete Investigative Assessments within the 45-day deadline provided by policy adversely impacts child safety and effective case planning.

Strengthen efforts such as public education campaigns to promote infant "safe sleep." An unsafe sleep environment was identified as a contributing risk factor in 41 percent of the infant fatalities OFCO reviewed. Through increased public education and awareness, many of these deaths were preventable.

Preventing Abusive Head Trauma. Shaking a baby is an extremely dangerous form of child abuse, given the long-term consequences to victims. The most common cause for shaking a baby is inconsolable crying, which is normal infant behavior during the first three to five months of life. The Ombudsman supports coordinated public education campaigns such as "the Period of PURPLE Crying" Program which utilizes a three prong approach reaching maternity wards, pre and post-natal health care units and public education media campaigns.

Amend "Sirita's Law" (RCW 13.34.138) clarifying that the department's duties and responsibilities in this statute apply both when a child is returned home to a custodial parent as well as when the child is placed in the home of a non-custodial parent. In some cases, the department asserts that the provisions of "Sirita's Law" only apply when a child is "returning home," and not when the child is being placed with a non-custodial parent.

Policymakers should consider the risk-benefit of finalizing adoptions when an order terminating parental rights is under appeal and whether state law, court rules or department policy should prohibit or limit this practice. Once parental rights are terminated, an adoption may proceed even if the court decision terminating parental rights is under appeal. This can have devastating results when an adoption is finalized and the underlying termination of parental rights is overturned on appeal.

Improve oversight of the use of psychotropic medications for foster children. The use of psychotropic medication for youth in foster care is much higher than the rate of use for youth in general. Concerns identified by the Ombudsman include: off-label use of prescription psychotropic medications in children, use of multiple medications, lack of coordination between providers, and use of medications as behavioral restraint.

I. ROLE OF THE OMBUDSMAN

“It was quite evident to me that people in CPS respected [the Ombudsman] as someone who worked from a fair and balanced position...”

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.¹ The Ombudsman provides families and citizens an avenue to obtain an independent and impartial review of DSHS decisions. The Ombudsman is also empowered to intervene to induce DSHS to reconsider or change problematic decisions that are in violation of the law or that have placed a child or family at risk of harm, and to recommend system-wide improvements to the Legislature and the Governor.

INDEPENDENCE

One of the Ombudsman's most important features 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.

IMPARTIALITY

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.

CONFIDENTIALITY

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

CREDIBLE REVIEW PROCESS

OFCO has a **credible review process** that promotes respect and confidence in OFCO's oversight of DSHS. Ombudsmen are qualified to analyze issues and conduct investigations into matters of law, administration, and policy. We have collective experience and expertise in child welfare law, social work, mediation, and clinical practice and are trained in the United States Ombudsman Association Governmental Ombudsman Standards. In November 2009, OFCO and DSHS entered into an inter-agency agreement to improve communication, accountability and bring greater clarity to the working relationship between the two agencies.²

¹ The death of three year old Lauria Grace, who was killed by her mother while under the supervision of the Department of Social and Health Services (DSHS) and the discovery of years of 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.

² The inter-agency agreement is available online at http://www.governor.wa.gov/ofco/interagency_ofco_dshs.pdf

AUTHORITY

Under chapter RCW 43.06A, 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.³ 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.

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.

- 4 **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.
- 4 **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.
- 4 **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

³ See also RCW 13.50.100(6)

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.

- 4 **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 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) to perform these activities. The Ombudsman's work activities are described in more detail in the sections that follow.

II. LISTENING TO FAMILIES AND CITIZENS

- Inquiry and Compliant Profiles

*“[The Ombudsman] always listened, had great advice.
...was always the consummate voice of reason.”*

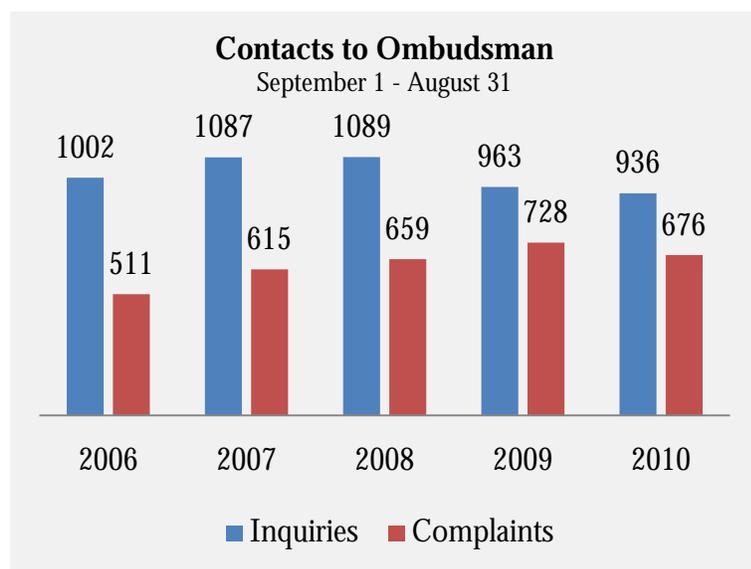
INQUIRY AND COMPLAINT PROFILES

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 2010 reporting year.⁴ Data from previous reporting years is included for comparison.

CONTACTS TO THE OMBUDSMAN

Families and citizens contacted the Ombudsman **1,612** times in 2010. These contacts were **inquiries** made by people seeking information. Approximately 42 percent of these contacts were formal complaints seeking an Ombudsman investigation.



Source: Office of the Family and Children’s Ombudsman, September 2010

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.

⁴ The Ombudsman’s annual reporting period is September 1 to August 31.

MANDATED NOTIFICATION OF CRITICAL INCIDENTS

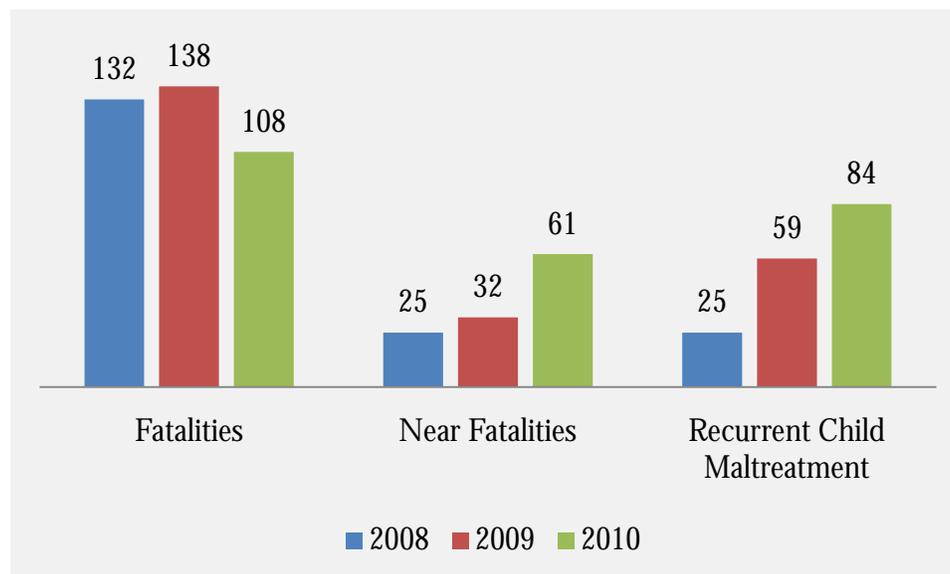
Effective June 2008, the Department of Social and Health Services, Children's Administration (DSHS CA) is required to notify OFCO regarding:

- Ø Child fatalities,
- Ø Child near fatalities and
- Ø Cases in which there has been recurrent child maltreatment, defined as a third founded report of child abuse or neglect regarding the same child or family within a one-year period.

The graph below describes the number of DSHS CA notifiers received and reviewed by OFCO during the three most recent reporting periods. The section on child fatalities and near fatalities appearing later in this report does not include all notifications of these incidents received from DSHS, but rather those incidents that meet OFCO's criteria for review during the calendar year.⁵ The increase in near fatality and third founded case notifications is associated with more reliable notification to OFCO and does not necessarily indicate there has been an increase in these incidents.

DSHS/CA NOTIFICATIONS RECEIVED DURING OFCO REPORTING YEAR, 2008-2010

September 1 – August 31



Source: Office of the Family and Children's Ombudsman, October 2010

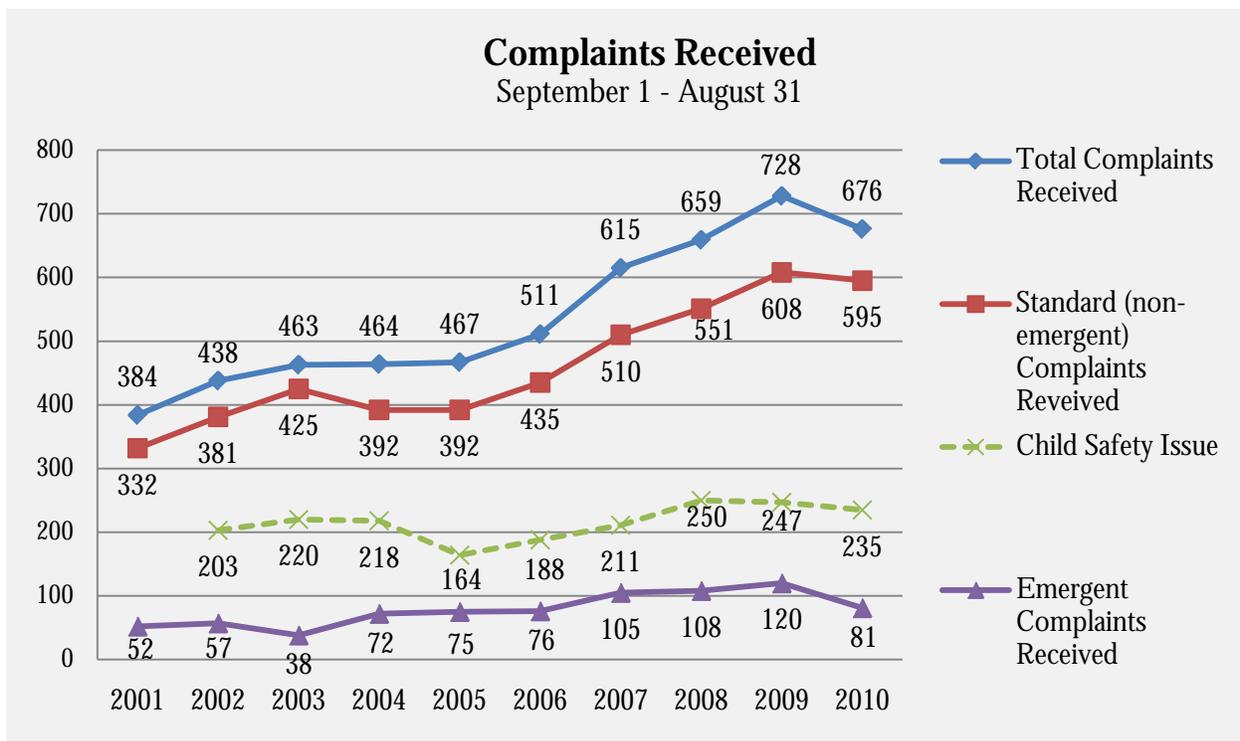
⁵ For further discussion of these criteria and fatality reviews, see OFCO Critical Incident Case Reviews, page 66

COMPLAINTS RECEIVED

A complaint to the Ombudsman must involve an act or omission by DSHS or another state agency serving children that affects:

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

The Ombudsman received 676 complaints in 2010. Of the complaints received, 81 were emergent (12 percent). Emergent complaints most often involved child safety or situations in which timely intervention by the Ombudsman could make a significant difference to a child or family's immediate well-being. Over one-third of all complaints involved a child safety issue (235 complaints, or 35 percent).



Source: Office of the Family and Children's Ombudsman, September 2010

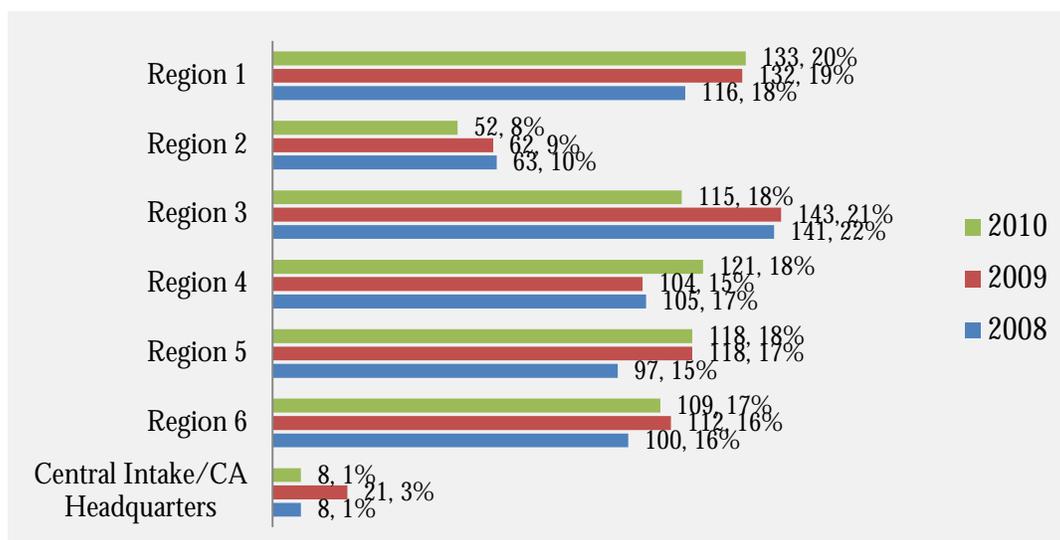
DSHS REGIONS AND DIVISIONS IDENTIFIED IN COMPLAINTS

DSHS Children’s Administration (CA) is the state’s only provider of child protection services and largest provider of child welfare services. It is therefore not surprising that CA was the subject of 97 percent of complaints in 2010.⁶

Of the complaints against the CA, 97 percent were directed at DCFS, which includes Child Protective Services (CPS), Child and Family Welfare and Adoption Services (CFWS or CWS), Family Reconciliation Services (FRS), and Family Voluntary Services (FVS). A small percentage of complaints (three percent) 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.

COMPLAINTS BY DSHS REGION

During the 2010 reporting year, complaints decreased in Regions 2 and 3. The largest increase occurred in Region 4. Complaints in each region for the ten year period from 2000-2010 are shown in Appendix A.



Source: Office of the Family and Children’s Ombudsman, September 2010



<i>Regional Offices</i>	<i>Population⁷</i>	<i>Clients served By CA⁷</i>
Region 1 – Spokane	838,400	29,174
Region 2 – Yakima	565,200	22,799
Region 3 – Everett	1,084,200	34,037
Region 4 – Seattle	1,861,300	39,281
Region 5 – Tacoma	1,035,300	31,930
Region 6 – Vancouver	1,103,600	37,238

⁶ The remaining complaints were directed against other DSHS divisions (such as the Division of Developmental Disabilities [DDD] and Division of Behavioral Health & Rehabilitation [DBHR]), Washington Courts, local Court Appointed Special Advocate (CASA)/Guardian Ad Litem (GAL) programs, DSHS contract providers and tribal welfare services.

⁷ <http://clientdata.rda.dshs.wa.gov/>

COMPLAINTS RECEIVED BY DCFS OFFICE AND REGION 2009-2010

	2009		2010	
	DCFS	DLR	DCFS	DLR
Region 1 Totals	131	1	130	3
Spokane	81		72	2
Colville	16	1	13	
Moses Lake	17		13	
Wenatchee	6		14	1
Colfax	2		4	
Newport	3		6	
Omak	5		7	
Republic	0		1	
Clarkston	1		0	

Region 2 Total	59	3	50	2
Yakima	17	3	18	
Richland/Tri-Cities	20		16	1
Walla Walla	6		8	1
Toppenish	4		3	
Ellensburg	6		3	
Sunnyside	5			
White Salmon	1		1	
Goldendale	0		1	

Region 3 Total	140	3	114	1
Everett	45	3	26	
Bellingham	17		13	1
Alderwood/ Lynnwood	11		23	
Arlington/Smokey Point	26		26	
Mount Vernon	15		9	
Monroe/Sky Valley	15		11	
Oak Harbor	9		5	
Friday Harbor	2		1	

Statewide	21		8	
CA Headquarters	20		6	
Central Intake	1		2	

	2009		2010	
	DCFS	DLR	DCFS	DLR
Region 4 Total	101	3	117	4
King South/Kent	16		28	1
Martin Luther King Jr.	29		19	
King West	24		22	
King East/Bellevue	13		24	
Office of Indian Child Welfare	6		7	
Seattle Centralized Services	4		9	
White Center	1		7	
Seattle Central	8	3	1	3

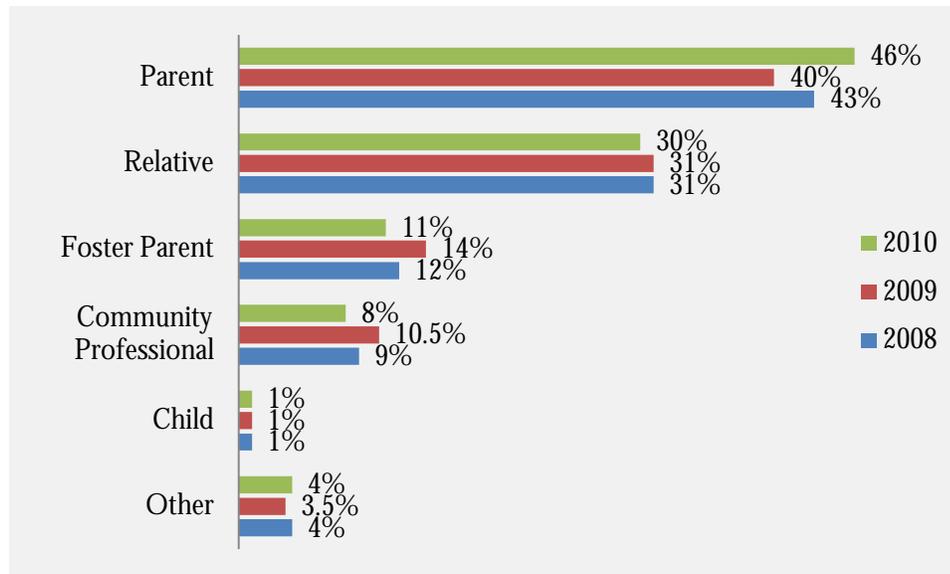
Region 5 Total	114	4	114	4
Centralized Services	90	4	4	4
Pierce East			38	
Pierce West			46	
Bremerton/Kitsap	24		26	

Region 6 Total	110	2	106	3
Vancouver	31		27	
Aberdeen	11		18	1
Port Angeles	9		6	
Centralia	5		9	
Tumwater	10		8	
Kelso	11		8	
Shelton	3	1	7	
Stevenson	5		2	
Lacey/Olympia	11	1	7	2
South Bend	4		3	
Long Beach	0		7	
Port Townsend	8		3	
Forks	2		1	

COMPLAINANT PROFILES

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 few children contacting the Ombudsman on their own behalf.



Source: Office of the Family and Children's Ombudsman, September 2010

RACE/ETHNICITY OF THE PERSON 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 2008*	OFCO 2009*	OFCO 2010*	WA State Census**
Caucasian	80.1%	81.2%	73.5%	83.8%
African American	9.7%	8.9%	10.7%	3.9%
American Indian/Alaska Native	6.7%	5.4%	5.0%	1.8%
Asian/Pacific Islander	1.8%	2.1%	1.8%	7.5%
Other	1.5%	1.2%	3.3%	--
Multi-Racial	5.5%	5.8%	3.3%	3.1%
Hispanic***	5.0%	5.9%	5.3%	10.3%
Declined to Answer	5.6%	4.5%	9.0%	--

*Data adds up to over 100 percent because OFCO complaint form allows people to select more than one race/ethnicity.

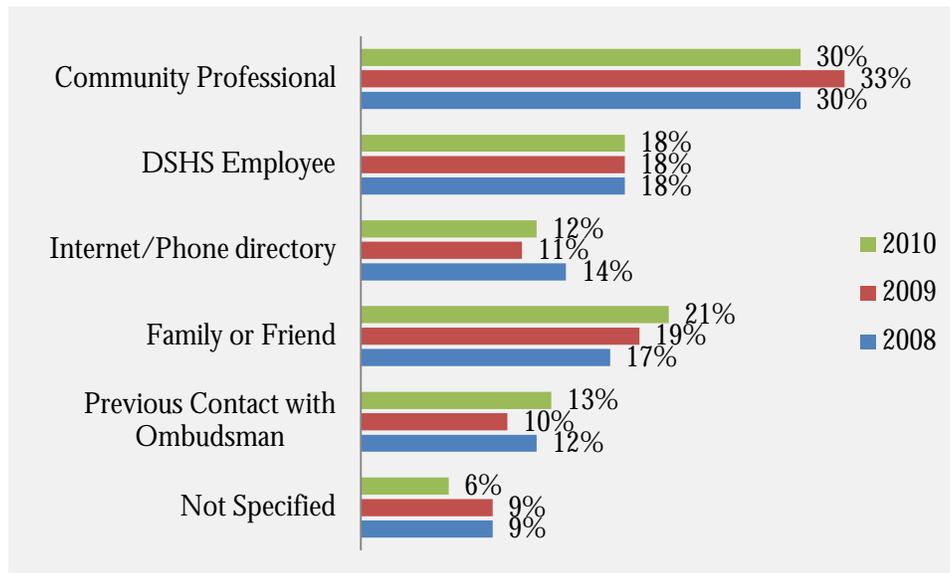
**Taken from US Census 2009 estimates at <http://quickfacts.census.gov/qfd/states/53000.html>

*** People of Hispanic ethnicity may be of any race, so also are included in applicable race categories.

As the table above shows, African Americans and American Indians are over-represented in complaints made to OFCO as compared with their representation in state population data, while Hispanics and Asians are under-represented. OFCO may need to strengthen outreach efforts to Hispanic and Asian population groups. However, when racial data of children who were the subject of our complaints is compared with the population of children served by the CA, OFCO appears to be evenly representing children in the child welfare system.

HOW THEY HEARD ABOUT THE OMBUDSMAN

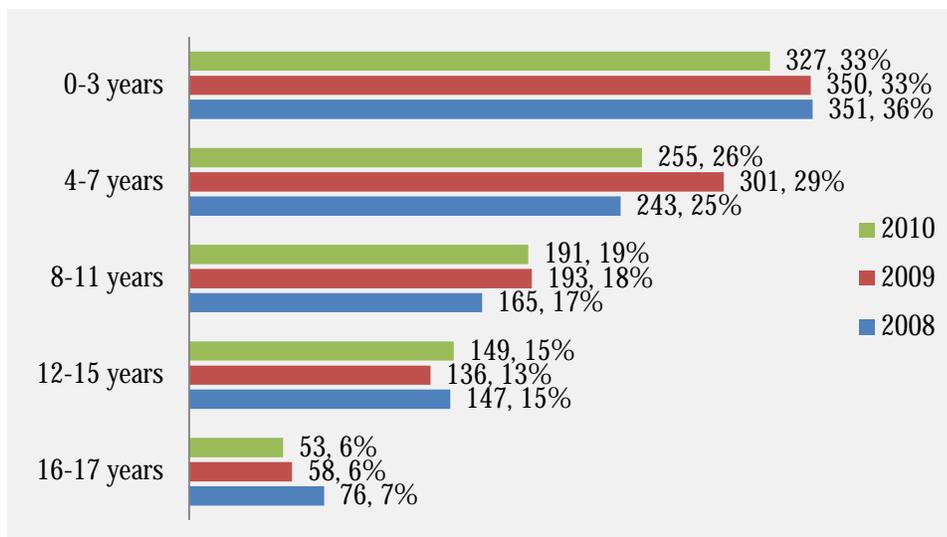
The majority of individuals filing complaints with the Ombudsman indicated that they were referred to the office by someone else. Many individuals reported that they were referred by a **community professional/service provider** (e.g., teacher, counselor, child care provider, doctor, private agency social 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 website or telephone directory**. The remaining complainants did not specify how they heard about the Ombudsman.



Source: Office of the Family and Children's Ombudsman, September 2010

AGE OF CHILDREN IDENTIFIED IN COMPLAINTS

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



Source: Office of the Family and Children's Ombudsman, September 2010

Note: Children identified in more than one complaint are counted more than once.

Note: 1 percent of children were 18 years or older in 2009 and 2010.

RACE/ETHNICITY OF CHILDREN IDENTIFIED IN COMPLAINTS

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

Race/Ethnicity	OFCO 2008*	OFCO 2009*	OFCO 2010*	Children's Administration**	WA Population**
Caucasian	80.8%	78.8%	77.9%	59.7%	80.6%
African American	17.2%	15.8%	20.2%	9.8%	4.5%
American Indian/Alaska Native	11.3%	12%	11.5%	12.1%	2.0%
Asian/Pacific Islander	3.5%	4.7%	4.8%	1.4%	6.8%
Other	2.7%	2.0%	2.3%	3.4%	0%
Multi-Racial	15.5%	14.3%	17.4%	11.8%	6.0%
Hispanic***	12.5%	11.9%	14.0%	15.5%	15.5%
Declined to Answer	0.1%		0.8%	1.7%	

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

**Race of children in placement, taken from Children's Administration Performance Report 2008

<http://www.dshs.wa.gov/pdf/ca/08Report1.pdf>

*** People of Hispanic ethnicity may be of any race, so also are included in applicable race categories.

COMPLAINT ISSUES

The following table shows the number of times various issues within these categories were identified in complaints.⁸ A new category added to the table since last year is that of complaints involving child safety in child care facilities, a component of Department of Early Learning services which falls broadly within OFCO's jurisdiction.⁹

As in previous years, issues involving the **separation and reunification of families** (raised **313** times in complaints) and the **safety of children living at home or in substitute care** (raised **235** times in complaints), were by far the most frequently identified issues in complaints to the Ombudsman. **Both of these complaint categories decreased slightly** in 2010; however, some of the subcategories within each of them shifted noticeably. Concerns about the *safety of children in out-of-home care* have **decreased steadily** since 2008; 20 percent fewer complaints about this issue were received in 2010 than 2009, following a 25 percent decrease in 2009 compared with 2008.

Complaints about **family separation and reunification** looked quite different in 2010 compared with 2009:

- Complaints about *children being unnecessarily removed from parents* **increased by 16 percent** since 2009 and by **two-thirds** since 2008.
- Complaints about *lack of contact between children and their parents or other family members* **increased by 30 percent** since 2008 and 2009 when the numbers were very similar. The increase in complaints about lack of contact between siblings may be attributable to the child welfare community's increased attention to this issue.
- Complaints about *unnecessary removals of children from relative placements* declined further in 2010, after decreasing in 2009 over 2008, representing a **decrease of 36 percent** since 2008.
- Complaints about *inappropriate placements of children* **decreased by 29 percent** since 2009, returning to a similar number as in 2008.
- Complaints about the agency's *failure to reunite families* dropped further from 2009 numbers to a **decrease of 25 percent** since 2008.

Also as in previous years, the **welfare and permanency of dependent children** remained our third-highest category of complaint issues (raised **161** times in complaints); however, as in the top two major issue categories, the numbers within certain subcategories changed noticeably:

- Complaints about *unnecessary moves of children or inadequate transition between moves* **decreased by 29 percent**¹⁰ in 2009, returning to a similar amount as received in 2008.
- Complaints about *delays in permanency* for children **increased 200 percent**.¹¹
- Complaints about *adoption support services and other adoption issues* **more than doubled** in 2010, compared with 2009 and 2008.
- Complaints about *inadequate services to children in facilities* **decreased** markedly, by over three-quarters.

⁸ Many complainants raise multiple complex issues, however only the primary complaint issues are documented in the Ombudsman's complaint tracking database, and reported in the "frequently identified issues" table in this report. Anecdotally, complainants often express concerns about communication failures, unprofessional conduct, retaliation, and inadequate or delayed services, as issues secondary to the primary complaint issue(s).

⁹ See OFCO's authorizing statute, RCW 43.06A.010.

¹⁰ Because complaints about "multiple moves" in foster care were tracked separately from this category in 2010 for the first time, the percent decrease includes complaints about multiple moves.

¹¹ OFCO started tracking complaints about delays in permanency separately in 2009; when those numbers are combined with other permanency issues, as they were in 2008, the change in numbers is less remarkable.

It is difficult to draw conclusions about patterns or trends in other complaint issues given their relatively small numbers, and the fact that OFCO captures only the major complaint issues in complaints that identify multiple issues. Nevertheless, some changes regarding complaint issues may be worth noting. Complaints about **foster parent retaliation dropped**, but complaints about **licensing issues almost doubled**. Licensing issues include investigations of licensing complaints, the licensing process, and corrective action taken by DLR regarding foster care licenses. Complaints regarding lack of support of foster parents remained steady. **Children's legal issues** (often to do with the lack of a guardian ad litem (GAL) or attorney, or failures to follow the Indian Child Welfare Act in the cases of Native American children) **increased** markedly, as did **communication failures**. Complaints about FamLink issues decreased by 75 percent between 2009 and 2010, most likely as a result of the agency resolving payment issues to providers that were complained about frequently in 2009.

FREQUENTLY IDENTIFIED COMPLAINT ISSUES

ISSUE	NUMBER OF COMPLAINTS		
	2008	2009	2010
CHILD SAFETY	250	247	235
Failure to protect children from parental abuse or neglect	138	144	150
Physical abuse	48	45	50
Sexual abuse	24	27	29
Emotional abuse	13	15	13
Neglect/lack of supervision	53	52	51
Other	0	5	7
Developmentally disabled child in need of protection	2	2	0
Children with no parent willing/capable of providing care	17	14	9
Failure to address safety concerns involving dependent child in foster care or other substitute care	76	60	48
Failure to address safety concerns involving child being returned to parental care	17	26	25
Safety of children in institutions	0	1	3
DEPENDENT CHILD HEALTH, WELL-BEING AND PERMANENCY	165	167	161
Unnecessary/inappropriate change of child's placement, inadequate transition to new placement	45	59	35
Placement instability/multiple moves in foster care	-- ¹²	-- ¹³	7
Failure to provide child with medical, mental health, educational or other services, or inadequate service plan	52	41	41
Unreasonable delay in achieving permanency	-- ¹⁴	3	9
Inappropriate permanency plan /other permanency issues	47	40	26
ICPC ¹⁵ issues	-- ¹⁶	1	4
Inadequate transition to independent living	-- ¹⁷	3	3
Failure to provide appropriate adoption support services/other adoption issues	14	16	33
Inadequate services to dependent/non-dependent children in institutions and facilities	7	14	3

¹² Not tracked separately in 2008, captured as inappropriate change of child's placement (preceding category).

¹³ As above.

¹⁴ Numbers for this category were added to numbers for "inappropriate permanency plan" in 2008.

¹⁵ Interstate Compact on the Placement of Children.

¹⁶ These numbers were not separately tracked in 2008.

¹⁷ These numbers were not separately tracked in 2008.

ISSUE	NUMBER OF COMPLAINTS		
	2008	2009	2010
FAMILY SEPARATION AND REUNIFICATION	309	329	313
Unnecessary removal of child from parental care	40	57	66
Unnecessary removal of child from relative placement	28	28	18
Failure to place child with relative (including siblings)	68	62	62
Failure to place child with other parent	-- ¹⁸	3	0
Other inappropriate placement of child	22	34	25
Failure to provide appropriate contact between child and parent/other family members (excluding siblings)	43	44	57
Failure to provide contact with siblings	-- ¹⁹	2	8
Failure to reunite family	86	81	65
Inappropriate termination of parental rights	5	5	2
Concerns regarding voluntary placement and/or service agreements for non-dependent children	10	6	8
Other family separation concerns	7	7	2
COMPLAINTS ABOUT AGENCY SERVICES	19	51	49
Inadequate CPS investigation	7	1	1
Failure to screen in CPS referral	3	0	0
Delay in completing CPS investigation	3	4	3
Unreasonable CPS findings	--	31	29
Failure to notify subject of CPS investigation of CPS findings	3	0	0
Heavy-handedness by CPS worker/unreasonable demands on family	3	8	11
Poor case management, high caseworker turnover, other poor service issues	-- ²⁰	7	1
Lack of coordination between DSHS Divisions	-- ²¹	--	4

¹⁸ Not separately tracked in 2008.

¹⁹ Not separately tracked in 2008.

²⁰ Not separately tracked in 2008.

²¹ Not separately tracked in 2008 and 2009.

ISSUE	NUMBER OF COMPLAINTS		
	2008	2009	2010
OTHER COMMON COMPLAINT ISSUES	100	110	143
Foster parent retaliation	6	12	7
Foster care licensing issues	-- ²²	5	9
Lack of support/services to foster parent/other foster parent issues	15	15	13
Retaliation against relative caregiver	-- ²³	2	1
Lack of support/services to relative caregiver/other relative caregiver issues	4	7	6
Breach of confidentiality by agency	7	10	14
Unprofessional conduct, harassment, retaliation or discrimination by agency staff	9	10	10
Children's legal issues	4	1	12
Violation of parent's rights	-- ²⁴	10	9
Failure to provide parent with services/other parent issues	39	11	9
Communication failures	16	7	38
FamLink²⁵-related issues (mostly delay in payment to foster parents/providers)	-- ²⁶	12	3
Inaccurate agency records	-- ²⁷	8	9
Department of Early Learning – child safety in child care facilities	-- ²⁸	--	3

²² This number was reported together with the next category along with other foster parent issues in 2008.

²³ Not tracked in 2008.

²⁴ This category was reported together with the next category along with other parent issues in 2008.

²⁵ FamLink is CA's new computerized database introduced in late January 2009.

²⁶ Not tracked in 2008.

²⁷ Not tracked in 2008.

²⁸ Not tracked in 2008 or 2009.

III. TAKING ACTION ON BEHALF OF VULNERABLE CHILDREN AND FAMILIES

PART ONE: INVESTIGATING COMPLAINTS

- Completed Investigations and Results
- Intervention by the Ombudsman
- Ombudsman’s Adverse Findings
- Agency Responses to Adverse Findings

PART TWO: IMPROVING THE SYSTEM

- Systemic Intervention: Lack of Coordination between DSHS Divisions
- Systemic Issue: Psychotropic Medications and Dependent Children
- System Issue: FamLink

“This is the first time I have used this avenue of aid in resolving a case – I was very satisfied with the outcome of this case and the Office of the Family and Children’s Ombudsman certainly helped in the final resolution.”

PART ONE: INVESTIGATING COMPLAINTS

The Ombudsman reviews every complaint received to determine whether it falls within OFCO's jurisdiction.²⁹ Through impartial investigation and analysis, the Ombudsman determines an appropriate response such as:

- In cases where the Ombudsman finds that the agency is properly carrying out its duties with regard to the complaint issue, the Ombudsman explains why the alleged conduct is not a violation of law or policy or unreasonable under the circumstances and helps individuals better understand the role and responsibilities of child welfare agencies.
- In cases in which the Ombudsman makes an adverse finding regarding either the complaint issue or another problematic issue identified by the Ombudsman, the Ombudsman may work to change a decision or course of action by DSHS or another state agency.
- The Ombudsman often concludes that the state agency is acting clearly within its discretion and is reasonably exercising its authority, yet the complaint identifies legitimate concerns. In these cases the Ombudsman may provide assistance to help resolve the complaint.

The Ombudsman's goal in 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.

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:

1. The alleged agency action (or inaction) is within the Ombudsman's jurisdiction.
2. The action did occur.
3. The action violated law, policy or procedure, or was clearly inappropriate or clearly unreasonable under the circumstances.
4. 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.

²⁹ The Ombudsman may also initiate an investigation without a complaint. During the 2010 reporting period, OFCO initiated 14 investigations. Three of the OFCO-initiated investigations were closed and eleven of the investigations remained open (often for monitoring only) at the end of the reporting period.

COMPLETED INVESTIGATIONS AND RESULTS

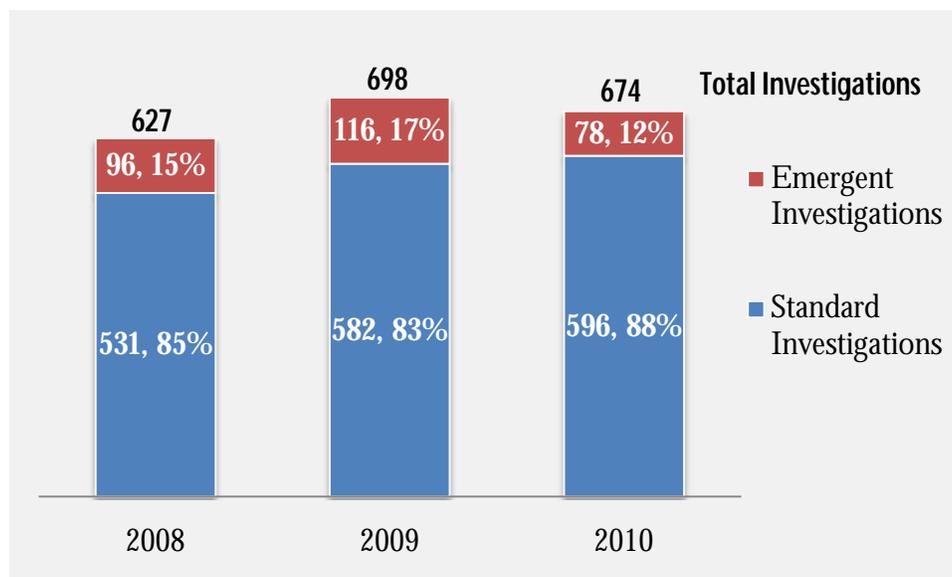
COMPLETED INVESTIGATIONS

The Ombudsman completed **674 complaint investigations** in 2010.³⁰ These investigations involved **975 children and more than 674 families**. As in previous years, the majority of these investigations were **standard non-emergent investigations** (88 percent).

In 2010, about one out of every eight investigations (12 percent) 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 alleviate a child or family’s distress. When taking an emergent complaint, the Ombudsman begins the investigation immediately after receiving a call from a complainant, or after screening a complaint received by mail as emergent. Over the years, the Ombudsman has substantiated or intervened in emergent complaints at a higher rate than non-emergent complaints. In 2010, the Ombudsman intervened or provided assistance to resolve concerns in 30 percent of emergent complaints, compared with nine percent of non-emergent complaints.

For examples of emergent complaints, see examples C and D in the Ombudsman in Action tables.³¹

Type of Investigations Completed
September 1 to August 31



Source: Office of the Family and Children’s Ombudsman, September 2010

³⁰ Of the 2010 complaints, 85 percent were investigations of complaints received during that reporting year, while 15 percent were of complaints received in a previous year. At the end of 2010, 11 percent 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 2010, including these identical complaints from more than one complainant, was 709.

³¹ Example C, page 37; Example D, page 40.

INVESTIGATION RESULTS

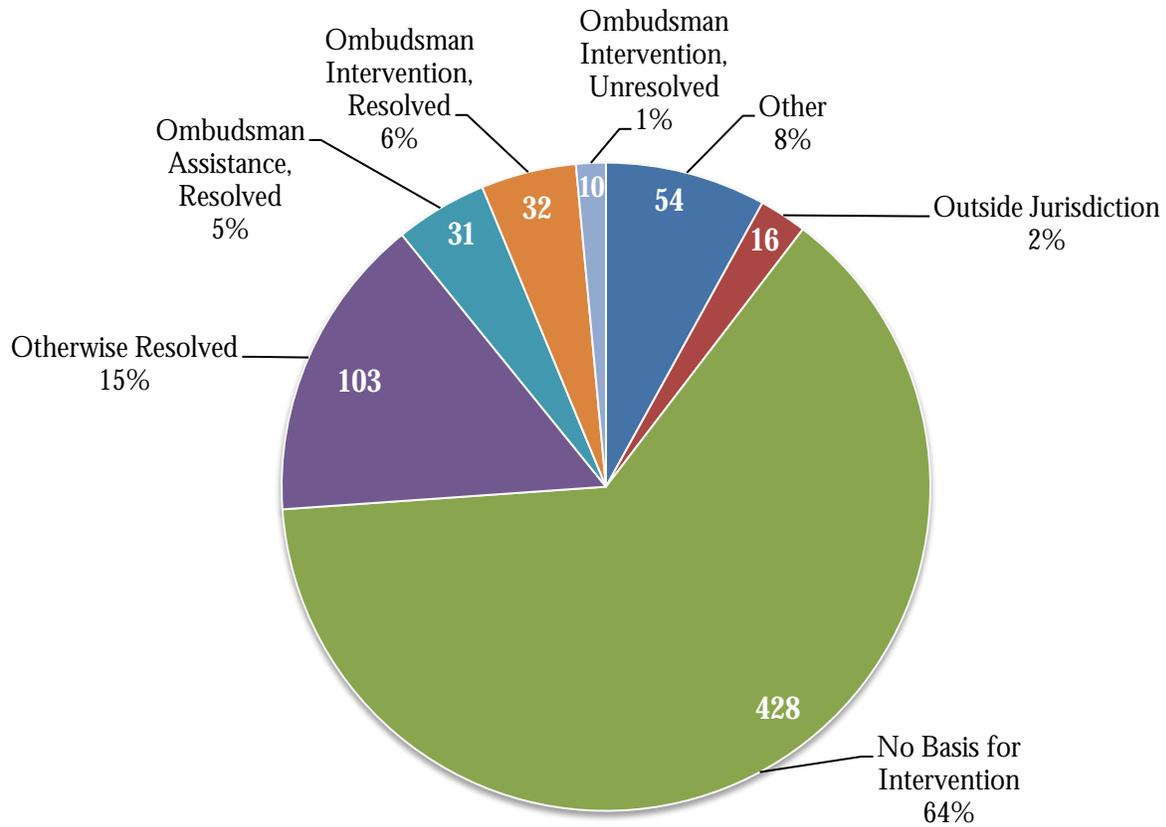
Complaint investigations result in one of the following courses of action:

- Ø **Ombudsman Intervention:** The Ombudsman substantiated the complaint issue and intervened to correct a violation of law or policy, or to achieve a positive outcome for a child or family.
- Ø **Ombudsman Assistance:** The complaint was substantiated, but the Ombudsman did not find a clear violation or unreasonable action. The Ombudsman provided substantial assistance to the complainant, the agency or both, to resolve the complaint.
- Ø **Otherwise Resolved:** The complaint issue may or may not have been substantiated, but was resolved by the complainant, the agency, or some other factor. In the process, the Ombudsman may have offered suggestions, referred complainants to community resources, made informal recommendations to agency staff, or provided other helpful information to the complainant.
- Ø **No Basis for Intervention:** The complaint issue was unsubstantiated, and the Ombudsman found no agency errors in reviewing the case. The Ombudsman explained why the alleged action is not a violation of law or policy or unreasonable under the circumstances and helped the complainant better understand the role and responsibilities of the child welfare agency.
- Ø **Outside Jurisdiction:** The complaint was found to involve agencies or actions that were outside of OFCO's jurisdiction. When possible, the Ombudsman refers complainants to an appropriate office or agency that may be able to assist them with their concern.
- Ø **Other:** The complaint was withdrawn, became moot, or further investigation or action by the Ombudsman was unfeasible for other reasons.

Investigation results have remained fairly consistent over the last three years. As in previous years, the Ombudsman **assisted or intervened** to resolve the situation in **11 percent of complaints** in 2010. This represents 72 complaints, involving at least 72 families, and many more children. Similar to previous years, **just under two-thirds** of complaint investigations in 2010 (**64 percent**) found the complaint issue to be **unsubstantiated**.

INVESTIGATIONS RESULTS

TOTAL COMPLAINTS=674



Source: Office of the Family and Children's Ombudsman, September 2010
Note: Total percentage is 101 percent due to rounding

INTERVENTION BY THE OMBUDSMAN

The Ombudsman takes action when necessary to avert or correct a harmful oversight or avoidable mistake by the Department of Social and Health Services (DSHS) or another agency. **Forty-two complaints (six percent) required intervention by the Ombudsman.**³² Many of these investigations required a substantial investment of time by the Ombudsman. As stated earlier in this section, the rate of intervention was higher in emergent complaints (14 complaints, or 18 percent) than non-emergent complaints (28 complaints, or five percent).³³

The following tables provide examples of four different types of interventions typically taken by the Ombudsman:

1. Interventions to induce corrective action.
2. Interventions to facilitate resolution of an agency error and/or a CA client's concerns.
3. Interventions to help the agency avoid errors and conduct better practice.
4. Interventions to help the agency avoid future mistakes. These are 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 the problem to the attention of agency officials, so steps can be taken to prevent such errors from recurring in the future (see Example D, in Preventing Future Mistakes, page 40).

The tables below provide examples of interventions for each of these four categories. Each example summarizes the investigative finding, the action taken by the Ombudsman to address the problem, and the outcome. The findings are organized by the key issue involved in the finding.

OMBUDSMAN IN ACTION: INDUCING CORRECTIVE ACTION

<i>Key Issue</i>	<i>Investigative Finding</i>	<i>Ombudsman Action</i>	<i>Outcome</i>
Unreasonable removal of a three year old child from a relative caregiver	CWS removed a three year old dependent child from a relative placement the child had been in for most of the child's life, after learning about the relative's history of mental illness over 20 years ago, and the relative's failure to disclose this history during the foster care licensing process. The Ombudsman found the decision to remove the child and deny subsequent visits between the relative and the child, to be clearly unreasonable, based on the excellent care provided to the child during the placement, and the relative's lack of problems in the last 20 years.	The Ombudsman requested a review of this decision by CA Headquarters. After reviewing the case, CA agreed to conduct an adoption home study on the relative. While the adoption home study was being completed, the child's new foster-adopt home requested that the child be moved due to the child's failure to attach to the new family.	The adoption home study on the relative was approved, and the now legally free child was placed back in the relative's home for adoption.

³² This percentage represents a two percent decrease since 2009.

³³ Emergent complaints were also resolved by CA without Ombudsman intervention or assistance at a considerably higher rate (23 percent) than standard complaints (14 percent).

<p>Failure to take appropriate action to protect children from abuse and neglect</p>	<p>DCFS/CPS entered into a Voluntary Placement Agreement³⁴ with the parents of two non-dependent children, ages five and nine, after allegations of physical abuse by the father, and neglect (failure to protect) by the mother were founded. A subsequent Child Protection Team staffing recommended various services for the parents, and expressed concern that the problems in the family would not be resolved in the agreed-upon 60 days and that a longer period of out-of-home care should be considered. CPS obtained an extension on the VPA for an additional 30 days and transferred the case to Family Voluntary Services (FVS). FVS, however, was able to provide only limited services due to law enforcement's ongoing investigation. The Ombudsman found that the parents were violating the safety plan and having unauthorized contact with the children.</p>	<p>The Ombudsman contacted the CPS supervisor and requested a review of the children's safety in their current placement, and to consider filing a dependency petition.</p>	<p>CPS filed a dependency petition and moved the children to a different placement to ensure their safety.</p>
<p>Inadequate CPS investigation, unreasonable CPS finding</p>	<p>DCFS/CPS failed to adequately investigate allegations of physical abuse and neglect of two children, ages three and nine months, by their parents. The older child was in an in-home dependency. The Ombudsman found that the referral had been screened in for a 72-hour response, yet the initial face-to-face contact with the family occurred only ten days after the referral was received. No safety assessment was documented as required by policy. CPS never interviewed the father, despite his being named as a subject in the referral and being present in the home at the time of the initial CPS visit. The Ombudsman also concluded that CPS's finding that the allegations of maltreatment were "founded" was not supported by the evidence gathered during CPS's investigation.</p>	<p>The Ombudsman contacted the CPS supervisor to request a review of the investigation and the finding.</p>	<p>CPS did so, and changed the finding from "founded" to "unfounded".</p>

³⁴ Voluntary Placement Agreements have been discontinued as of December 1, 2010 per a budget reduction plan issued by DSHS CA in September, 2010. See [Agency Plan for 6.287 Percent GF-S Allotment Reduction](http://www.dshs.wa.gov/pdf/budget/DSHSCAplan.pdf) at <http://www.dshs.wa.gov/pdf/budget/DSHSCAplan.pdf>

Delay in permanency for a three year old dependent child	CWS failed to comply with timelines stipulated in federal law (ASFA ³⁵) to expedite permanency for a three year old dependent child who had been in out-of-home care for two years and four months, and in a pre-adoptive home for 19 months. CWS had not referred this case for a petition to terminate parental rights even though the parents were neither engaged in services nor visiting the child.	The Ombudsman contacted the area administrator and requested a review of the case for delay in permanency.	The area administrator agreed to have the termination petition prioritized. The petition was forwarded to the Attorney General's office within three weeks.
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OMBUDSMAN IN ACTION: FACILITATING RESOLUTION

<i>Key Issue</i>	<i>Investigative Finding</i>	<i>Ombudsman Action</i>	<i>Outcome</i>
EXAMPLE A CPS referral screened out unreasonably	CPS intake declined to accept a referral alleging bruising on a nine year old non-dependent child, reportedly inflicted by the parent's paramour, because the referent did not have the family's current address. The Ombudsman found that the family's address was already in the FamLink system, as there was a pending investigation regarding this family.	The Ombudsman called the intake supervisor to inform her of this information.	The intake supervisor agreed to call the referent and conduct an intake. In addition, the supervisor asked law enforcement to conduct a child welfare check on the children.
EXAMPLE B Well-being of foster youth receiving Foster Care to 21 services	CWS informed a foster parent that the foster care payment and services for a foster youth who was about to turn 18 would be reduced. The youth was still in high school and needed the same level of care and services.	The Ombudsman contacted the CA Independent Living Program manager and learned that since the youth was still in high school, the foster care rate and services should continue to be based on the youth's needs and re-evaluated every six months, as per usual procedures. The Ombudsman contacted the social worker, supervisor and area administrator to ensure that they were aware of the correct policy determining this youth's placement.	CWS agreed that the current rate and services would remain in effect until the regular six month foster care rate review.

³⁵ Adoption and Safe Families Act of 1997, Public Law 105-89 105th Congress, 42 USC 1305.

<p>EXAMPLE C Mitigating risk associated with children's court ordered return to unsafe home environment.</p>	<p>The court ordered the return home of three non-dependent children, ages five, nine and twelve, against DCFS's recommendation. The children had been removed due to ongoing chronic neglect and physical abuse. The CPS referral resulting in the children's removal was founded for physical abuse and for neglect. The family had a history of 19 CPS referrals in the last 11 years, alleging substandard living conditions. The judge stated that he did not believe the children were at substantial risk of harm. The Ombudsman agreed with the agency's assessment that the home was a clearly unsafe environment for the children.</p>	<p>The Ombudsman contacted CA Headquarters to request a review of this case³⁶ to determine what could be done to ensure the children's safety and well-being under the circumstances.</p>	<p>A Practice Consultant from Headquarters reviewed and staffed the case with the DCFS office involved. Family preservation services were provided to the family, with a primary goal of increasing the safety of the home. DCFS monitored the children's safety in the home through regular home visits and frequent communication with service providers involved with the family.</p>
<p>Unreasonable denial of foster care license</p>	<p>DLR denied a relative caregiver's application for a foster care license due to the caregiver's old criminal record from another state. This was the relative's third attempt to obtain a foster license, while caring for two dependent children, ages four and five, for the past two and a half years. After the most recent unsuccessful attempt to resolve this barrier, the relative had been informed by the other state that the old convictions had been expunged due to no subsequent convictions in 18 years.</p>	<p>The Ombudsman requested that the DLR area administrator review the licensing file to clarify the issue regarding the criminal record. This review found conflicting information, and DLR requested a review of the expungement records by the Assistant Attorney General, who confirmed that the records were indeed expunged and were no longer disqualifying.</p>	<p>The Ombudsman requested that DLR assist the relative with a third attempt to obtain a license, and expedite the process. This occurred.</p>

³⁶ OFCO requested a review of this case along with others with similar safety concerns in that DCFS office – see last finding in next table.

OMBUDSMAN IN ACTION: ASSISTING THE AGENCY IN AVOIDING ERRORS AND CONDUCTING BETTER PRACTICE

<i>Key Issue</i>	<i>Investigative Finding</i>	<i>Ombudsman Action</i>	<i>Outcome</i>
Unreasonable removal from permanent placement	CWS planned to remove three legally free children, ages thirteen, seven and two years old, from their foster-adopt home, due to expiration of an administrative approval allowing more children than the home is licensed for. The Ombudsman found this plan to be clearly unreasonable, as the children had been living in the home for more than two years, and there was an imminent plan for either adoption or guardianship of the children by the foster parents.	The Ombudsman contacted the DLR area administrator with a request to explore what could be done to extend the over-capacity approval until permanency was achieved for these children.	DLR, CWS and the foster parent reached an agreement that the children would remain in the home pending adoption proceedings, after which the foster parent would close the foster care license. This was achieved.
Foster care drift for young children	In the process of investigating two unrelated complaints regarding permanency planning and services for two different children in foster care, the Ombudsman found that both of these two year old dependent children had both been placed in at least six different homes within a one year period. One of the children was showing clear signs of trauma related to disrupted attachment and care, as diagnosed by a psychologist. The other child was exhibiting behavior and emotional problems. The Ombudsman found that such placement instability was not only a violation of the Braam Settlement Agreement ³⁷ , but especially troubling given the developmental stage of these young children.	The Ombudsman wrote a letter to the CA Assistant Secretary to bring these two cases to her attention, recommending “a closer examination of the casework practice in these cases [which] may lead to improved practice to avoid moving children multiple times in the future.”	The Assistant Secretary responded that these cases were “thoroughly reviewed . . . with the staff involved to address both performance and practice concerns.” One of the children had been returned home, and services such as a developmental evaluation, speech therapy, Parent-Child Interaction Therapy, special education, and specialized day care were set up. The agency plans to “keep the case open until we are sure that [child] is well monitored in the school system.” The other child was placed in a potential permanent placement and a petition for termination of parental rights was filed. The child’s case had been reassigned, but performance issues with the previous social worker and supervisor were addressed. The case is being monitored at a high level (by the Deputy Regional Administrator).

³⁷ Braam v. State of Washington Final Settlement, July 31, 2004, available at: <http://www.braampanel.org/SettlementAgreement.pdf>

<p>No representation for legally free child during critical decisions</p>	<p>In the course of investigating a complaint regarding a ten year old legally free child who had experienced multiple out-of-home placements and the recent disruption of a pre-adoptive placement, the Ombudsman discovered that the child had no representation in court.</p>	<p>The Ombudsman contacted the area administrator to request that either a CASA/GAL or an attorney be sought to represent the child. The area administrator declined, with the rationale that legally free children are not the priority for CASA or attorney representation, and that the child's case was being handled by a special adoption recruitment unit. The Ombudsman appealed to the regional administrator with this request.</p>	<p>The regional administrator readily agreed to pursue representation for the child in court. A VGAL was assigned, and immediately began active involvement in case planning for the child.</p>
<p>Child safety concerns in several cases within a DCFS office</p>	<p>In reviewing a number of cases within a particular DCFS office, the Ombudsman found a pattern of inadequate safety planning to ensure children's safety.</p>	<p>The Ombudsman contacted CA Headquarters to request a review of these cases with the goal of improving that office's practice to ensure child safety.</p>	<p>A Headquarters Practice Consultant was assigned to the office to review the cases and work with the office to improve practice. This resulted in a work group developing a structured plan focused on child safety, including new procedures such as a review of all safety plans by the area administrator, weekly review of cases by a safety committee, additional staff training, a peer review process, and specific strategies for quality assurance monitoring.</p>
<p>Unreasonable pursuit of termination of parental rights</p>	<p>CWS referred a petition to terminate parental rights to the prosecutor, despite the fact that the parent had successfully completed court-ordered services to remediate parental deficiencies identified in the dependency order. The Ombudsman found this action to be clearly unreasonable. Furthermore, CWS placed the three year old child with a relative in a distant state, hindering adequate visitation between the parent and child.</p>	<p>The Ombudsman contacted the regional administrator and requested a review of the decision to pursue termination of parental rights, as well as a review of the visitation plan.</p>	<p>The regional administrator immediately arranged for the parent to visit with the child out-of-state, but declined to change the permanency plan. Soon thereafter, the parent filed a motion for reunification and the court ordered the agency to file a termination petition within 14 days or pursue reunification. The Supreme Court's decision in <u>In re A.B.</u>³⁸ then prompted further staffing of this case, and the agency decided to begin transitioning the child home.</p>

³⁸ For a summary of this decision, see section titled Case Law Update later in this report.

OMBUDSMAN IN ACTION: PREVENTING FUTURE MISTAKES

<i>Key Issue</i>	<i>Investigative Finding</i>	<i>Ombudsman Action</i>	<i>Outcome</i>
EXAMPLE D Child safety in foster care: catching an oversight in licensing a foster home	In licensing a foster home, DLR failed to review a prior referral in which a foster parent had admitted to sexually abusing a four year old relative when the foster parent was an adolescent.	The Ombudsman immediately contacted the DLR area administrator to inform her of this error. The administrator identified the likely cause of this oversight as DLR's failure to search FamLink using both the legal and common names of the foster care license applicant. The administrator initiated an immediate investigation of the foster parent's background.	Following DLR's review of the license, the foster home was closed. The administrator directed the agency's background check specialists to check aliases and nicknames when doing background checks and child maltreatment history checks of the FamLink database.
Violation of parents' right to confidentiality	DCFS disclosed unfounded and inconclusive reports of child abuse or neglect against the relatives of two dependent children, who wanted to care for the children, to the children's CASA and the court. By law ³⁹ , the department is required to destroy any records of unfounded or inconclusive reports older than six years, unless a prior or subsequent founded report has been received. However, the agency has been unable to expunge these reports from the FamLink database, ⁴⁰ and this history was therefore reviewed by DCFS in considering the relatives for placement (and provided to the CASA). Based on the information presented in court, the judge denied the parent's motion for placement of the children with these relatives.	The Ombudsman recommended that DCFS refer the relatives for a home study, and to ensure neutrality and fairness, that the home study be completed by a different DCFS field office, or a DSHS-contracted provider.	DCFS agreed, and home studies were assigned to a different office.

³⁹ RCW 26.44.031(2)(b).

⁴⁰ See page 64 for action taken by the Ombudsman to address the issue of the agency's technical inability to expunge CPS history from the FamLink database.

<p>Failure of communication/ cooperation with law enforcement by CPS</p>	<p>CPS Intake provided incorrect information to a law enforcement officer who called the designated after-hours law enforcement line to inform DCFS that a dependent youth had been booked into juvenile detention, and to request that the assigned CWS social worker attend the youth's court hearing the following day. The officer made two unsuccessful calls, was referred to a different number, and finally left a message for the assigned worker, who did not receive the message in time to attend court.</p>	<p>The Ombudsman contacted the area administrator to request that the individuals involved be provided with additional training or supervision regarding the handling of after-hours calls from law enforcement.</p>	<p>The area administrator agreed to do so.</p>
<p>Violation of parent's rights</p>	<p>CWS failed to inform a parent of a dependent child placed in out-of-home care, that the child had been moved to a different placement, until ten days after the move. This resulted from a failure of communication between the assigned worker and the supervisor who was covering for the worker.</p>	<p>The Ombudsman notified the agency of this finding after the fact.</p>	<p>The agency responded in writing as follows: "Steps have been taken to re-educate staff of Department policies surrounding notification of parents. A detailed checklist is being developed for social workers to complete for each case to ensure that staff covering for other staff who are out of the office on expected or unexpected leave are aware of the logistics of each case and what issues or tasks need to be completed prior to their return. The Department thanks you for bringing this matter to our attention."⁴¹</p>

⁴¹ Letter from CWS supervisor to OFCO dated August 18, 2010.

MOST INTERVENTIONS BY THE OMBUDSMAN RESULT IN RESOLUTION

The vast majority of complaints in which the Ombudsman intervened or assisted resulted in the complaint issue being resolved (78 percent). In the remaining 22 percent of complaints in which the Ombudsman assisted or intervened, the agency did not change its position. Nevertheless, in the majority of these cases, the complaint issue was either resolved via other avenues or became moot in one third of these complaints. For example:

NO FINAL VISIT FOR PARENT AFTER TERMINATION OF PARENTAL RIGHTS

A parent complained to the Ombudsman that DCFS was unreasonably seeking to terminate her parental rights despite her completion of various court-ordered services. After a two and a half month long investigation, the Ombudsman found that DCFS's decision to file a termination petition was in compliance with law and policy, and not clearly unreasonable under the circumstances of the case. The court granted the termination, and the parent requested a final visit to say good-bye to her child. The agency declined. While the agency is not obliged to offer a post-termination visit by law or policy, these visits are frequently offered on humane grounds. In this case, the Ombudsman found the agency's position to be clearly unreasonable based on the close relationship between the parent and child that had developed during twice-weekly visits, and the absence of safety concerns to the child should a final supervised visit be provided. The Ombudsman therefore intervened to request that the agency change its position and consult with the Tribe and the child's CASA regarding a good-bye visit. The Tribe and CASA disagreed, believing that the parent's antagonistic attitude toward the department would create a negative experience for the child. In light of this, the Ombudsman accepted the agency's decision to not provide a final visit.

The complaint or other problematic issue identified by the Ombudsman remained unresolved despite the Ombudsman's intervention in only two complaints. In one complaint, the agency declined to change a founded finding of maltreatment against a parent that the Ombudsman found to be clearly unreasonable. In the second complaint, the agency declined to reinstate visits between a dependent infant and fictive kin with whom the parents had requested their child be placed, after the Ombudsman found that decision to be clearly unreasonable. The infant was ultimately placed in a different home.

IN MANY CASES, THE OMBUDSMAN OFFERS ASSISTANCE TO RESOLVE COMPLAINTS WITHOUT “INTERVENING”

Complaints receiving “Ombudsman Assistance” are different from complaints in which the Ombudsman intervened, in that the findings of the Ombudsman’s investigation did not necessarily rise to the level of a clear violation of law or policy or a clearly unreasonable action or decision on the part of the agency, but the complaint had validity justifying the Ombudsman’s assistance in resolving the concerns. In 2010, 30 complaints (five percent)⁴² were resolved by the Ombudsman in this manner by ensuring that *critical information was obtained and considered* by the agency, by *facilitating timely communication* among the people involved in order to resolve the problem, or by *mediating a compromise*. For example:⁴³

COLLABORATION IMPROVES SAFETY PLANS FOR MEDICALLY-FRAGILE CHILDREN

A foster mother with years of experience caring for medically-fragile infants contacted the Ombudsman with concerns about DCFS’ ongoing failure to provide adequate contingency plans to ensure the safety of medically-fragile infants in her care. The foster parent had repeatedly requested DCFS’ help in arranging skilled respite care in case of a personal emergency, yet no such plan was in place when the foster parent actually experienced an emergency. When paramedics arrived at the foster parent’s home, they attempted to leave the infant with a neighbor; however, the infant had complicated cardiac issues that required specialized care. The foster parent requested that the infant be transported to Children’s Hospital to ensure proper medical care; however the child was taken to a different hospital. Although the infant was medically stable, the hospital felt unprepared to provide care, and called DCFS to pick her up. DCFS placed the infant in another medically specialized foster home while the foster parent was hospitalized.

The Ombudsman worked with the foster parent, legislative staff, and DCFS to review the facts of this case and of other medically fragile children in the foster parent’s care from 2005-2010, and the applicable agency policies. The foster parent’s concerns were substantiated, and a meeting was convened by the CA Assistant Secretary on July 2, 2010, with the foster parent, CA’s Director of Field Operations, State Representative Rolfes, and the Ombudsman. As a result of that meeting, Assistant Secretary Revels Robinson committed to take immediate action. A committee, which included the foster parent, was appointed to address the lack of policy regarding contingency safety planning for medically fragile children when their skilled caregivers have emergencies necessitating urgent respite care. About a month later, the foster parent reported to the Ombudsman that she was participating with the committee in writing new policy to address gaps in safety planning and the provision of skilled respite care for medically fragile children. This work was still in process as of November, 2010, with a plan for the new policy for medically fragile children to be part of the April, 2011 Policy Roll-Out for training CA staff.

⁴² This percentage was identical in 2009.

⁴³ For other examples, see Examples A and B in the Ombudsman in Action table, page 36.

SOME COMPLAINTS ARE RESOLVED WITHOUT SIGNIFICANT ASSISTANCE BY THE OMBUDSMAN

In 2010, **15 percent of complaints were resolved between the agency and the complainant without significant assistance or intervention by the Ombudsman.** In most cases, the Ombudsman still contacts the agency to confirm that steps are being taken to resolve the issue. **Some complainants report that the mere fact of the Ombudsman contacting the agency about the issue is enough to ensure that it is resolved.** This percentage has remained consistent since 2008. For example:

TIMELY SERVICES FOR CHILD

A foster parent contacted the Ombudsman with concerns about the agency's delay in obtaining a psychiatric evaluation for an eight year old legally free child in their care. The Ombudsman found that DCFS had had difficulty accessing timely psychiatric services for the child, who was in a foster-adopt placement. The child had exhibited violent behaviors for the last seven months and the child's pediatrician, who had seen him two months previously, had recommended that the child have a psychiatric evaluation as soon as possible, as there were concerns that the child's behaviors may be related to his psychotropic medications. The Ombudsman contacted the newly-assigned adoption worker, who was making diligent efforts to obtain services for the child and family, and urged that the psychiatric evaluation in particular be arranged as soon as possible. Within days the family was enrolled in wraparound services with a private agency program, with access to a psychiatrist. The child was seen by a psychiatrist within a couple of weeks, who changed the child's medications. After monitoring the case for several weeks, the Ombudsman confirmed with the foster parent that the child seemed to be doing much better. The Ombudsman closed the complaint as "resolved", but noted the systemic concern regarding the agency's difficulty in accessing timely mental health services for dependent children.

THE OMBUDSMAN FINDS NO BASIS FOR INTERVENTION IN THE MAJORITY OF COMPLAINTS

In 2010, just under two-thirds of complaint investigations were closed after the Ombudsman either found no basis for the complaint, or found no unauthorized or *clearly unreasonable actions* by the agency warranting intervention. The Ombudsman may still have facilitated better communication between the agency and the complaint, talked with the complainant and the agency about alternative courses of action for resolving the concerns, and educated the complainant about the role and responsibilities of the child welfare agency. For example:

YOUTH CHALLENGES PLACEMENT DECISION

A 16 year old dependent youth contacted the Ombudsman, upset about an impending change of his out-of-home placement. The youth's placement with a relative was ending due to the relative's sudden illness. There were no other relatives available, and reunification with the parents was not possible. The youth wanted to be placed with the family of his best friend, as a suitable adult placement, and had been told by his CWS social worker that this was not possible, but the youth did not understand why. The youth had contacted his attorney and was under the impression that the attorney was taking action to advocate for him, but upon following up discovered that the attorney was out of town until after the move was to occur. The Ombudsman contacted CWS and found that the agency had not ruled the youth's preferred placement out, but did have some legitimate concerns that needed to be assessed. The agency had referred the family for a home study, and planned to make a decision once the home study was completed. Since the youth needed to be moved imminently, however, an interim placement was needed. CWS had found a foster home well-suited to teens that would allow the youth to remain in the geographic area and attend the same school. The Ombudsman encouraged the agency to explain the situation to the youth as fully as possible, and provided the youth with information regarding how to request a different attorney if necessary.

FAMILY MEMBER CONCERNED ABOUT CHILDREN'S SAFETY

In another example, the Ombudsman found no basis for a complaint that DCFS/CPS was failing to adequately investigate allegations of physical abuse of two non-dependent children, ages two and four, in the care of their custodial parent. The Ombudsman found that CPS was in the process of investigating four referrals made in a one-month period, alleging physical and sexual abuse of the children. The parents were engaged in a custody dispute, and there was a restraining order between them. The Ombudsman monitored the investigations and found them to be in compliance with applicable law and policy. CPS conducted thorough investigations, interviewing several relatives and collaterals (including medical providers and law enforcement). The investigations resulted in unfounded findings. The case was presented to the Child Protection Team, who recommended parenting education for both parents. The CPS case was closed after referrals were made for these services. The Ombudsman monitored the case for six months to ensure that any new referrals were investigated thoroughly; no new referrals were received, and the complaint was closed.

OMBUDSMAN'S ADVERSE FINDINGS

After investigating a complaint, if the Ombudsman concludes that the agency's actions are either in violation of law, policy, or agency procedure, outside of the agency's authority, or clearly unreasonable under the circumstances, the Ombudsman makes an adverse finding against the agency.

Adverse findings fall into three broad categories:

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

If these criteria are met and the Ombudsman believes that the agency's action or inaction could cause foreseeable harm to a child or parent, the Ombudsman intervenes to persuade the agency to correct the problem. The Ombudsman shares the adverse finding with supervisors or higher-level agency officials, and may recommend a different course of action, or request a review of the case by higher-level decision-makers. If the Ombudsman's finding involved poor practice by the agency rather than a violation or clearly unreasonable action, 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. When a complaint or several complaints raise a systemic issue, the Ombudsman may open a "systemic investigation," and/or make a "systemic finding." Systemic issues and findings arising from complaints are discussed in the latter part of this section (see page 53).

INTER-AGENCY AGREEMENT – ENHANCED TRANSPARENCY AND ACCOUNTABILITY

Effective November, 2009, OFCO and DSHS entered into an inter-agency agreement, creating a new protocol for the working relationship between our two agencies.⁴⁴ This agreement provides greater transparency in the work of OFCO and DSHS and accountability by DSHS in responding to OFCO's findings and recommendations. The agreement stipulates that OFCO will provide notice to CA in writing of any adverse finding(s) made on a complaint investigation. CA is invited to formally respond to the finding, and may present additional information and request a revision of the finding. This has set a new precedent in formalizing the communication of OFCO's adverse findings to CA, and in many cases, CA provided a detailed response, sometimes with a request for a modification of OFCO's finding. In the spirit of this new agreement, OFCO has decided to present adverse findings for the 2010 reporting year, without a comparison of findings in previous years, since our findings criteria and process underwent further revision and improvement as a result.

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

⁴⁴ The inter-agency agreement is available on OFCO's website at http://www.governor.wa.gov/ofco/interagency_ofco_dshs.pdf

ADVERSE FINDINGS BY ISSUE FOR OFCO REPORTING YEAR 2010

Issue	Number of Adverse Findings
Child Safety	15
Failure by CWS to ensure/monitor dependent child's safety (examples: failure to conduct health and safety visits; inadequate monitoring of supervised parent-child visits; failure to report child injuries to CPS)	7
Failure by CPS/FVS ⁴⁵ to ensure/monitor non-dependent child's safety	3
Inadequate CPS investigation/case management	2
Failure to screen in CPS referral for investigation/other screening errors	1
Failure to staff case with Child Protection Team prior to return home	1
Failure by DLR to ensure safety of foster home/facility	1
Family Separation and Reunification	5
Failure to provide appropriate contact between parent and child	1
Failure to provide contact with relative/fictive kin	1
Unreasonable removal of non-dependent child from home	1
Unreasonable removal of dependent child from relative caregiver	2
Dependent Child Health and Well-Being	8
Failure to provide adequate medical care	1
Failure to provide appropriate services to meet special needs	3
Placement issues (unnecessary/multiple moves, delays in placement, lack of availability, inappropriate placement type)	4
Dependent Child Permanency	8
Delay in permanency	8
Parents' Rights	14
Failures of notification, public disclosure or breach of confidentiality	6
Delay in completing CPS investigation	6
Unreasonable finding of CPS investigation	1
Unreasonable pursuit of termination of parental rights	1

⁴⁵ Family Voluntary Services.

Foster Parent/Foster Care Issues	9
Poor communication by agency, unreasonable treatment	1
Violation of foster parent rights	1
Overly lengthy DLR/CPS investigation, inappropriate findings	1
Failure to provide foster parent with support services	1
Failure to follow licensing investigation protocol	1
Unreasonable licensing delays/other licensing errors	3
Unreasonable DLR licensing investigation finding against foster parent	1
Children's Legal Issues	3
Lack of attorney or guardian ad litem for dependent child	1
Violations of Indian Child Welfare Act	2
Poor Casework Practice Resulting in Harm to Child or Family	11
Failure to conduct supervisory reviews	1
Communication failures	2
High caseworker/supervisor turnover affecting continuity of case	2
Inaccurate, incomplete or delayed documentation	4
Other poor practice	2
Relative Caregiver Issues	5
Poor communication, poor treatment, lack of support	2
Failure to notify relative caregiver of CPS finding	2
Unreasonable CPS finding against relative caregiver	1
FamLink Issues	1
Failure to expunge old CPS referrals per RCW 26.44.031	1
Other Findings	3
Lack of coordination between DSHS divisions resulting in harm to child/family	3
TOTAL NUMBER OF FINDINGS	82
TOTAL NUMBER OF CLOSED COMPLAINTS WITH ONE OR MORE FINDING	62

It should be noted that given the relatively small number of adverse findings, as well as OFCO's practice of limiting adverse findings in any given investigation to only the most egregious failures or actions by the agency, it is not possible to draw meaningful conclusions from this data. With that caution in mind, however, some general observations may be made to assist DSHS in identifying some potentially problematic areas. The above table shows that adverse findings regarding **child safety concerns** – accounting for **18 percent** of the total adverse findings – **were made more frequently** than other categories of findings. Most of these safety concerns involved dependent children. The next largest category of adverse findings involved **violations of parents' rights (17 percent)**. Another **17 percent** of adverse findings involved agency violations or unreasonable actions against **foster parents and relative caregivers**, while almost **ten percent** of overall findings involved **delays in permanency** for dependent children.

The number of adverse findings for each DSHS region is shown in Appendix B. **Regions 1, 3 and 4 accounted for over 80 percent** of the complaints with adverse findings, while Regions 2 and 5 had comparatively few.

AGENCY RESPONSES TO ADVERSE FINDINGS

Pursuant to the Inter-Agency Agreement between OFCO and the Department of Social and Health Services,⁴⁶ OFCO provided written notice of any complaint adverse findings to DSHS, to allow the agency to review the findings and respond. OFCO received several responses to these notifications, many of which were quite detailed; five of CA's responses included a request for OFCO to modify or reverse a finding, based on additional or clarifying information provided by CA. OFCO modified a finding in three of these cases.

The following excerpts from correspondence between CA and OFCO illustrate this process.

CA ACKNOWLEDGEMENT OF ADVERSE FINDING, NO REQUEST FOR MODIFICATION

OFCO'S FINDINGS

DCFS CWS failed to follow Executive Order 95-04 and Children's Administration Practices and Procedures Guide § 2562(A)(2)(b)(i), (iii) by agreeing to the return of the child prior to staffing the case with the Child Protection Team (CPT). Here, the case was presented to the CPT the day after DCFS agreed to the court order returning [dependent child, age two] to the care of [the parent]. The CPT did not recommend return home of [child] to [parent], citing significant concerns as to [the parent's] ability to parent the child, [the parent] not having completed all services, and proper assessments of the child's needs not yet having been obtained. See CPT Staffing Recommendations Form, [date], attached. By policy, recommendations of the CPT as to returning a child home are binding on DCFS unless impasse procedures are followed. See Practices and Procedures Guide § 2562(B).

DCFS CWS did not complete a Reunification Assessment as required by policy. See Practices and Procedures Guide 43051(C).

DCFS CWS failed to conduct and/or failed to document health and safety visits with children in out-of-home placement every 30 days, in violation of Practices and Procedures Guide § 4420. Case notes show that the assigned social worker conducted a health and safety visit with both children in the foster home on [four months ago]. The next documented health and safety visit was [currently, four months later] for the [dependent child, age five], and [two weeks later] for the [two year old child].

DCFS RESPONSE

The department agrees that a CPT was not conducted prior to [the two year old child's] return to his mother.

The Department acknowledges that a Reunification Assessment was not completed as required by policy. This issue has been addressed with the unit by the supervisor. The unit and the Supervisor will ensure that Reunification Assessments are completed for all children and youth returning home.

⁴⁶ See http://www.governor.wa.gov/ofco/interagency_ofco_dshs.pdf

The social worker failed to follow policy by documenting health and safety visits within the required time frames for the month of [three month period]. However, the social worker, according her to individual monthly tracking log did see [the two year old] on [dates in each of those three months]. On [three days ago] the following case notes were entered [documenting these contacts].

MODIFICATION OF AN ADVERSE FINDING

OFCO'S ORIGINAL FINDING

The family and DCFS reported that [specific] services agreed upon between DCFS, the family, [the DCFS-contracted private agency] and other involved parties to support an in-home dependency with Behavioral Rehabilitation Services, were either inadequate or not provided at all. As a result, the parents were feeling unable to manage the youth at home, and the in-home placement was jeopardized. DCFS transferred the services to another private agency. Although the youth was not ultimately successfully stabilized in the home and had to be placed out of home once again, the family was satisfied with the new services received.

DCFS REQUEST FOR MODIFICATION OF FINDING

[CWS supervisor] respectfully disagree with the statement that [DCFS] was dissatisfied with the level of service provided by [the private agency]. I believe the largest barrier throughout this situation was the lack of clear and coherent communication by all parties involved.

OFCO'S MODIFIED FINDING

Based on the information you provided, we will modify our finding to delete the conclusion that "DCFS [was] dissatisfied with the level of service being provided by [the private agency] to the family. We retain our finding that the family was clearly dissatisfied with the level of service provided, based on their expectations following a meeting held between DCFS, [the private agency], and the family prior to the youth returning home and the commencement of BRS services. As you stated in your response, DCFS transferred services to a different agency "due to the perceived irreparable damage that had occurred through the lack of communication" presumably between [the private agency] and the family. OFCO found no lack of evidence of a lack of communication between DCFS and the family.

DENIAL OF REQUEST FOR MODIFICATION OF AN ADVERSE FINDING

OFCO'S ORIGINAL FINDING

DCFS/CPS failed to notify a parent of a founded finding made following a CPS investigation. Six months later, the parent contacted CPS to enquire about the outcome of the investigation, stating that no letter had been received. The parent was informed that a letter had been sent six months previously, but the agency could not locate the confirmation of delivery and signature card usually received from the post office. DCFS therefore sent a new notification letter to the parent.

DCFS REQUEST FOR MODIFICATION OF FINDING

In response to OFCO's finding, CPS responded that at the time this CPS finding was made, the agency was converting to an electronic tracking record for notification letters. The post office provided an electronic delivery confirmation notice to DCFS (of which the agency provided a screen printout for OFCO's records) but the notice does not automatically provide a proof of delivery (similar to the old signature confirmation cards), informing that "a proof of delivery may be available through your local Post Office for a fee." CPS maintained that it had a record of having sent a letter to the parent at the conclusion of the investigation, and was therefore asking that this finding be reversed.

OFCO'S RESPONSE

Thank you for your prompt and detailed response to our letter of [date]. I am writing to inform you that after careful consideration of the information you provided to support your request to reverse the adverse finding OFCO made in this case, we have decided to uphold our initial finding. The basis for upholding this finding is that although DCFS has a record of the delivery confirmation of the original CPS findings letter, the post office is unable to provide DCFS with the signature confirmation at this point. Therefore, DCFS remains unable to verify that [parent] signed for the letter. Furthermore, we note that DCFS acknowledged to [parent] in its letter dated [date] that [parent] "inadvertently did not receive the original founded letter that was sent out in [date]."

We acknowledge that DCFS has taken corrective action to ensure that signature verifications will be obtained from USPS in future on all certified letters.

PART TWO: IMPROVING THE SYSTEM

SYSTEMIC INTERVENTION: LACK OF COORDINATION BETWEEN DSHS DIVISIONS

The Department of Social and Health Services (DSHS) is the largest state agency providing services to its citizens. As DSHS states on its website,⁴⁷ “each year, more than 2.2 million children, families, vulnerable adults and seniors come to us for protection, comfort, food assistance, financial aid, medical and behavioral health care and other services.” DSHS Administrations and Divisions other than the Children’s Administration that are most often collaterally identified in complaints to OFCO are the Division of Developmental Disabilities,⁴⁸ and the Division of Behavioral Health and Rehabilitation,⁴⁹ which provides public mental health services to children.

Over the years, OFCO has received several complaints from families frustrated by an apparent lack of collaboration and coordination between two or more DSHS Divisions providing the family with services, or that the family was encountering obstacles trying to access these services. OFCO has also independently observed inter-division problems in the course of investigating other complaints. When Susan Dreyfus was appointed Secretary of DSHS in May 2009, Ms. Dreyfus communicated her desire to unify the different missions of the different divisions within the agency to create a strong perception in the community as “one DSHS”. In August 2009, Ms. Dreyfus released her new vision for DSHS as “One Department, One Vision, One Mission, One Core Set of Values,” in providing “high-performing programs in an integrated organization working in partnership for statewide impact.”⁵⁰ Ms. Dreyfus announced that her Executive Leadership Team would “work to align the organization’s strategic and financial resources for maximum impact on behalf of the citizens we serve and our employees, who are key to our ultimate success.”⁵¹

In light of this unified mission for DSHS, OFCO wrote a letter to Ms. Dreyfus in October 2009, bringing to her attention a number of current or recent complaints OFCO was investigating in which cross-system issues appeared to be hampering needed services for the child or family. Ms. Dreyfus assigned these cases to a cross-system workgroup for review, and to resolve any remaining problems. The workgroup was comprised of management staff from the Children’s Administration, the Division of Behavioral Health and Recovery, and the Division of Developmental Disabilities.

Three examples of these cases, in which OFCO made an adverse finding regarding lack of coordination between DSHS Divisions, are presented here, followed by the response received from the workgroup after developing an action plan.

⁴⁷ See <http://www.dshs.wa.gov/aboutus/>

⁴⁸ A division of the Aging and Disability Services Administration, serving adults as well as children.

⁴⁹ A division of the Health and Recovery Services Administration, as above.

⁵⁰ DSHS Publications: Framework for the Future, updated April 22, 2010.

⁵¹ DSHS Publications: DSHS Organizational Chart, updated November 2, 2010.

CASE EXAMPLE 1:

DIFFICULTY ACCESSING SERVICES FOR YOUTH ABOUT TO AGE OUT OF DCFS SYSTEM

BACKGROUND PROVIDED BY OFCO

“Anthony” is a 17 year old dependent youth who has been in out-of-home care provided by CA Division of Children and Family Services (DCFS) since he was 14 years old, due to his parent’s inability to care for him at home. He has spent the last couple of years in a specialized group home contracted with Behavioral Rehabilitation Services (BRS). He has done well there. Anthony frequently runs, steals, acts out in the community, and places himself in dangerous situations. He has very little concept of cause and effect. Charges of theft and burglary were dropped when Western State Hospital found him incompetent. Anthony has Pervasive Developmental Disorder, Tourette’s syndrome, ADHD, and Oppositional Defiant Disorder. Cognitive testing over the years has had varied results from mild mental retardation to borderline retardation. Anthony’s parent applied for Division of Developmental Disabilities (DDD) services for the first time five years ago and was denied. DCFS has made subsequent referrals which have also been refused. DDD’s rationale for denial was that he has had a variety of IQ scores since he was five years old, ranging from 55 to 77 (55 was the most recent score at age 15, which would place him in the low end of mild retardation), and that his IEP did not specify developmental disability, only behavioral impairments. DDD referred DCFS to the Regional Support Network (RSN).⁵² DCFS was concerned about the youth’s need for placement after he turned 18 as he cannot function independently, so it tried to appeal this decision but was told DCFS could not challenge a division within the same agency. Therefore, the parent appealed DDD’s decision. The appeal hearing has been delayed several times, meanwhile the youth is getting closer to 18 with no plan in place for which agency will serve him after he turns 18. In the last year, the youth has exhibited sexualized behaviors, obsessive behaviors, has assaulted staff at his group home, run away from school, and torn up his room when frustrated. At the group home, he had a full-time case aide and was in a self contained classroom at school. The youth was returned home to his mother a month-and-a-half before his 18th birthday. Six days later, the youth and his mother were visiting relatives, and he became agitated and assaultive. A physical altercation ensued, and the police were called to the scene. The youth was arrested and later released to his mother. This reunification may be unsuccessful. The youth turns 18 soon with no plan in place for ongoing services.

CROSS-SYSTEM PROBLEMS IDENTIFIED BY OFCO

Denial of services by DDD; RSN does not appear to be involved at all. CA is bearing the total responsibility for this youth with multiple needs across systems.

⁵² The Regional Support Network serves as the gateway for children to Medicaid patients to access public mental health services. Services are provided by mental health facilities authorized by the RSN. All out-patient and acute in-patient services must be authorized by the RSN serving that geographic area. See DSHS publication “Mental Health Services for Children and Youth.”

DSHS RESPONSE⁵³

Cross-System Collaboration Activities:

- CA provided services with [three different private agencies] for the family prior to the youth aging out.
- DDD conducted a Medicaid Personal Care (MPC) assessment on [date] to assess for eligibility. [Anthony] is currently eligible for 82 hours of MPC services.
- DDD Waiver Enrollment Request was completed on [date] to request respite services.
- DDD and DCFS meet monthly to discuss client's transition from DCFS to DDD.

Current Status:

- The youth is living with his mother in [location].
- Anthony is enrolled in [private agency] for counseling and medication reviews.
- Anthony's mother is in the process of becoming the contracted provider with DDD and will be paid to provide Medicaid Personal Care services to Anthony.
- Case has been dismissed from court as Anthony has turned 18 and the dependency has ended. Social worker working on closing the case with CA.
- The waiver enrollment request was initially denied by DDD, however Anthony became eligible for DDD services prior to his 18th birthday. Anthony's request is being tracked on the waiver request database with a request date of [date].

CASE EXAMPLE 2: DELAY IN SERVICES TO LEGALLY FREE CHILD

BACKGROUND PROVIDED BY OFCO

"Katy" is a ten year old legally free child who is suspected to have organic brain damage and mental retardation. Over the past year, various professionals have recommended that Katy be evaluated for Reactive Attachment Disorder, Post Traumatic Stress Disorder, Fetal Alcohol Syndrome/Effects, evaluation and treatment for possible sexual abuse and possible sexual reactivity or aggression, and that she receive a comprehensive neuropsychological evaluation. Her sexualized and aggressive behaviors have overwhelmed several foster and relative placements. Katy entered foster care at age four and was placed with a relative from age seven through nine then placed back into foster care. Nine months and two foster homes later, her foster parents could no longer manage her behavior and requested that she be moved immediately. Faced with no viable alternative at short notice, Katy's former relative placement agreed to provide temporary care, with the understanding that DCFS would obtain evaluations and assessments while searching for a permanent placement. A private agency continues to provide wraparound BRS services. Records indicate that DCFS has focused on finding a permanent home for Katy prior to obtaining adequate assessments and evaluations of her needs and necessary treatment. Eight months ago, DCFS identified an adoptive home out-of-state and made efforts over the next several months towards moving Katy to this placement. The potential adoptive parent visited Katy four months ago, but after spending two days with her, stated that she felt this child was not ready to be adopted until her behaviors stabilize.

⁵³ Note that these responses are presented here as taken directly from a letter to OFCO from David Dickinson, Director of Division of Behavioral Health and Recovery, dated November 2, 2010.

When told that WA would not consider allowing Katy to be placed in residential treatment upon arrival in her new home, the potential adoptive placement fell through. In the meantime, Katy had started Dialectical Behavior Therapy, but the therapist reported that she was unable to make progress due to her cognitive limitations.

At this point, there seems to be agreement among providers that Katy most urgently needs a full neuropsychological work-up to determine which of her issues are neurological, physical, psychological, or behavioral. This is a necessary prerequisite to Katy receiving accurate diagnoses and appropriate treatment. DCFS is now working on making a referral for this evaluation. It is anticipated that there may be a significant waiting list.

CROSS-SYSTEM PROBLEMS IDENTIFIED BY OFCO

At a team meeting over four months ago, team discussed that the private agency was looking into whether or not Katy qualified for DDD services. Also, Katy's psychiatrist recommended a full psychological evaluation, which would require RSN approval. There are no further notes as to the status of either DDD or RSN involvement with Katy, and she has not yet received the recommended neuropsychological evaluation. Additionally, although DCFS continues exhaustive efforts to search for an adoptive home for Katy, adoption may not be a viable option for this child until her needs are fully described and addressed, which may require the involvement of either DDD and/or mental health services.

DSHS RESPONSE:

Cross-System Collaboration Activities:

- The following are involved in coordinating cross-system and legal services: CA, guardian ad litem, counseling through [private agency], the RSN, and [private agency providing a wide range of services].
- Katy receives mental health counseling from [private agency], a RSN provider.
- Psychotropic medication is monitored by primary care physician.

Current Status:

- Katy is in a temporary [relative] placement and transitioning to a potential permanent placement on [date].
- The child has had several placements in the last two years and getting her linked to services is difficult when she moves from region to region.
- The relative receives respite services from [private agency].
- Katy was seen for a neuropsychological evaluation on [date] and report is pending additional family history.
- The social worker has prepared [an application] for DDD services.

Outstanding Issues:

- CA is seeking a permanent placement for Katy.
- The neuropsychological report and DDD eligibility is pending.
- The social worker is seeking a child psychiatrist to monitor Katy's psychotropic medications.
- A request for a medication consultation and medication management can be made of [private agency].

- CA has been advised that the “Provider Assistance Line” (PAL) is available to the primary care provider if psychiatric consultation is indicated for assessment and/or medication management. This is a state-funded program that provides timely telephone consultation by child psychiatrists to primary care providers treating children and youth with mental health issues.

CASE EXAMPLE 3:

UNNECESSARY MOVE OF 18 YEAR OLD DEVELOPMENTALLY DISABLED YOUTH DUE TO FUNDING ISSUES

BACKGROUND PROVIDED BY OFCO

“Jane” is a dependent youth who is about to turn 18. Jane was adopted after being placed in foster care as an infant. She experienced severe abuse and neglect during her first few months of life, and presented with significant behavioral and developmental challenges from the time of her initial placement with her foster-adopt parents. She has a history of violent and sexually inappropriate behavior, and she requires an intense level of supervision and care. At age four, Jane was placed into foster care under a voluntary placement agreement, and was returned home after two and a half years. Her parents were unable to manage her, so she returned to care at age seven, and became dependent a year later. Since then she has been in nine different placements, including group homes, foster homes, and Child Study and Treatment Center two times. Each of these transitions was difficult for her. For the past four years, Jane has lived at [a BRS group home], where she has reportedly thrived. The group home has utilized a variety of creative measures to keep Jane safe and limit excessive stimulation. She has been able to attend high school.

Recently, Jane was found eligible for DDD services. On her 18th birthday, the plan is for her to move to an adult family home through DDD. Efforts are being made to allow Jane to continue to attend the same high school. The dependency case will be dismissed and DCFS will close their case, and case management will shift to DDD. While this case may be an example of effective DCFS and DDD collaboration, there is some disagreement as to whether a move at this juncture is in this youth’s best interests. There is concern that she is not ready to be treated as an adult, and that DDD is not yet aware of the extent of her needs and may not be able to meet those needs. The transition into a new placement will likely cause this youth great distress; due to her developmental delays, she has not been informed of the move, although she knows a move is possible and she has been taken to visit two possible facilities. Her parents continue to be very involved with Jane but are not able to care for her.

CROSS-SYSTEM PROBLEMS IDENTIFIED BY OFCO

Jane is an adopted child who has been known to DCFS since she was an infant; given the recognition of her developmental delays in early childhood, as documented in DCFS records, the delay in applying for DDD services is puzzling. Although Jane will likely require long-term placement in an adult family home through DDD, such a move may be less disruptive once she has completed high school. Lack of BRS funding for youth past the age of 18 appears to be prompting this move and may be an issue in similar cases.

DSHS RESPONSE

Cross-System Collaboration Activities:

- DDD eligibility intake activity began [soon after Jane turned 17] and continued [for four months] when eligibility was determined.
- DDD and DCFS meet monthly to discuss client's transitioning from DCFS to DDD.
- DDD and DCFS agreed [two months after Jane turned 18] to the inclusion of more comprehensive client information during transition planning to better inform DDD placement decisions.
- Residential Care Services (RCS) opened an investigation into an incident following Jane's move into DDD services, in which Jane and her roommate left their Adult Family Home (AFH) without notifying the provider and were gone for several hours.
- CA and DDD collaborated to transition Jane from a BRS home to an AFH.

Current Status:

- Jane is currently living in an AFH located within the same school district she attended while in DCFS placement. Jane selected this AFH from three possible options and moved in on [her 18th birthday]. Her CA dependency was dismissed the following day.
- Jane's AFH provider reports that her transition has gone smoothly with the exception of some adjustments related to an appropriate clothing choice and some issues related to the influence of her current roommate.
- As a result of the RCS investigation, DDD and RCS agreed that a move to a different AFH would be in Jane's best interest in order to establish a better roommate match. DDD has been in communication with Jane and her family regarding plans to locate a new AFH that is within her current school district however this does limit her options in finding another AFH.

Outstanding Issues:

- DDD will continue to work with Jane and her family to locate an AFH with a more suitable roommate match. Ultimately, Jane will need to decide if she wants to move, as she is her own legal decision maker. It is not clear if there has been a discussion in terms of guardianship; however Jane's family is included in all discussions regarding her service planning.

In follow-up, DSHS informed OFCO that an ongoing workgroup was established to focus on "Integrated Case Management," to "achieve a level of effective collaboration and coordination of policy and program development and the delivery of services from DSHS Administrations at the state and local level."⁵⁴

⁵⁴ Letter to OFCO from D. Dickinson, see footnote 53.

SYSTEMIC ISSUE: PSYCHOTROPIC MEDICATIONS AND DEPENDENT CHILDREN

In mid-2010, the King County Dependency CASA Program contacted OFCO with concerns regarding the prescription of psychotropic medications to dependent and legally free children. The CASA Program noted that in many cases, the assigned CASA happens to discover that the child is taking psychotropic medications, and the court does not appear to have been informed.

One specific case brought to OFCO's attention involved a 12 year old dependent youth placed in a group care facility. The youth's Court Appointed Special Advocate (CASA) had recently learned through a regular report to the court that the youth was receiving four psychotropic medications a day, prescribed by a pediatric nurse practitioner contracted by the group home. The CASA was concerned in particular about the medication Seroquel, an atypical antipsychotic which carries a warning of the risk of suicidality in children. There was also concern about the combination of the four medications, the upward trend in dosing over time, possible off-label use,⁵⁵ and that the medications may be being utilized as a behavioral restraint. Thus, the CASA requested a medication evaluation by an independent child psychiatrist. DCFS and the group home opposed this request, objecting to the doctor requested by the CASA. The court ordered this evaluation over the department's objection.

In another case, OFCO staff participated in a Family Team Decision Making Meeting regarding a 13 year old legally free youth in a relative placement. During this meeting, the youth's behaviors and treatment were discussed, and DCFS learned for the first time that the youth had been prescribed the antipsychotic drug Thorazine. DCFS staff were concerned that the youth had been taking this powerful medication for some time, without DCFS or court knowledge or approval. A medication evaluation was conducted shortly thereafter, and approval for the medication granted.

State law regarding psychotropic medication management⁵⁶ provides in pertinent part that:

- The department shall identify those children with emotional or behavioral disturbances who may be at high risk due to off-label use of prescription medication, use of multiple medications, high medication dosage, or lack of coordination among multiple prescribing providers, and establish one or more mechanisms to evaluate the appropriateness of the medication these children are using, including but not limited to obtaining second opinions from experts in child psychiatry.
- The department shall review the psychotropic medications of all children under five and establish one or more mechanisms to evaluate the appropriateness of the medication these children are using, including but not limited to obtaining second opinions from experts in child psychiatry.
- The department shall track prescriptive practices with respect to psychotropic medications with the goal of reducing the use of medication.
- The department shall encourage the use of cognitive behavioral therapies and other treatments which are empirically supported or evidence-based, in addition to or in the place of prescription medication where appropriate.

⁵⁵ This is the practice of prescribing medication to treat symptoms or a condition other than that for which the medication has been approved, or its use with an age group, or in a dose or form other than that approved by the drug manufacturer and the US Food and Drug Administration.

⁵⁶ RCW 74.09.490(1) (b) – (e).

In light of these responsibilities, OFCO contacted CA Assistant Secretary, Revels Robinson, to bring her attention to these cases and identify several concerns, along with recommendations for addressing these problems and ensuring law and policy is followed in every case:

The CA Assistant Secretary responded that the issue of reporting the child's medications to the court is being explored with the Attorney General.

OFCO CONCERNS

- **General Concerns: off-label use of prescription psychotropic medications in children, use of multiple medications, lack of coordination between providers, and use of medications as behavioral restraint.**
- **Legally free children/youth (who usually do not have representation by a CASA or guardian ad litem (GAL)) appear to be especially at-risk. CA policy allows the social worker to authorize the administration of psychotropic medications for legally free children.⁵⁷**
- **Children and youth placed in group care facilities may also be at heightened risk, due in part to the nature of the behaviors commonly exhibited by youth placed in group care (and thus, a possible corresponding increased need for behavioral management).**

OFCO RECOMMENDATIONS FOR IMPROVEMENT

- **When the child is not legally free, require strict compliance with laws and policies⁵⁸ regarding obtaining informed consent and/or court orders before psychotropic medications are administered to dependent children.**
- **Review cases of legally free children where the CA social worker has authorized psychotropic medications and require this information be presented to the court.**
- **Require information regarding a child's prescribed medications to be included in every Individual Service and Safety Plan (ISSP, report provided to court at regular intervals).**
- **Work cooperatively with parents, youth and/or youth's attorney, CASA/GAL, and group care facilities to obtain second opinions and medication evaluations when requested.**

A workgroup initiated by the King County Dependency CASA Program, in which OFCO was invited to participate, is currently examining the issue of court and agency oversight of psychotropic medication use with dependent children. The group is working to better inform the child welfare community about the importance of the court taking an active role in reviewing the use of

⁵⁷ CA Practices and Procedures Manual, Section 4541.

⁵⁸ RCW 74.09.490; RCW 71.34; CA Practices and Procedures Manual Section 4541.

psychotropic medications for dependent youth. One concern identified by the workgroup is whether judges have sufficient information and guidance about what questions need to be asked in order to effectively review or approve the use of these medications. The work group aims to develop a bench card for judges to use for such reviews.⁵⁹ Such questions might include:

- Who originally prescribed this medication and what are their qualifications?
- Was a second opinion sought, and if so was there agreement about the prescription?
- When was the medication regimen last reviewed, and by whom?

The King County work group believes that CA social workers, who are assigned responsibility for approving and reviewing psychotropic medications taken by children, should receive similar information and guidance.

OFCO notes the recent publication of a report by the Tufts Clinical and Translational Science Institute, of a *Multi-State Study on Psychotropic Medication Oversight in Foster Care*.⁶⁰ The study found that the use of psychotropic medication for youth in foster care is much higher (between 13 percent and 52 percent) than the rate of use for youth in general (four percent). Researchers surveyed state child welfare and affiliated agencies to examine current policies and guidelines on the use of psychotropic medication in foster care, including the “red flags” used by these agencies to ensure oversight of safety and quality of care concerns regarding the use of these medications. Based on survey responses, the study identifies ten primary components of effective oversight of medication use in this population.

While the extent of this issue in Washington State is unclear, the use of psychotropic medication for dependent children and related problems deserves further inquiry. This review should also consider successful programs in other states to improve coordination and oversight of this critical aspect of health care for children under state supervision.

⁵⁹ OFCO conversation with Linda Katz of King County Dependency CASA Program, December 6, 2010.

⁶⁰ For the full report, see http://160.109.101.132/icrhps/prodserv/docs/Executive_Report_09-07-10_348.pdf

SYSTEMIC ISSUE: FAMLINK

Children's Administration's new statewide automated child welfare information system (SACWIS), FamLink, has been in use since late January 2009. In 2009, OFCO received many complaints related to long delays in processing payments to foster parents, private agencies and other contracted service providers; these complaints were no longer being received in 2010. However, DCFS line staff and managers continue to report technical problems with data entry and retrieval and the impact that this has on their ability to do their jobs effectively. OFCO also continues to hear from parents whose CPS cases have not been closed despite an investigative finding having been made, and are remaining open indefinitely due to technical problems associated with FamLink.⁶¹ OFCO routinely experiences difficulty finding certain records – children's legal and placement histories, for example, are frequently incomplete; family relationships are often unclear, making it difficult to know which individual's case histories to search through in order to find a particular child's history. Worker caseloads are difficult to count reliably, as the status of cases is often unclear due to use of terms such as "inactive," "CNC" (apparently, to mean "cannot close"), "pending," and other ambiguous status categories.

OFCO continues to experience difficulties in accessing an individual's CPS referral history (referred to in FamLink as "Prior Involvement"). One issue is that prior involvement (integrating all reports, both screened-in and screened-out, CPS and non-CPS), is not available chronologically. Another issue is how information is organized in FamLink by case, usually under the mother's name. As a result, a report of abuse of a child in a foster home will appear only under the foster parent's case, and not under the child's parent's case. It is therefore easy to miss all the referrals related to a particular child if one does not search the records in each of the child's placements (and assuming the placement information is up-to-date). **The Ombudsman is concerned about the adverse impact of these FamLink issues in the field – particularly on intake workers who need easily accessible and accurate information to make quick decisions involving child safety.**

The Washington State **Child and Family Services Review** (CFSR) conducted in the fall of 2010 by the federal Children's Bureau⁶² included a review of Washington's Statewide Information System. The following are excerpts from the summary report issued following the review, highlighting a general perception of the system's user-unfriendliness.⁶³

⁶¹ This issue is discussed in more detail, with OFCO's recommendation to address this problem, in the report section titled Systemic Finding: Late Investigative Assessments Leave Children at Risk of Harm on page 91.

⁶² Located within the US Department of Health and Human Services.

⁶³ Full report available at <http://www.dshs.wa.gov/pdf/ca/StateAssessSection4.pdf>

**EXCERPTS FROM THE SUMMARY REPORT ON THE GENERAL PERCEPTION OF
FAMLINK'S USER-UNFRIENDLINESS***

Some of the staff continue to rate FamLink as unsatisfactory as a user friendly system. The implementation of FamLink required staff to adhere to specific work flows in their case work activities. These workflows are established by the Practice Model; federal requirements; legislative mandates; Braam lawsuit; and policy.

Staff is required to manage the many requirements of the integrated work of child welfare. FamLink was designed to support the interrogation (sic) of this work and requires staff to follow the established workflows. Some staff has reported disappointment as they had expectations for a system that would be more efficient to navigate, but have found FamLink, at least through the implementation and transition period, to be more complicated and time intensive.

Case carrying staff does not find the reports useful as the FamLink reports tool displays the information very differently than they have previously used.

Strengths/Ongoing Challenges

Strengths

- FamLink provides assistance for staff to better serve children and families throughout the state – more than just a way to document activities
- FamLink supports practice with tools and information about families
- FamLink requires consistency statewide

Challenges

- New Practice coupled with Implementation of the new automated system
- The impact of data conversion/from legacy system to FamLink included 20 years of historical data
- Integrated model required specific workflows that staff may traditionally have not followed
- Reduction of staff and resources leaving 75 percent of planned staff resources for operations and ongoing maintained (sic) of new application

Summary

The Children's Administration now has a powerful tool to assist in the management of the child welfare system. However, usefulness of the data and reports as both case management and administrative tools is dependent upon accurate and timely data entry at the field staff level. Responsibility for data entry has had an impact upon and increased staff workload. Staff continues to seek easier and more efficient methods to document their case work in a timely and accurate manner.

Staff do have the four required data items (status, demographic characteristics, location, and goals for the placement) entered into FamLink and they are retrievable for every child.

*Full report available at <http://www.dshs.wa.gov/pdf/ca/StateAssessSection4.pdf>

Many of the difficulties described above and the lack of confidence they generate in the user – that all existing records are accurate and have been successfully retrieved – result in a pervasive perception that the system is user-unfriendly and highly prone to user error. Lack of user confidence raises serious questions about whether FamLink is accomplishing its mission.

Some technical problems with FamLink have more serious implications (or actual negative consequences) than others. For example:

OFCO made a rather serious adverse finding regarding the agency’s violation of law (see table of findings, under “FamLink Issues,” on page 48) in the course of investigating a complaint that a dependent child had not been placed with a relative. OFCO found that the relative’s outdated unfounded or inconclusive and/or screened-out CPS referrals were presented by DCFS and a CASA in court to justify the agency’s position that the child should not be placed with the relative. This happened in part because the relative’s old unfounded and screened-out CPS referrals had not been expunged from FamLink as required by the now three year old law (passed in 2007) requiring that such history be expunged from the agency’s records.⁶⁴ OFCO contacted CA Headquarters to find out how the agency was planning to come into compliance with this law. CA informed that there was no current mechanism in FamLink for the destruction of records required by this law, nor was there any process by which records may be destroyed on a case-by-case basis. CA reported that a module-design was underway to address this problem in FamLink, expected to be completed by October, 2010.

When the Ombudsman followed up with CA in November, 2010, CA informed that the module was not yet operational, and was projected to be in place in January, 2011, or thereafter. This means that outdated unfounded CPS history continues to be accessible in the agency’s database. The CA Office of Constituent Relations informed OFCO that until such time that FamLink has the capacity to enable these old records to be deleted, current policy for field offices when workers come across information meeting the criteria specified in RCW 26.44.031, that information is to be ignored and not used against the subjects of the reports, and further disclosure of the information should not occur.⁶⁵

⁶⁴ RCW 26.44.031 requires DSHS/CA to destroy all records concerning:

- (a) A screened-out report, within three years from the receipt of the report; and
- (b) An unfounded or inconclusive report, within six years of completion of the investigation, unless a prior or subsequent founded report has been received regarding the child who is the subject of the report, a sibling or half-sibling of the child, or a parent, guardian, or legal custodian of the child, before the records are destroyed.

⁶⁵ Conversation between OFCO and CA Office of Constituent Relations referenced in letter from OFCO to CA dated August 20, 2010.

VI. IMPROVING THE SYSTEM

PART ONE: OFCO CRITICAL INCIDENT REVIEWS

- Summary of Findings
- Child Fatality Reviews
- Near Fatality Reviews
- Systemic Investigation: Recurrent Maltreatment
- Systemic Finding

PART TWO: WORKING TO MAKE A DIFFERENCE

- Case Law Update
- Systemic Improvement Efforts
- 2010 Legislative Activities

“You are great partners and we learn more every day. ... Thank you for your diligence and for working so closely with us.”
–DSHS/CA Administrator

PART ONE: OFCO CRITICAL INCIDENT CASE REVIEWS

BACKGROUND

The Ombudsman conducts administrative reviews of cases of recurrent child maltreatment as well as all fatalities and near fatalities of children whose family had an open case with DSHS at the time of death or near fatality, or within a year prior.⁶⁶ OFCO reviews all fatalities and near fatalities that meet these criteria regardless of if there is a possibility the fatality or near fatality was caused by physical abuse or neglect. These critical incidents are treated as emergent in order to assure the safety of any children remaining in the home. In this reporting period, OFCO conducted 167 administrative reviews of critical incident cases (64 child fatalities, 25 near fatalities and 78 cases of recurrent maltreatment).

OFCO'S ADMINISTRATIVE REVIEW PROCESS

Upon notification from Children's Administration (CA), the Ombudsman begins collecting information from FamLink and other sources. OFCO has developed a database specifically to organize relevant case information including: family and child-specific identifying information; current allegations of child abuse or neglect; prior involvement with child welfare agencies, the court, or criminal history; risk factors such as substance abuse or domestic violence; and information about the alleged perpetrator and the relationship to the child. The Ombudsman also creates a chronology for each case describing significant events. Through this process, the Ombudsman is able to identify common factors and systemic issues regarding these critical incidents, as well as areas of concern in specific cases such as the assigned worker's caseload.

OFCO'S PARTICIPATION IN EXTERNAL CASE REVIEWS

In addition to OFCO's independent reviews, the ombudsman participates in CA and local county child death and critical incident reviews across the state. These reviews provide the ombudsman with a unique perspective both as to how reviews are conducted and on common factors in child fatalities and critical incidents.⁶⁷ When conducting critical incident reviews, OFCO focuses on whether child abuse and or neglect were contributing factors and if there were any opportunities for the child welfare system to assist the family and protect the child. This allows the Ombudsman to take action to protect children and develop recommendations to protect our state's most vulnerable population.

⁶⁶ RCW 74.13.640 requires the department to notify the Ombudsman of near fatalities of children in state care or receiving services, or who were in state care or receiving services within a year prior to the near fatality. RCW 43.06A.110 requires the Ombudsman to report on the status of implementation of child fatality review recommendations. RCW 26.44.030(13) requires the department to notify the Ombudsman of cases with three founded allegations of child abuse or neglect.

⁶⁷ For example, the ombudsman attends the King County Child Fatality Review. This multi-disciplinary group reviews all deaths of children under the age of 18 with the goal of creating and implementing strategies to prevent child fatalities.

SUMMARY OF FINDINGS

FATALITY REVIEWS

- Sixty-six percent of the child fatalities that OFCO reviewed were of children under the age of two years. OFCO found:
 - Unsafe sleep environment continues to be a significant risk factor in many infant deaths.
 - Under current CPS intake practices, CPS referrals reporting bruises to infants are not always opened for investigation.
 - Greater effort, including public education campaigns such as “The Period of Purple Crying”, is needed to prevent abusive head trauma of infants.
- Minority children continue to be overrepresented within the child welfare system and child fatalities are disproportionately high for American Indian and Alaskan Native and African American children.
- In 2009, OFCO observed decreases in the number of child fatalities directly attributed to physical abuse or neglect and the number of child fatalities with an open CA case, compared to 2008.

NEAR FATALITY REVIEWS

- In 2010, OFCO reviewed 25 child near fatality cases. The number of near fatalities reviewed by OFCO has increased each year since 2008. OFCO believes the increase in near fatalities is associated with more reliable notification to OFCO and does not necessarily indicate an increase in near fatality incidents.*
- During the course of a near fatality review, OFCO observed that law enforcement DUI arrests did not always generate a CPS referral when children were present in the vehicle. OFCO raised this issue, which led to legislative amendments to close this gap in the system.
- At the department’s request, OFCO conducted an independent in-depth near fatality case review and documented problems associated with flawed CPS investigations, inadequate use of assessment tools, and lack of supervisory reviews.

RECURRENT MALTREATMENT REVIEWS

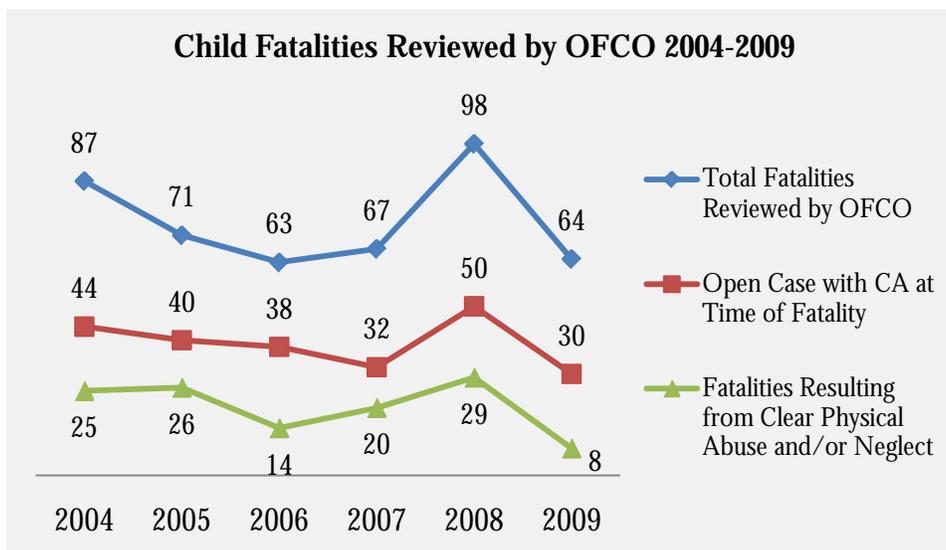
- Child Protective Services routinely fails to complete Investigative Assessments within the 45-day deadline as required by policy. The timely completion of investigations is crucial to child safety and effective case planning.
- In 2010, OFCO observed large increases in incidence of mental health, substance abuse, and domestic violence in recurrent maltreatment cases.
- Recurrent maltreatment cases continue to primarily involve child neglect.

*Data from 2010 is included in the near fatality graphs, since OFCO does not reconcile the numbers with CA as is done with the fatalities. It can take many months for the medical examiner or coroner to certify the manner and cause of death. Since this is not a necessary step in the review of near fatalities OFCO can report his data more immediately.

CHILD FATALITY REVIEWS

NUMBER OF FATALITIES REVIEWED BY OFCO

The Ombudsman reviews all fatalities of children whose family had an open case with DSHS CA at the time of death or within a year prior. Since 2004, the number of fatalities reviewed by OFCO has fluctuated between 63 and 98. OFCO typically reviews approximately 11 percent of the overall number of child deaths in Washington State.⁶⁸ In the past year, OFCO notes a decrease in the number of child fatalities directly attributed to physical abuse or neglect, as well as a decrease in the number of child fatalities with an open CA case.



Source: Office of the Family and Children's Ombudsman, November, 2010, based on analysis of DSHS CA data

DID CHILD ABUSE OR NEGLECT CONTRIBUTE TO THE CHILD'S DEATH?

OFCO reviews child fatalities to determine if child abuse and/or neglect contributed to the fatalities, and if so, how. A finding of clear physical abuse or neglect as a contributing factor in the child's death does not necessarily imply a failure on the part of DSHS CA. We found that in 2009, physical abuse caused the child's death in two cases⁶⁹ (three percent) and neglect clearly contributed to the child's death in six cases (nine percent). OFCO also found that in an additional nineteen cases (30 percent) child abuse or neglect factors were present and may have contributed to the child's death. Thirty (47 percent) of the fatalities were related to an open DCFS case and 52 percent of the cases were closed at the time of death but open with DCFS within the previous year. An additional two

⁶⁸ The total number of child deaths in WA State is: 719 in 2005; 683 in 2006; 700 in 2007; 777 in 2008; 701 in 2009. For additional information: <http://www.dshs.wa.gov/pdf/ca/FatalitiesinWa.pdf>

⁶⁹ There was professional disagreement on if one of these fatalities was caused by physical abuse. The Medical Examiner determined the manner of death to be homicide, while the medical consultant stated the injuries to the child could have been the result of intense and prolonged CPR efforts. OFCO deferred to the Medical Examiner determination.

fatalities occurred in a daycare licensed by the Department of Early Learning (DEL).⁷⁰ Case examples are summarized in Appendix C.

CHILD FATALITY DEMOGRAPHICS AND DISPROPORTIONALITY

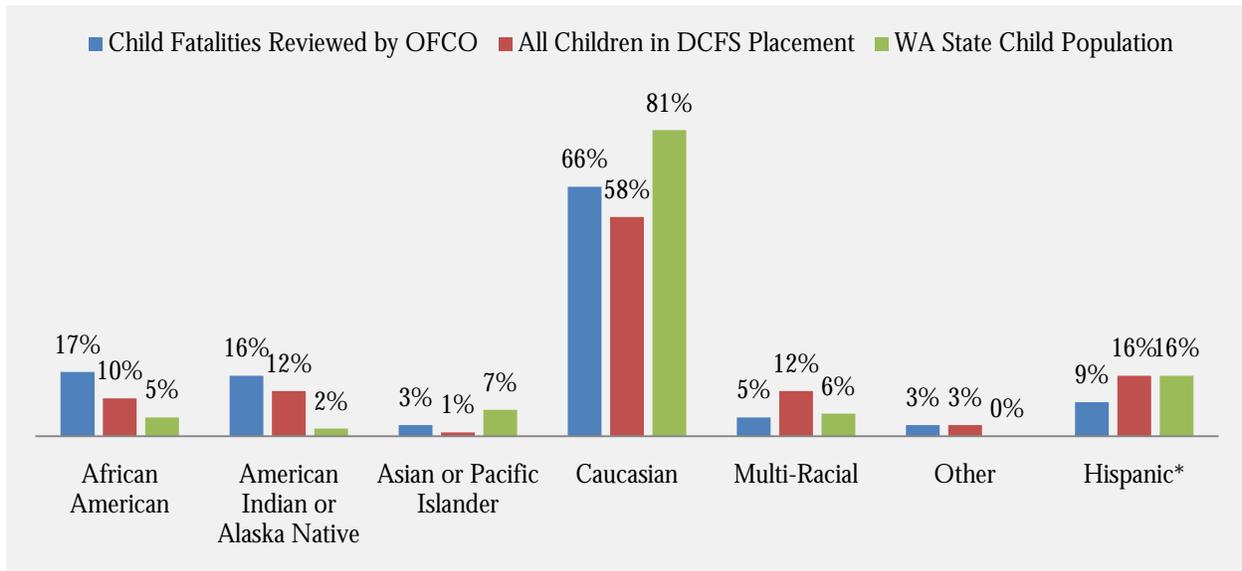
Consistent with data for all child deaths in Washington State, the majority of fatalities that OFCO reviewed in 2009 (66 percent) were of children under the age of two years. Fifty-two percent were females and 48 percent were males. Child fatalities continue to be disproportionately high for American Indian and Alaskan Native and African American children relative to their percentage of the overall state population. While American Indian and Alaskan Native children make up two percent of the children in Washington State, they represent 16 percent of the child fatalities reviewed by OFCO. Similarly, African American children make up five percent of the state's child population yet represent 17 percent of the child fatalities reviewed.

This pattern of racial disproportionality is found not only in child fatalities, but across the United States in all social welfare systems. The disproportionality in child fatalities may be reflective of the overrepresentation of children of color in the child welfare system, compared to their numbers in the population. Although abuse and neglect do not occur at higher rates for children of color compared to white children, they are more likely to be the subjects of referrals to Child Protective Services, they enter child welfare systems at higher rates, remain in care for longer periods of time, are less likely to be placed in adoptive homes, and experience less successful outcomes than white children.

In 2007, the Washington State Legislature required the formation of the Washington State Racial Disproportionality Advisory Committee to explore the root causes of and make recommendations for remediation of the racial disproportionality and disparity in our state's child welfare system. The Advisory Committee issued a comprehensive report detailing a process to address and eliminate racial disproportionality from our child welfare system. The report was presented in December 2008 to the DSHS Secretary, who forwarded it to the Legislature. The Executive Summary is accessible through DSHS's website. The latest regional reports on the implementation of this process were presented in June 2010 and are also available on the DSHS website.

⁷⁰ DEL is a separate agency from DCFS. However, DLR-CPS investigates allegations of child abuse or neglect occurring at a daycare facility.

RACE/ETHNICITY OF 2009 CHILD FATALITIES



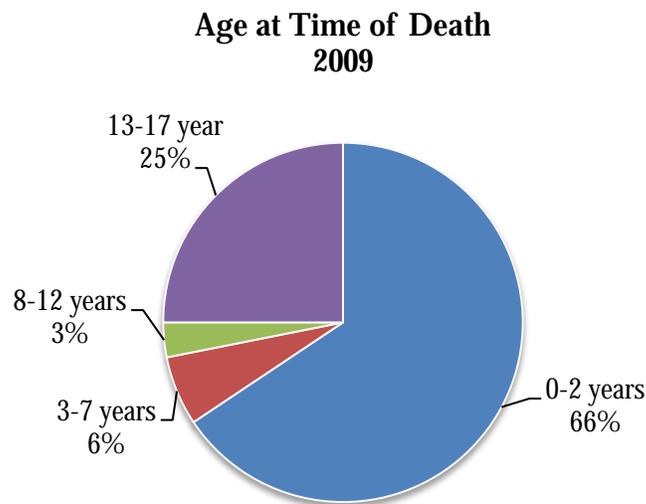
Source: Office of the Family and Children’s Ombudsman, November 2010, based on analysis of DSHS CA data and WA State Children populations taken from Children’s Administration Performance Report 2008 <http://www.dshs.wa.gov/pdf/ca/08Report1.pdf>

*People of Hispanic ethnicity may be of any race, so also are included in applicable race categories

Note: Data adds up to over 100 percent because people may self-identify with multiple races.

AGE AT TIME OF DEATH

The majority of child fatalities reviewed by OFCO were of children two years of age or younger. Common factors regarding sleep environment, CPS referrals of pre-mobile infants with bruises and prevention efforts addressing “Shaken Baby Syndrome” are discussed below.



Source: Office of the Family and Children’s Ombudsman, November 2010, based on analysis of DSHS CA data

INFANT SAFE SLEEP ENVIRONMENTS AND PUBLIC EDUCATION EFFORTS

The Medical Examiner or Coroner identified sleep environment/co-sleeping as the cause⁷¹ of death or a contributing risk factor in 14 of 34 (41 percent) of infant fatalities OFCO reviewed. The following case examples demonstrate the dangers of an unsafe sleep environment and the ongoing need for public outreach and education on infant sleep environment.⁷²

- Ø A six day old infant was placed to sleep on the parent's chest as the parent slept on a couch. The deceased infant was found on the side of the parent with a mark on their forehead consistent with a seam on the couch. The coroner determined the manner of death to be an undetermined infant death from co-sleeping.
- Ø A seven month old infant was wrapped in a receiving blanket and placed to sleep between the parents in an adult bed. One parent awoke to find they were lying on top of their infant, who was unresponsive. The coroner determined the manner of death an accident and the cause of death was positional asphyxiation.
- Ø A one month old infant was bed-sharing with her mother on an adult mattress. The sleep surface included two adult pillows and a comforter underneath the infant. The Medical Examiner determined that the manner of death was natural and the cause of death was Sudden Infant Death Syndrome noting risk factors of bed sharing and soft sleeping materials.

The American Academy of Pediatrics states infants should always be placed to sleep on their back in a smoke free environment and dressed in light clothing to avoid overheating. A crib or bassinet near the parent's bed is the safest place for the infant to sleep and makes it easier to breastfeed and bond with the infant. The crib or bassinet must be free of toys, soft bedding, blankets, and pillows.⁷³

Based on national child fatality data, there has been much professional discourse in the last several years on the issue of an infant's sleeping environment. Washington State is no exception. OFCO continues to participate in an Infant Safe Sleep Workgroup⁷⁴ facilitated by Representative Mary Helen Roberts with the purpose of promoting Safe Sleep Campaigns to educate the public on safe sleep environments for infants. The group hopes to provide this information to enable parents to make informed choices about their infant's sleep environment. Based on input at monthly meetings, a postcard was developed by members of the workgroup with the basics of safe sleep and additional resources (See Appendix D). Recently, the group was awarded a mini-grant to add the safe sleep

⁷¹ Cause of death is not the same as the manner of death. See page 114 for definitions and examples of cause and manner of death.

⁷² Other details surrounding the death have been eliminated to highlight the issue related solely to the child's sleeping environment.

⁷³ <http://www.healthychildcare.org/pdf/SIDSparentsafesleep.pdf>

⁷⁴ Members include representatives from King County Public Health, Northwest Infant Survival and SIDS Alliance, Parent Trust for Washington Children, WA State Department of Health, WA State Department of Social and Health Services, Native American Women's Dialogue on Infant Mortality, King County Sheriff & Medical Examiner's Office, Seattle Children's Hospital, the Council for Children & Families, and Safe Kids King County.

postcard into the CHILD Profile⁷⁵ mailings, which are mailed to the approximately 90,000 families per year who give birth in Washington State.

REFERRALS ALLEGING BRUISES ON INFANTS

State law and department policies require Child Protective Services (CPS) to investigate complaints of any recent act or failure to act on the part of a parent or caretaker that results in death, serious physical or emotional harm, or sexual abuse or exploitation of a child, or that presents an imminent risk of serious harm. An investigation is not required of non-accidental injuries which are clearly not the result of a lack of care or supervision by the child's parents.⁷⁶ The primary purpose of CPS is to assess risk of child maltreatment rather than to substantiate specific allegations of child abuse or neglect.⁷⁷

In reviewing child fatality and near fatality cases, OFCO has seen cases where CPS referrals reporting infants with bruises were not screened in for investigation. While a bruise itself is not indicative of child maltreatment, bruising to a pre-mobile infant in circumstances that generate a referral to CPS deserves heightened attention. By accepting these referrals for investigation, CPS at least then has the opportunity to assess risk of maltreatment in the home and when necessary take steps to protect a vulnerable infant. The Ombudsman brought this issue to the department's attention. CA is now considering changing policy to require that CPS referrals alleging bruising to an infant will be opened for investigation. In OFCO's 2009 report on *Patterns of Mandated Reporter Referrals*,⁷⁸ the Ombudsman identified that most child fatalities were preceded by a CPS referral from a mandated reporter.

OFCO RECOMMENDATION:

OFCO Recommends that CPS accept for investigation all reports of bruises to pre-mobile infants.

⁷⁵ CHILD Profile is Washington's Health Promotion and Immunization Registry system developed by the Department of Health. CHILD Profile distributes an array of information in both English and Spanish to help ensure Washington's children receive the preventive health care they need from birth through age six.

<http://www.doh.wa.gov/cfh/childprofile/>

⁷⁶ RCW 74.13.031(3); CA Practices and Procedures Guide, section 2210; CA Case Services Policy Manual, section 2130.

⁷⁷ CA Practices and Procedures Guide, section 2210.

⁷⁸ http://www.governor.wa.gov/ofco/reports/mandated_reporter_referrals_2006_08.pdf

The following case summaries illustrate how accepting a referral regarding bruises to an infant may very well have prevented future harm.

- Ø A four month old infant was taken to the emergency room with bruises on his chin and forehead. Doctors determined that the infant had a brain bleed and retinal hemorrhages consistent with abusive head trauma. His head injury was fatal. The infant also had older bruises on his legs and arms. The parent reported that the infant was injured after a fall off the couch. Additionally, three CPS referrals were not accepted for investigation in the month prior to the infant's death. Two of these reports, one by a relative and the other by a mandated reporter, alleged there were bruises on the infant. Law enforcement conducted a welfare check and reported the infant appeared uninjured. As a result, CPS intake screened out the referral.
- Ø A two month old infant was swaddled and placed on a twin bed propped up with pillows and covered with a comforter. The infant was found deceased and face down in the bedding. Less than one month prior to the death (at age four weeks), CPS received a report from a medical provider that the infant had a bruise with swelling on its face. The parent explained to the doctor that the infant had slipped out of their hands and hit their face on a hard surface causing the bruise and swelling. The infant started to vomit, so was admitted for observation. Doctors discharged the infant and stated this explanation was plausible. This report did not screen in for investigation, because there was no allegation of child abuse or neglect.

The Ombudsman discussed this recommendation with Dr. Kenneth Feldman.⁷⁹ Dr. Feldman provided the following research and information on incidents of bruising to pre-mobile infants.

Bruises in pre-mobile infants are very uncommon. Dr. Naomi Sugar found that only 0.6 percent of children under six months old had a single bruise.⁸⁰ Bruises did not become common until children started to cruise. Dr. Labbe also noted that only 1.2 percent of children under 8-9 months old had a single bruise.⁸¹ However, bruises are frequent sentinel injuries before serious child physical abuse. Both Dr. Feldman and Dr. Pierce reported anecdotes of children with bruising who concurrently had serious occult abuse.⁸² Dr. Sheets observed that 30 percent of children with abusive head trauma had preceding bruising that had not been evaluated.⁸³ Likewise, Dr. Jenney noted that 37 percent of children who had been previously seen by a doctor, who missed the diagnosis of abusive head trauma, had bruising at the time of that visit. Because the diagnosis was missed 27.8 percent sustained additional injuries and 9.1 percent died.⁸⁴ Dr. Pierce observed that any bruises in an under four month old infant are strongly associated with abuse.⁸⁵ A greater number of bruises, bruises in unusual body locations and a greater total body area of bruising also are correlated with abuse.⁸⁶

Current best medical practice for bruised pre-mobile infants, who do not have an overt bruise cause—such as a motor vehicle crash—is to do a full physical examination, conduct a full skeletal survey, a cranial CT scan and testing for bleeding disorders. Likewise, these children should be investigated for abuse risk factors. However, the percentage of children younger than six months-old with bruising without obvious causation on the initial medical examination that have serious occult abuse or bleeding disorders is currently unknown.⁸⁷

⁷⁹ Kenneth Feldman, MD is a general pediatrician who divides his time between half time primary care pediatrics and half time child abuse consultation. He is the past Medical Director of the Seattle Children's Protection Program. He also provides inpatient care supervision at Seattle Children's in Seattle, Washington. He previously supervised care on the PICU and in the Emergency Department at Children's. He is a Clinical Professor of Pediatrics at the University of Washington and a member of the General Pediatric Division. He is the recipient of the 2008 Ray Helfer Award of the Helfer Society, dedicated to medical education on child maltreatment. Research interests have focused on childhood injuries, both unintentional and inflicted. Tap water burn injuries have been an area of continuing interest.

⁸⁰ Sugar NF, Taylor JA, Feldman KW. Arch Pediatr Adol Med 1999;153:399.

⁸¹ Labbe J. Pediatr 2001;108:271.

⁸² Pierce MC, Smith S, Kaczor K. Pediatr Emerg care 2009;25:845 and Feldman KW. Pediatr Emerg Care

⁸³ Sheets LK, Leach M, Nugent M, Simpson P. Helfer Society Annual Meeting (lsheets@chw.org)

⁸⁴ Jenny C, Hymel KP, Ritzel A, et al. JAMA 1999;281:621.

⁸⁵ Pierce MC, Kaczor K, Aldridge S, O'Flynn J, Lorenz DJ. Pediatr 2010;125:64.

⁸⁶ Pierce MC, Kaczor K, Aldridge S, O'Flynn J, Lorenz DJ. Pediatr 2010;125:64 and Dunstan FD, Guildea ZE, Kontos K, Kemo AM, Sibert JR. Arch Dis Child 2002;86:330.

⁸⁷ Dr. Feldman and his colleagues at Seattle Children's are conducting a study to answer that question (contact 206-987-2194 or kfeldman@u.washington.edu).

PREVENTING SHAKEN BABY SYNDROME: THE PERIOD OF PURPLE CRYING

ONE CHILD'S STORY

Shaking a baby can have devastating effects on her brain and life prospects. Consider Hailey, a foster child brought to OFCO's attention through a citizen complaint. As a result of being shaken as a baby, eleven year old Hailey now endures cerebral palsy, blindness, mental retardation, respiratory disorder, severely brittle bones, and limb atrophy. She is unable to speak, and requires tube feeding. Hailey frequently suffers from pneumonia. When this happens, her lungs must be suctioned, sometimes more than once a day. She requires round-the-clock care to ensure her body is turned on an hourly basis, so resides in a state-facility where she is cared for by a team of 12 medical professionals. Hailey's story is not unique. In 2008, OFCO reviewed 34 cases with young children who experienced severe head trauma.⁸⁸

BIG PICTURE: SHAKEN BABY SYNDROME IS ON THE RISE

In 2003, national estimates indicated that 17 out of 100,000⁸⁹ infants experienced Abusive Head Trauma, or "Shaken Baby Syndrome".⁹⁰ Recent studies suggest a 55 percent increase in incidence since 2007, when the recession began.⁹¹ Large numbers of cases remain undetected.⁹² Experts estimate that 30 percent of children with a clinical diagnosis of Abusive Head Trauma had at least one prior visit to the emergency room where the diagnosis was missed. Said another way, when these children were clinically diagnosed with Abusive Head Trauma, it was clear to medical professionals that the child had been shaken over time. General outcomes for infants, like Hailey, who come to clinical attention, are dire: 20 to 35 percent die. Of the survivors, 65 to 85 percent have significant neurological and developmental abnormalities; 40 percent are blind; more than half experience behavioral problems.⁹³

WHAT WE'RE DOING ABOUT IT

In response to this alarming trend, the Washington State Shaken Baby Prevention Taskforce was formed by Carol Jenkins, of Seattle Children's Protection Program.⁹⁴ Director-Ombudsman Mary Meinig is a founding member of this interdisciplinary group, which includes medical professionals, law enforcement, agency officials, child advocates and other community professionals dedicated to

⁸⁸ 21 of the 34 children had family history with DSHS/CA within one year of experiencing abusive head trauma. 26 of the 34 children were infants.

⁸⁹ What is the impact of abusive head trauma? Summit Factsheet. 2010

⁹⁰ The American Academy of Pediatrics recommends using the term "Abusive Head Trauma" rather than "Shaken Baby Syndrome." More information is available online at: <http://www.aap.org/advocacy/releases/may09headtrauma.htm>.

⁹¹ An Increase in Abusive Head Trauma during the Current Recession: A Multi-Center Analysis. Rachel P. Berger, Janet Fromkin, Haley Stutz, Kathi Makoroff, Kenneth Feldman, Philip V. Scribano, Tom Songer. Children's Hospital of Pittsburgh of UPMC, Pittsburgh, PA; Cincinnati Children's Hospital, Cincinnati, OH; Seattle Children's/Harborview Medical Center, Seattle, WA; Nationwide Children's Hospital, Columbus, OH; University of Pittsburgh School of Public Health, Pittsburgh, PA.

⁹² Ronald Barr presentation at the University of Washington School of Public Health. Audio available online at: <http://www.nwcp.org/training/courses/maternal-child-health-mch-training-for-professionals/>

⁹³ Ibid.

⁹⁴ The Washington State Shaken Baby Prevention Task Force was formed in 2010, and convenes monthly at Seattle Children's. The Tasked Force is actively seeking funding to assist in disseminating prevention information.

preventing abusive head trauma to infants.⁹⁵ The goal of the taskforce is to help Washington State hospitals, clinics and agencies that have contact with pregnant women, as well as caregivers of newborns, disseminate promising⁹⁶ new evidence-based materials from The National Center on Shaken Baby Syndrome, called *The Period of PURPLE Crying*. The letters in PURPLE describe six characteristics of colic, including: “peak of crying,” “unexpected,” “resists soothing,” “pain-like face,” “long-lasting,” and “evening” which is when most inconsolable crying occurs. *The Period of PURPLE Crying* materials include a short DVD and booklet. They are designed to be relevant for the public at large, culturally sensitive, and low-cost.⁹⁷

SUMMIT KICKS OFF PUBLIC EDUCATION CAMPAIGN

On September 23, 2010 the task force hosted a summit to kick-off shaken baby prevention efforts in Washington State, titled *Preventing Tomorrow’s Tragedies: the Period of PURPLE Crying approach to Shaken Baby Prevention*. More than 150 professionals were in attendance, including staff from the Children’s Administration, public health nurses, birthing hospital staff, law enforcement, and representatives from the insurance industry. A summary of information presented at the summit is provided below.

THE EVIDENCE

Dr. Ronald Barr, who has conducted 30 years of research on the biological and behavioral determinants of infant behavior, and co-developer of The Period of PURPLE Crying program, opened the summit by presenting evidence which forms the basis of the PURPLE program.⁹⁸ Key messages from the presentation included:

- Shaking a baby is an extremely dangerous form of child abuse, given the long-term negative consequences to victims (described above). Shaken Baby Syndrome is the only form of child abuse that has positive feedback loop or an immediate positive response for the caregiver. When a baby is shaken, it stops crying and “nothing bad happens”. Shaking does not leave bruises.
- Unpredictable and inconsolable crying, or colic, is normal infant behavior during the first three to five months of life and is not related to parental behavior. While individual infants vary in how much they cry, all infants across cultures, regardless of parenting style, cry more during the first three to five months of life.
- The most common cause for shaking a baby is inconsolable crying. Caregivers become frustrated when they cannot soothe an infant.
- Accurate and supportive advice delivered at the right time can help frustrated parents understand that it is okay to put their baby down in a safe place and walk away while they take a moment to calm down. The Period of PURPLE Crying is designed to accomplish this.

⁹⁵ Information about the Washington State Shaken Baby Syndrome Task Force membership is available online at <http://www.wsha.org/files/83/PURPLESummitbrochure2010.pdf>.

⁹⁶ Barr RG, Rivara FP, Barr M, Cummings P, Taylor J, Lengua LJ, Meredith-Benitz E. *Effectiveness of educational materials designed to change knowledge and behaviors regarding crying and shaken baby syndrome in mothers of newborn infants: a randomized controlled trial.*

⁹⁷ More information about The Period of PURPLE Crying is available at <http://www.purplecrying.info/>.

“AN OUNCE OF PREVENTION IS WORTH A POUND OF CURE”⁹⁹

Undoubtedly, the emotional costs of Shaken Baby Syndrome are incalculable to victims, families, and the community at large. However, understanding the financial costs is an important aspect of quantifying the need for prevention. To this end, Ms. Meinig, Carol Jenkins, of the Seattle Children’s Protection Program, and Amy Kernkamp, of the Children’s Advocacy Center of Tacoma presented information regarding the financial burdens associated with Shaken Baby Syndrome. Consider the following costs associated with one case:

- Average initial hospital costs (at Children’s) = \$81,159
- Average law enforcement investigation = \$5000
- Average cost to prosecute a SBS case that goes to trial = \$15,000 – \$20,000
- Average Superior Court costs related to the trial = \$14,000 – \$20,0000
- Residence in a 24 hour state run facility (for Hailey) = \$7000/month
- DSHS/CA expenditures (for Hailey’s current care) = \$4000/month

The PURPLE program materials cost approximately \$2 per family.

THE VICTIMS’ PERSPECTIVE

Beverly Bowen-Bennett, a former foster parent of children affected by abusive head trauma, and Tara Mitchell, a parent of a survivor shared their stories with Summit participants. Ms. Mitchell, who was recently interviewed by local media, explained that when her son “was six months old he was shaken and thrown by his biological father.” According to Ms. Mitchell, “That day our life changed.” Ms. Mitchell now describes her son a high-functioning survivor, who struggles with behavioral and social challenges.¹⁰⁰

STATEWIDE IMPLEMENTATION: HOW TO DO IT?

Marilyn Barr, Executive Director, and Julie Price, Prevention Program Manager of the National Center on Shaken Baby Syndrome, discussed how organizations can help achieve the goal of implementing the PURPLE program across the state. The implementation process uses a “triple dose approach with enhancements and reinforcements.” The first dose calls for reaching maternity wards. The second dose entails disseminating information through pre- and postnatal primary health care units or public health visiting nurses. The third dose is a public education and media campaign (the Summit itself is part of “dose three”). Scripts are provided to an array of community professionals in a variety of settings to reinforce consistent messaging.

RESPONDING TO THE CALL FOR ACTION: WASHINGTON HOSPITALS PILOT PURPLE

In 2008, the Seattle Children’s Protection Program out of Children’s Hospital secured grant funding to pilot the PURPLE program for one year in two hospitals with ethnically diverse populations: the University of Washington Medical Center (UWMC) in Seattle and Valley Medical Center (VMC) in

⁹⁹ This quote is attributed to Benjamin Franklin.

¹⁰⁰ Ms. Mitchell’s story is available online at: <http://www.king5.com/health/childrens-healthlink/Shaken-baby-prevention-program-encouraged-for-all-new-parents-104510514.html>, or on her personal website at <http://nevershake.webs.com/>

Renton. Debi Grace, RN and Kelle Baxter, RN/MSW, Nurse Managers for the pilot sites, discussed their experience implementing the PURPLE program. It is clear that nurses feel good about providing parents with tangible tools, and new parents are happy to have concrete information.¹⁰¹ Educating parents about normal crying is a natural extension of post-partum care. The VMC pilot is underway and the UWMC pilot is now complete. The PURPLE program was such a success at UWMC that hospital leadership secured independent funding to ensure the materials could be distributed as part of normal practice.

NEXT STEPS

The task force continues to convene monthly to ensure PURPLE program materials are disseminated as part of normal practice in all 63 birthing hospitals across the state. Realizing this vision will require both buy-in from hospital leadership and funding to train nurses. The task force is actively seeking funding to distribute this life-saving information to all new parents. More information about the PURPLE program is available online at www.purplecrying.info.

¹⁰¹ Fall 2010 Valley Voices. “Understanding that Infant Crying is Normal Can Help Prevent Shaken Baby Syndrome.”

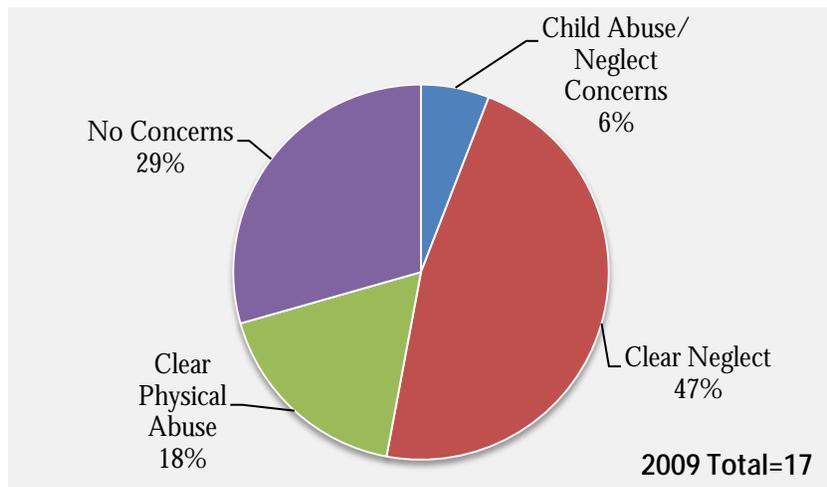
NEAR FATALITY REVIEWS

OFCO reviewed 17 near fatality cases in 2009 and 25 near fatality cases in 2010. The number of near fatalities reviewed by OFCO has increased each year since 2008. The increase in near fatalities is associated with more reliable notification to OFCO and does not necessarily indicate that there has been an increase in near fatality incidents. CA notification to OFCO of near fatalities became a requirement in June 2008.¹⁰²

- **Age of Child** – In 2010, near fatalities of children under the age of two years doubled. Eleven of the 25 near fatalities in 2010 were infants under that age of one year, and five of these eleven near fatalities were non-accidental.
- **DSHS CA Case Involvement** – Sixteen of the 25 near fatality cases reviewed involved families with open DCFS cases and half of these open cases involved active CPS investigations.¹⁰³
- **Near Drowning** – Five of the seven near-drowning incidents since 2008 happened when the child was left unattended in a bathtub.
- **Adolescents** – Attempted suicides and drug overdoses accounted for the majority of near fatalities of adolescents. Non-accidental injuries that resulted from drive-by shootings and stabbings and car accidents accounted for the remaining near fatalities of adolescents.

DID CHILD ABUSE OR NEGLECT CONTRIBUTE TO THE NEAR FATALITY?

OFCO reviews near fatalities to determine if child abuse and/or neglect contributed to the near fatalities and if so, how. We found that in 2009, of the 17 cases reviewed, physical abuse caused the child’s near fatality in three cases and that neglect clearly contributed to the child’s near fatality in eight cases.



Source: Office of the Family and Children’s Ombudsman, November 2010, based on analysis of DSHS CA data

¹⁰² Data from 2010 is included in the near fatality graphs, since OFCO does not reconcile the numbers with CA as is done with the fatalities. It can take many months for the medical examiner or coroner to certify the manner and cause of death. Since this is not a necessary step in the review of near fatalities OFCO can report this data more immediately.

¹⁰³ One additional near fatality case was open to DEL. Open DCFS cases include: Family Voluntary Services (FVS); Child Protective Services (CPS); and Child Welfare Services (CWS).

OFCO INDEPENDENT REPORT IDENTIFIES FLAWED INVESTIGATION

In February 2010, a two month old child was taken to the hospital in critical condition, suffering a skull fracture, fractured clavicle, and fractured ribs and bruising. The father was later arrested and charged with Assault of a Child in the First Degree. The mother was charged with Criminal Mistreatment of a Child in the Second Degree. Child Protective Services (CPS) filed for dependency and placed both this two month old child and a one year old sibling in protective custody.

This was not the first time that the father has faced criminal charges and CPS involvement due to physical abuse of an infant child. In 1993, CPS filed for dependency on the father's six week old child, who suffered two broken legs, a fractured clavicle and fractured ribs. The father was initially charged with Assault of a Child in the First Degree and pled guilty to the reduced charge of Assault of a Child in the Third Degree. The child was eventually returned to his parents care, and the dependency was dismissed in 1995.

In the twelve months prior to this two month old child's injuries in February 2010, CPS twice received reports of child abuse or neglect related to allegations of parental substance abuse, domestic violence and physical abuse of the older sibling.¹⁰⁴ Each investigation was closed without services, despite a determination that the final risk level was "Moderately High," identifying an elevated risk of future maltreatment and an indication that services should be offered to the families.

Susan Dreyfus, Secretary of the Washington State Division of Social and Health Services (DSHS) and Denise Revels Robinson, Assistant Secretary of Children's Administration (CA) requested that OFCO conduct an external review of state child welfare agency involvement with this family. Due to the critical injuries inflicted on this infant child and the family's prior involvement with the Division of Children and Family Services (DCFS), the Ombudsman had independently decided to investigate this case.¹⁰⁵

The Ombudsman reviewed DCFS records and reports from 1993 to 2010 concerning this family, criminal and civil court records related to the father, the father's first wife and the father's second wife, and applicable Children's Administration Policy and Procedure and state law. The purpose of the Ombudsman's investigation was to determine DCFS' compliance with department policy and procedure, and state law, and to identify necessary changes, if any, in law, policy and procedure that will better protect children from abuse and neglect.

¹⁰⁴ CPS referrals were received in February 2009 and April 2009.

¹⁰⁵ OFCO routinely reviews child fatalities and near fatalities across the state in cases where the child was in the care of, or receiving child welfare services from, DSHS CA at the time of death or within one year of his or her death, or who died while in state licensed care.

OFCO FINDINGS

While the Ombudsman review included DCFS' response to allegations of child abuse and neglect regarding this family from 1993 to 2010, the ombudsman's case review focused on the CPS investigations conducted in February and April 2009, as these investigations were closed just six months before the child's injuries in February 2010. The Ombudsman identified the following areas of concern:

Inadequate CPS Investigations did not explore prior child abuse, domestic violence and substance abuse. As a result, the department failed to appreciate the father's history and the risks associated with: the critical injuries inflicted by the father on an infant child in 1993; the suspicious injuries to another infant child in 1994; the father's domestic violence conviction in 1997; and his significant criminal history between 1998 and 2006. The ombudsman identified the following gaps in CPS' investigations:

- Failure to obtain relevant civil and criminal court records regarding the parents
- Failure to contact collateral sources such as community professionals who had relevant information about this family
- Failure to seek medical examination of child or obtain medical records
- Drug/alcohol evaluations of the parents were not requested
- Mental health and domestic violence concerns were not fully explored

Assessment tools were not used correctly. CPS uses various assessment tools to evaluate risk of child abuse or neglect as well as to identify problems experienced by children and their families in order to implement a safety plan and or provide appropriate and effective services.¹⁰⁶ These assessment tools are only effective if they are completed in an accurate and timely manner. The ombudsman found that:

- Safety Assessment did not accurately document risk, resulting in an inappropriately low risk level being assigned
- Investigative Assessment was not completed within 45 days of CPS Intake
- No explanation in Structured Decision Making Assessment as to why services were not offered even though services were indicated by the assessment

When used effectively, these tools can determine whether or not CPS takes further action to address parental deficiencies and reduce the risk of harm to a child. In this case, because assessment tools were not used properly, no safety plan was implemented for this family.

Supervisory Case Reviews did not occur. The CPS supervisor is required to review all open CPS cases to determine if: the case record and files are complete; the investigation is complete and no further action is necessary; and the 45 day rule requirement governing investigations and the completion of risk assessments have been met. The ombudsman found:

- No documentation that monthly supervisory case reviews were held
- None of the investigative errors were identified or corrected

¹⁰⁶ RCW 26.44.030(16); RCW 74.14A.020; and CA Case Services Policy Manual 3220

Whether or not the injuries to this child were ultimately preventable is conjecture and speculation. However, due to inadequate CPS investigations in February and April 2009, the department missed two opportunities to engage this family, monitor the children's safety, and attempt to offer services to address identified issues regarding mental health, substance abuse, domestic violence and child abuse.

CHILDREN'S ADMINISTRATION'S RESPONSE

Children's Administration initiated steps to improve department practices and compliance with agency policies including:

- ***Special Case Reviews*** – CA conducted case reviews of randomly selected cases to assure compliance with department practices and procedures.
- ***Staff Training*** – Training sessions addressed topics such as lessons learned from case reviews and the effective development and implementation of safety plans.
- ***Supervisor Training*** – Training emphasized integrating child safety with strength based case work so that social workers work effectively with families and maintain case focus on child safety.

LAW ENFORCEMENT NOW REQUIRED TO REPORT DUI ARRESTS TO CPS WHEN CHILDREN ARE IN VEHICLE

While law enforcement officers are mandated reporters of child abuse and neglect, OFCO found inconsistent practices in whether officers contacted CPS and reported child neglect when a parent or caregiver was arrested for driving under the influence of alcohol or drugs and children were present in the vehicle. The following summary of a near fatality case review is an example of a DUI arrest not being reported to CPS:

A two year old child was paralyzed from a car crash when the parent was driving under the influence of alcohol. Two months earlier, the parent had been arrested for a DUI and reckless endangerment, with a Blood Alcohol Content level two times over the legal limit. Two children, a newborn and the two year old, were in the car at the time of the arrest. Law enforcement did not report this to CPS. Additionally, the mother had been in court just days prior to the crash for violating court orders not to drink and drive. A medical professional ultimately reported child abuse and neglect concerns to CPS due to the child's injuries resulting from the parent's driving while under the influence of alcohol.

The Ombudsman brought this issue to the attention of legislators and policymakers, and testified at legislative hearings. During the 2009-2010 Legislative Session, Representative Mary Helen Roberts sponsored SHB 3124 which was enacted into law, and requires law enforcement to notify CPS when a child under the age of 13 years is present in the vehicle of a person arrested for driving a vehicle while under the influence of alcohol or drugs.¹⁰⁷

¹⁰⁷ SHB 3124: <http://apps.leg.wa.gov/documents/billdocs/2009-10/Pdf/Bills/Session%20Law%202010/3124-S.SL.pdf>

SYSTEMIC INVESTIGATION: RECURRENT MALTREATMENT

BACKGROUND

Beginning in 2008, DSHS/CA is required to notify OFCO of families or children who experience three founded¹⁰⁸ reports¹⁰⁹ of alleged abuse or neglect within the last twelve month period.¹¹⁰ This notification requirement enables the Ombudsman to review problematic cases and intervene as needed. Additionally, a close review of cases of recurrent maltreatment can indicate whether Washington State's child welfare system is effective at reducing the recurrence of child maltreatment.¹¹¹

STATUS OF IMPLEMENTATION

Despite DSHS/CA's efforts, OFCO has not received accurate, timely notification of cases with three founded reports. Delays in notification from DSHS/CA (up to six months in some cases), limits OFCO's ability to review these cases and intervene where appropriate to ensure child safety or effective case planning. OFCO continues to work with CA to develop an effective notification procedure.

DISCUSSION

For the period of September 1, 2009 through August 31, 2010, OFCO received a total of 84 notifications, a 33 percent increase from the same period ending in 2009. Six of the notifications were the second notification regarding the same child or family, meaning that there was one or more subsequent founded report of maltreatment for the child or family within a one-year time period. OFCO reviewed the cases of 78 families for "systemic investigation."¹¹²

Because these families often have had considerable or extended involvement with the child welfare system, it is not uncommon for OFCO to be involved in these cases through another channel, such as through a complaint or a fatality, near fatality, or critical incident notification. In 2010, out of 78 cases, OFCO had 16 complaints or inquiries relating to the child or family, and six fatality, near fatality, or other critical incident notifications.

¹⁰⁸ "Founded" means the determination following an investigation by the department that, based on available information, it is more likely than not that child abuse or neglect did occur. RCW 26.44.020(8).

¹⁰⁹ In this context, "report" means a "referral" to Child Protective Services, which DSHS/CA now calls an "intake."

¹¹⁰ RCW 26.44.030(13).

¹¹¹ "Repeat Maltreatment" was identified as an area needing improvement in the 2010 Washington State Child and Family Services Review (CFSR). The CFSR also noted that there has been a significant drop in re-victimization rates since 2005. *July 2010 State Assessment*.

¹¹² See WAC 112-10-070(c)(i) ("A systemic investigation is intended to produce information that will enable OFCO to identify systemic issues and recommend appropriate changes in law, policy, procedure, or practice.").

The following is an example of a complaint that led to an OFCO intervention on behalf of a child experiencing recurrent maltreatment. In this case, CPS did not complete the third investigation within the time period required by policy (see page 91 for further discussion). Then, DSHS/CA's notification to OFCO of the third founded report was delayed an additional two months. Thus, by the time the OFCO received notification, the intervention was already complete and the complaint resolved:

**COMPLAINT ALERTS OFCO TO DCFS'S FAILURE TO ACT ON BEHALF OF A CHILD
EXPERIENCING RECURRENT MALTREATMENT**

OFCO received a complaint alleging that DCFS CPS was failing to take appropriate action to protect an eight year old child from ongoing abuse and neglect by her custodial parent. OFCO determined that the parent had two founded reports for physical abuse and neglect, and a third report was under investigation. CPS had assisted the non-custodial parent's attempt to obtain a protective parenting plan in family court, and had tried to engage the custodial parent in services, but neither effort had been successful. The child disclosed neglect in a recent CPS interview, and OFCO recommended that CPS file a dependency petition. The investigation resulted in a third finding of child abuse or neglect, and CPS filed a dependency and removed the child. However, the dependency court returned the child to the custodial parent. When another report alleging physical abuse was received a couple of months later and resulted in a fourth finding of child abuse or neglect, the agency went back into court and requested that the child be placed with the non-custodial parent, with supervised visits for the custodial parent. The court agreed.

SUMMARY OF DATA:

OFCO's data for this group of cases with three or more founded reports within one year appears to be fairly consistent with state and nation-wide child welfare data, in that:

- Reports of neglect constituted 77 percent of the founded reports, physical abuse 18 percent, and sexual abuse six percent.¹¹³
- Neglect is more likely to recur than physical or sexual abuse.¹¹⁴
- Caregiver substance abuse is the most prevalent risk factor (affecting 65 percent of the families) in these recurrent cases.

¹¹³ In the federal government report, Child Maltreatment 2007, nationwide statistics showed: "During FFY 2007, 59.0 percent of victims experienced neglect, 10.8 percent were physically abused, 7.6 percent were sexually abused, 4.2 percent were psychologically maltreated, less than one percent were medically neglected, and 13.1 percent were victims of multiple maltreatments." <http://www.acf.hhs.gov/programs/cb/pubs/cm07/chapter3.htm#types>.

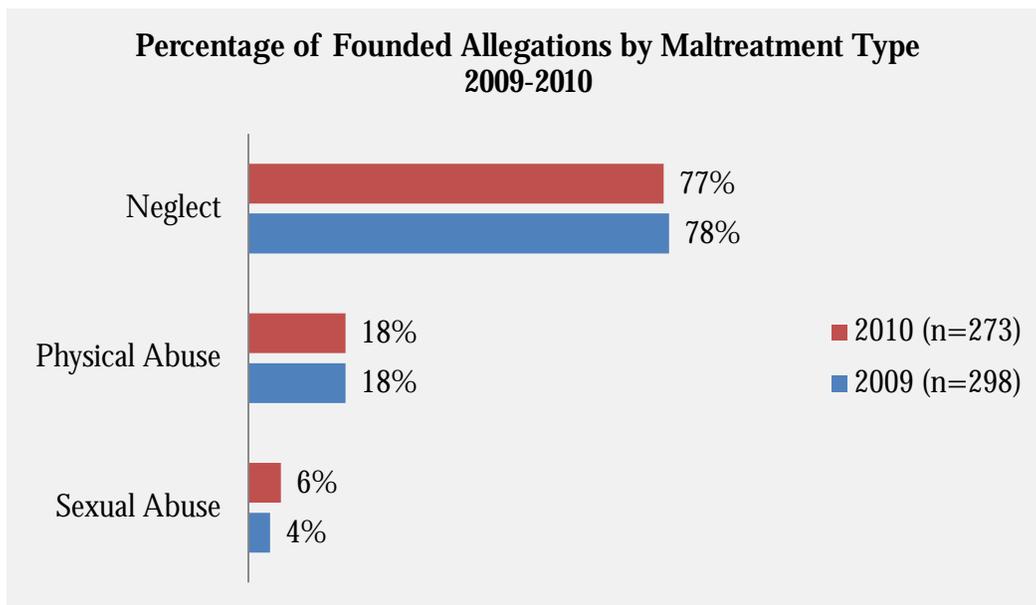
¹¹⁴ See, e.g., Child Neglect Fact Sheet, Children's Administration Office of Children's Administration Research, January 2005, available at <http://www.dshs.wa.gov/pdf/ca/NeglectFact.pdf> ("Families referred for neglect have higher re-referral and recurrence rates (18 percent and 12 percent) than do families referred for physical abuse (16 percent and three percent) or sexual abuse (13 percent and five to six percent)."); Pamela Diaz, Information Packet: Repeat Maltreatment, National Resource Center for Family-Centered Practice and Permanency Planning, May 2006, http://www.hunter.cuny.edu/socwork/nrcfcpp/downloads/information_packets/Repeat_Maltreatment.pdf at 3 ("In comparison to children who experienced physical abuse, children who were neglected were 23 percent more likely to experience recurrence.")

- In 2010 more families were affected by substance abuse (60 percent increase), domestic violence (143 percent increase), and mental health issues (78 percent increase) compared to 2009.
- A large percentage of families have had a previous dependency for either a parent (14 percent) or a child (43 percent). This also reflects an increase compared to 2009.

2010 data includes notifications received by OFCO within its reporting year, which commences September 1st and ends August 31st. 2009 data are provided for comparison.¹¹⁵

TYPE OF CHILD MALTREATMENT

The graph below summarizes the type of maltreatment substantiated in the first, second, and third founded reports.¹¹⁶ Consistent with previous findings, physical neglect is, by far, the most common type of maltreatment experienced by children in these recurrent cases, comprising nearly seventy-seven percent of all founded reports examined by OFCO.

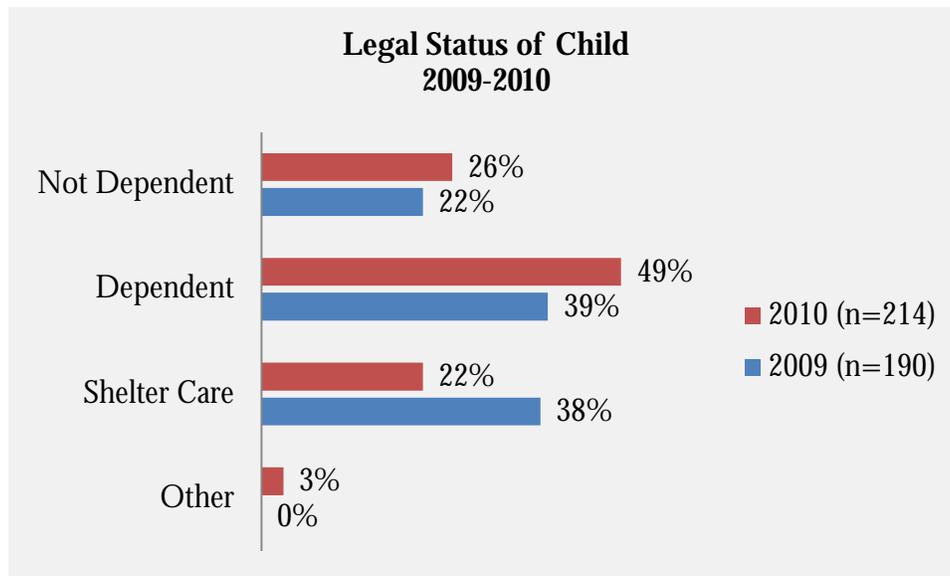


¹¹⁵ A note about 2009 data: as noted in OFCO’s 2009 Annual Report (page 174), “[T]he first notification [that OFCO received from DSHS/CA] in June 2008 included reports which constituted the third founded report of abuse or neglect for a child or family within the past year dating back to January 2008. Thus, the data summarized below [for 2009] covers January 1, 2008 – August 31, 2009.”

¹¹⁶ A single report may be substantiated for more than one type of maltreatment, e.g., a report of sexual abuse is often founded for sexual abuse against the offending caregiver and founded for physical neglect (failure to protect) against the non-offending caregiver who knew or should have known the abuse was occurring. In some cases OFCO received notification of more than three founded allegations of child abuse or neglect. All findings are included in the graph titled “Type of Maltreatment 2009-2010.”

LEGAL STATUS OF CHILDREN AT TIME OF NOTIFICATION

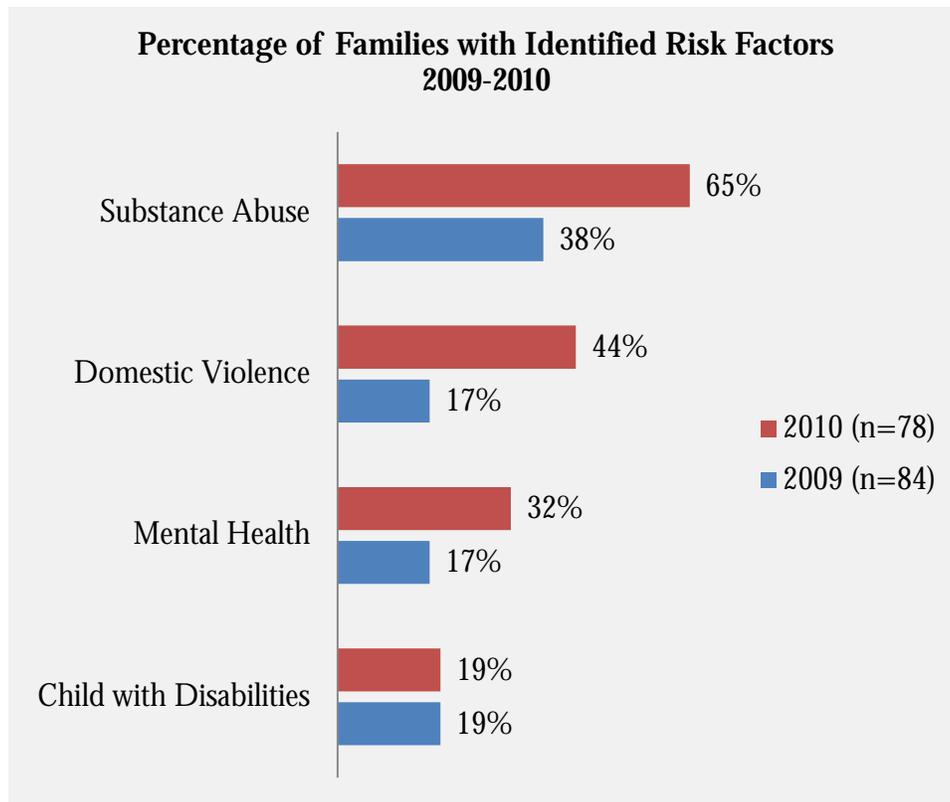
For a large majority (71 percent) of the cases reviewed, DSHS/CA had already taken affirmative legal action – either through an in-home or out-of-home dependency – to ensure the safety of the children.¹¹⁷ Twenty-six percent of children identified were not dependent or in shelter care at the time OFCO received notification of the child or family’s third founded report of child abuse or neglect.



¹¹⁷ Because of the time lag between when the report was received by DSHS/CA and when OFCO is notified of the third founded report, DSHS/CA has usually had sufficient time to determine whether or not legal action will be taken. Compared to 2009 numbers, more children are already dependent (rather than in shelter care) by the time notification is received. We suspect this may be due to some of the delays in the notification system this year.

PRESENTING RISK FACTORS¹¹⁸

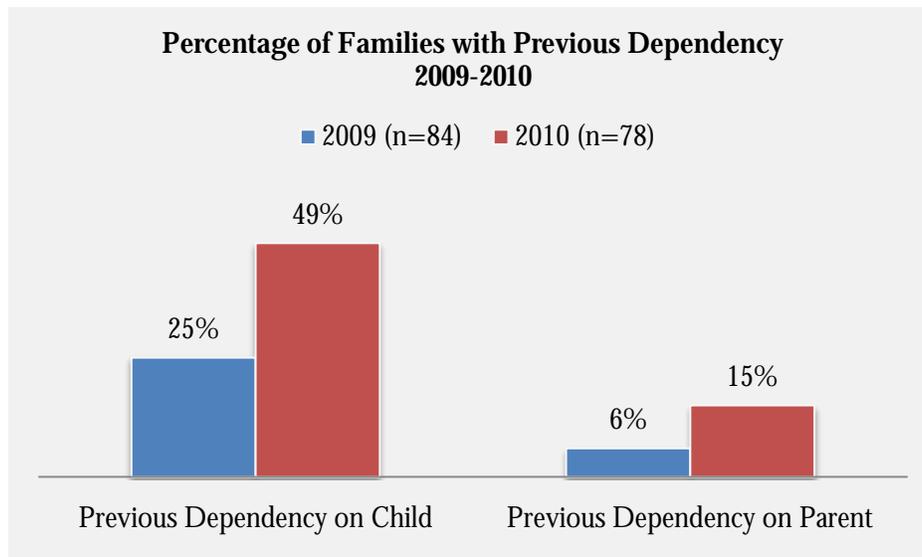
Substance abuse was identified as a risk factor in almost two-thirds (65 percent) of the families. These cases often involve parental abuse of alcohol or prescription medications. Forty-four percent of families experienced domestic violence and thirty-two percent experienced mental health issues. **Each of these risk factors has increased significantly compared to 2009**, from 38 percent for substance abuse (a 60 percent increase), 17 percent for domestic violence (a 143 percent increase), and 17 percent for mental health (a 78 percent increase). Last year, OFCO assumed that rates of caretaker substance abuse, domestic violence, and mental illness may have been low in our sample due to the fact that we only count cases where these risk factors are explicitly identified in the reports of child abuse or neglect. OFCO's review process and counting methods have not changed, yet the rates are drastically higher in 2010. In contrast, the percentage of families which have at least one child with a disability (19 percent) has remained the same compared to 2009.



¹¹⁸ Research has established poverty as a clear risk factor for recurrent maltreatment. OFCO does not currently have access to information about families' financial status, and thus has not collected information regarding families experiencing poverty.

PREVIOUS DEPENDENCIES

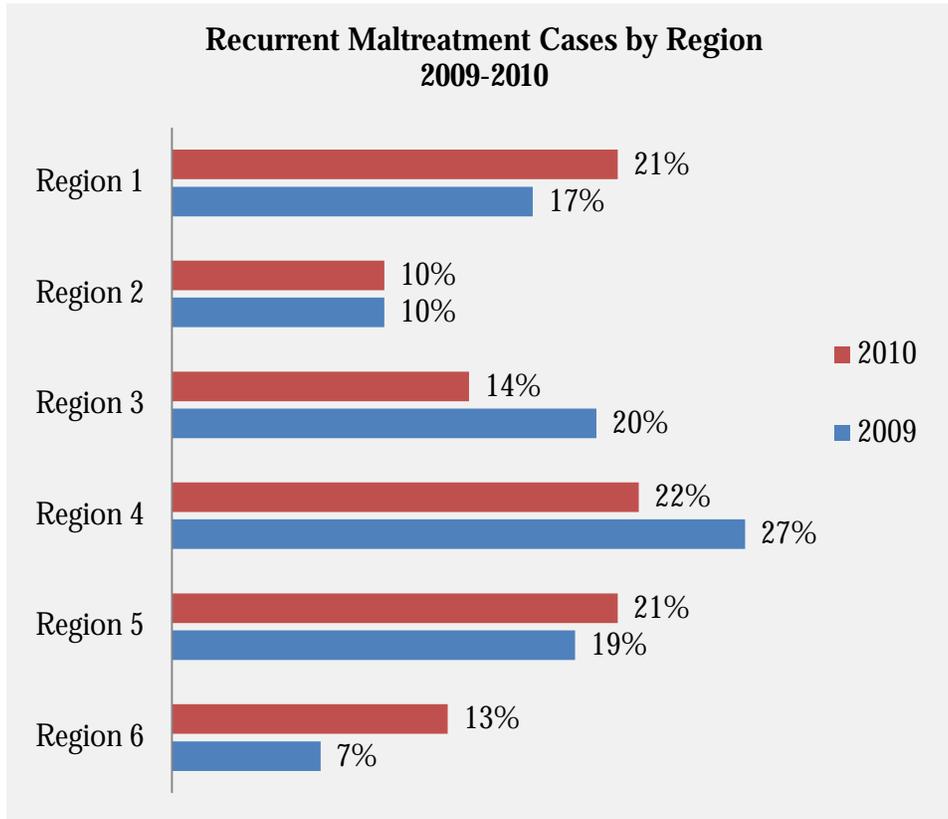
Another increase from 2009 is the number of families who have experienced a prior dependency; this number approximately doubled in 2010. In 2010, almost half of the families (46 percent) had at least one child who was previously dependent. The number of families with at least one parent who was dependent as a child also increased, from six percent to fifteen percent.¹¹⁹



These cases involve a wide range of circumstances: parents who were in foster care as youths; parents who have had rights terminated to older children; children with previous out-of-home placement(s) and subsequent reunification(s); children who are placed with non-custodial parents or relatives; and adopted children, now the victims of abuse or neglect in their adoptive homes. For the first time in 2010, four of the recurrent maltreatment cases involved abuse or neglect which occurred in licensed foster homes.

¹¹⁹ OFCO had expected these numbers to go down rather than up given that FamLink does not link all past history under the same case. In FamLink a “case” is usually found under the mother’s name, and thus, the mother or father’s own legal or placement history as a minor will not appear in this case, but rather the parent’s history appears in a case under the grandparent’s name.

RECURRENT MALTREATMENT CASES BY DCFS REGION



SYSTEMIC FINDING: LATE INVESTIGATIVE ASSESSMENTS LEAVE CHILDREN AT RISK OF HARM

OFCO FINDING

In our review of cases with three founded reports of child abuse or neglect within one year, OFCO finds that Child Protective Services routinely fails to complete Investigative Assessments within the 45-day deadline required by policy. The timely completion of investigations is crucial to child safety and effective case planning.

RECOMMENDATION TO DSHS/CA

Identify the common causes of delays in completing CPS investigations and take steps to ensure that Investigative Assessments are completed in a timely fashion.

According to DSHS/CA policy, CPS Investigative Assessments must be completed within 45 days of DSHS/CA receiving the report of alleged abuse or neglect.¹²⁰ The supervisor must review all cases open to CPS to determine if the 45-day rule requirement has been met.¹²¹ FamLink has an extensions/exceptions page where a supervisor can document an extension to the 45-day timeline and the reason why it is being granted.¹²²

The main purpose of the Investigative Assessment is to document the findings regarding the alleged abuse or neglect, as either founded or unfounded. At this juncture, risk is also assessed and decisions about case status are often made; if a case is to remain open, it will be transferred from CPS to another unit. Once the Investigative Assessment is complete, the subject of the report is notified of the finding, which triggers their right to request administrative review. This is an important due process protection given the fact that a “founded” finding of abuse or neglect remains on the subject’s record and can prevent them from employment in certain fields. Completion of the Investigative Assessment also triggers DSHS/CA’s notification to OFCO if the finding constitutes the third founded finding within the previous 12 months.

In 75 percent of the cases reviewed by OFCO with three founded reports, at least one Investigative Assessment remained incomplete past the 45-day deadline. Almost half (47 percent) of the 78 cases had two or more Investigative Assessments that were not completed on time. In a significant percentage, 17 percent, all three of the Investigative Assessments reviewed were untimely. The length of the delay varied; however, in some cases, CPS investigations remained open for months and even a year more than allowed by policy.

¹²⁰ Children’s Administration Practices and Procedures Guide, Section 2540.

¹²¹ Children’s Administration Practices and Procedures Guide, Section 2610(C). This policy does not specify any reasons for an extension or exception.

¹²² Some CPS supervisors may still document the reason an investigation is incomplete in a case note, which was the practice in the former CAMIS system.

Even in the few cases (six out of fifty-eight) where the supervisor granted the appropriate extension/exception to the 45-day rule, delays in case planning, notice, and due process protections remain concerning.

CASE EXAMPLE 1: CPS INVESTIGATIONS REGARDING TEN YEAR OLD CHILD REMAIN OPEN FOR SIX AND EIGHT MONTHS

DCFS filed a dependency petition and removed a ten year old child following a founded report from a medical professional that the parent was unable to provide necessary care for the child's life-threatening diabetes. The investigation found that the parent was using marijuana and may have untreated mental health issues. Siblings, ages six, eight and sixteen, remained in the home and no legal action was taken on their behalf. A second report was founded after several uncapped dirty needles were observed within reach in the younger children's bedroom. Thereafter, the assigned social worker and child's CASA went to the home to assess the possibility of the ten year old beginning overnight visits and found the home in deplorable condition, with an overflowing toilet, no working refrigerator, medications and needles accessible to the children, and little food other than a twenty-five pound bag of sugar. Law enforcement was called to the home but declined to place the six and eight year old children into protective custody. DCFS did not take any legal action to protect the younger children who remained in the home. The investigation into these allegations remained open for more than eight months. In the interim, a fourth report was received alleging continued concern for the younger children based again on the conditions of the home, as well as suspicion that the parent was not taking medications as prescribed. This fourth investigation remained open for six months. By the time the Investigative Assessments were completed for the third and fourth reports and both determined to be founded for neglect, the dependency court had ordered that the ten year old child return home, despite continued concerns that the parent was unable to adequately control the child's diabetes. DCFS has since requested re-placement for the ten year old child based on new concerns, which the court has not granted. Currently, the family is facing eviction.

CASE EXAMPLE 2: INVESTIGATIVE ASSESSMENTS COMPLETED ELEVEN MONTHS AFTER INVESTIGATION COMMENCED

Between July 2009 and April 2010, CPS screened in for investigation six separate reports of child abuse and/or neglect regarding children ages six and seven; five of these reports were made by mandated reporters. Two reports by mandated reporters in April 2010 were screened out. Allegations included serious concerns about the mother's mental health and being off her psychotropic medication, physical abuse of both children by the mother or her boyfriend, parental substance abuse, and the boyfriend returning to the home after perpetrating domestic violence. Four of these reports were determined to be founded for neglect. However, none of the Investigative Assessments were completed until June 2010 (almost a year after the intake for the July 2009 report). Furthermore, despite the recurrence of the maltreatment, DCFS did not take legal action until June 2010, after law enforcement requested placement of the children because the mother had to be transported to the emergency room in a delusional and incoherent state. The children were removed for three months, and then returned to their mother's care in a supportive housing environment.

Both of these cases illustrate how the lack of timely completion of investigations adversely affected child safety and the department's case planning, as well as the Ombudsman's ability to effectively intervene to ensure child safety and appropriate case planning upon notification of the third founded report under RCW 26.44.030(13). In the first example, DCFS CPS received the third founded report in November 2009. Thus, policy required the Investigative Assessment to be completed by early January 2010. With two founded reports, DCFS may have had sufficient basis to file dependency petitions for the two younger children who remained in the home. Had the investigations been completed on time, OFCO also would have received notification of the case and would likely have intervened to ensure that DCFS CPS and CWS were communicating about possibly filing for dependency for the younger children. Such intervention may have prevented the fourth report of maltreatment.

In the second case example, DCFS CPS received the third founded report in February 2010, but did not complete any of the Investigative Assessments until June 2010. If the third investigation were concluded in April 2010, the Ombudsman may have intervened to ask DCFS CPS to take a more pro-active approach towards engaging the family in services given the long history of recurrent maltreatment, and to ensure appropriate screening decisions on the three subsequent reports of child abuse and/or neglect received in April 2010.

PART TWO: WORKING TO MAKE A DIFFERENCE

CASE LAW UPDATE

- Ø No Finality, Stability or Permanency: Adoption Decrees Entered While an Order Terminating Parental Rights is under Appellate Review
- Ø When Considering Termination of Parental Rights, the Court Must First Determine Parental Unfitness Before Addressing the Best Interest of the Child.
- Ø Interstate Compact for the Placement of Children Does Not Require a Receiving State's Approval of a Child's Placement with a Parent
- Ø CPS and Law Enforcement Interview of a Child Constituted an "Unreasonable Seizure" in Violation of the Fourth Amendment
- Ø Proposed Amendment To "Sirta's Law"

NO FINALITY, STABILITY OR PERMANENCY: ADOPTION DECREES ENTERED WHILE AN ORDER TERMINATING PARENTAL RIGHTS IS UNDER APPELLATE REVIEW

SUMMARY

Recent Court of Appeals and Supreme Court decisions reversing orders terminating parental rights illustrate the myriad of problems that may arise when adoptions are finalized while an appeal is pending. Policymakers should consider the cost-benefit of finalizing adoptions under these circumstances and whether state law, court rules, or department policy should prohibit or limit this practice.

BACKGROUND

Termination of parental rights is necessary before a child is legally eligible for adoption. Under current state law, once a trial court enters an order terminating parental rights following a contested trial, the department may consent to a foster parent or relative caregiver proceeding with adoption¹²³ and dismiss the child's dependency case, even if the parent is appealing the decision terminating their rights.¹²⁴ This can have a devastating impact on children and their adoptive and biological families if the appeals court later reverses the termination order.¹²⁵

When a decision to terminate parental rights is reversed on appeal, the only remedy for the biological parents and children whose legal relationship had been wrongfully severed is to vacate the

¹²³ Filing notice of appeal of an order terminating parental rights does not prevent the department or a private agency from finalizing an adoption. Any person may take action premised on the validity of the trial court's decision unless the decision is stayed. RAP 7.2(c).

¹²⁴ Parents have a right to appeal a decision depriving them of all parental rights with respect to a child as well as from a final order after judgment, such as a dependency disposition order, that affects a substantial right. RAP 2.2(a)(6) & (13).. All other issues arising from a dependency proceeding are subject to discretionary review by the court of appeals. A parent must file notice of appeal within 30 days of entry of the trial court's decision. RAP 5.2.

¹²⁵ See, Kate M. Heideman, *Avoiding the Need to "Unscramble the Egg": A Proposal for the Automatic Stay of Subsequent Adoption Proceedings When Parents Appeal a Judgment Terminating Their Parental Rights*, 24 St. Louis U. Pub. L. Rev. 445 (2005).

child's adoption. Finalizing adoptions while the appeal of an order terminating parental rights is pending leaves all of the parties involved, including the child and the adoptive parents, in a situation with no finality or stability. Additionally, since the underlying dependency case is dismissed when the adoption occurs, a "legal limbo" results if the order terminating parental rights is reversed and the case remanded for further proceedings. Presumably, the court must then vacate the existing adoption and re-establish the dependency action. Creating a situation where final orders of adoption later must be vacated is not only harmful to children and families but diminishes the integrity of the judicial system.

Summarized below are two recent decisions, from the Washington State Supreme Court and the Washington State Court of Appeals, that illustrate the problems that can occur when children are adopted while the underlying trial court decision terminating parental rights is under appeal. To address these issues legislators, judges and stakeholders should consider amending existing state law, court rules and/or department policy to provide for an automatic stay of adoption proceedings upon the filing of an appeal. Or, alternatively, to establish that a child is not eligible for adoption while an appeal of an order terminating parental rights is pending.

IN RE THE WELFARE OF A.B.¹²⁶

A.B. was born on October 27, 2001 with cocaine in her system. On October 29, 2001, the Division of Children and Family Services (DCFS), Child Protective Services removed A.B. from her mother's care and placed her in a foster home. The child's father was not married to the child's mother and was living in Las Vegas.

In February 2002, the court determined that the child was dependent and entered disposition orders against both parents. The father visited with A.B., completed a drug treatment program, maintained employment, gained custody of step-children from a different relationship, and established a residence with his parents. During the dependency, he was also in jail at different times on an immigration hold and for pushing a police officer.

On January 3, 2003, DCFS filed a petition for termination of parental rights. The court terminated the mother's parental rights on July 8, 2005. On March 31, 2006, after a contested trial, the court terminated the father's parental rights, even though the court did not find that the father was an unfit parent. The father appealed the trial court's decision.

Despite the father's pending appeal, A.B. was adopted in late 2006. In 2007, the Washington State Court of Appeals affirmed the trial court's decision. The Washington State Supreme Court granted the father's motion for discretionary review. In June 2010, the Supreme Court issued its decision reversing the order terminating the father's parental rights. The Supreme Court ruled that a parent has a due process right not to have the State terminate his or her relationship with a child, absent a finding that the parent is currently unfit to parent the child. The Court directed the trial court to supervise the "prompt but orderly transfer" of A.B. to her father's care.

¹²⁶ In re Welfare of A.B., 168 Wn.2d 908 (2010).

The dissenting opinion identifies the problems created by finalizing adoptions while an appeal is pending. Three and a half years after A.B. had been adopted, the dissent states:

“A.B. is living with her family. She has been raised by her mother’s cousin almost since birth. Her mother’s cousin has also adopted A.B.’s younger half brother, who has lived with his eldest sister his entire life. The ‘prompt but orderly transfer’ ordered by the court today will wrench this child out of the only home she has ever known and deprive a brother of his sister.”

IN THE MATTER OF THE DEPENDENCY OF B.R. AND T.V.¹²⁷

On May 31, 2005 CPS received a referral stating that 20 month old B.R. sustained a head injury and that the mother’s boyfriend’s report that the child fell down the stairs was not consistent with B.R.’s injury. On July 5, 2005, the mother agreed to an order of dependency permitting B.R. to remain in her home. The disposition order required her to complete an anger management assessment, continue to participate in domestic violence support group, and adhere to the protection orders against her former boyfriend and against B.R.’s father. On October 5, 2005, B.R. was removed from his mother’s care because she had not filed the return of service for the protection order against her ex-boyfriend.

T.V. was born on December 17, 2005 and CPS filed for dependency based on the prior physical abuse of B.R. and on the mother’s initial failure to obtain a valid protection order. On March 14, 2006, the mother agreed to a dependency order that allowed T.V. to remain in her care. The disposition order required her to maintain the protection order against the ex-boyfriend and attend domestic violence support groups. A week later the department also placed B.R. back in his mother’s care.

On May 24, 2007, the court found that the mother violated the no contact order with her ex-boyfriend by attending his mother’s funeral in August 2006 and the court ordered B.R. and T.V. placed into foster care. Despite the mother’s continued compliance with court ordered services, the department filed for termination of parental rights on January 7, 2009. Following a contested trial, the court terminated the mother’s parental rights on June 2009 and she appealed.

While the mother’s appeal was pending, the adoptions of B.R and T.V. were finalized in early 2010. Seven months later, on September 27, 2010, the Court of Appeals (Division I) issued its decision reversing the trial court’s order terminating the mother’s rights. The Court of Appeals determined that the evidence did not support a conclusion that the mother was unfit.

¹²⁷ Division I Court of Appeals, Docket No. 63788-6-I, filed September 27, 2010.

RESPONSES FOR CONSIDERATION

The legislature, the court, and child welfare stakeholders should consider amending state law and/or court rules to prohibit the entry of adoption decrees while an appeal from an order terminating parental rights is pending. Two possible approaches to address this issue are:

Ø **Amend RCW 26.33 to Prohibit Entry of an Adoption Decree while an Appeal is Pending**

It is the intent of the legislature that adoption decrees provide “finality for adoptive placements and stable homes for children.”¹²⁸ Yet as the above cases illustrate neither finality nor stability are possible while an appeal of an order terminating parental rights is pending. RCW 26.33 which governs the entry of adoption decrees could be amended to provide:

- If a notice of appeal from an order terminating parental rights has been filed, the court shall not order an adoption until the court of appeals affirms the order terminating parental rights; and
- If a motion for discretionary review of the court of appeals decision has been filed with the Supreme Court, the court shall not order an adoption until the motion is denied or the Supreme Court affirms the order terminating parental rights.¹²⁹

Ø **Amend the Rules of Appellate Procedure to Provide for an Automatic Stay Pending Appeal**

Current Superior Court Rules and Rules of Appellate Procedure allow the trial court or the court of appeals to hear motions to stay further proceedings pending appeal,¹³⁰ but do not adequately address the unique circumstances of an order terminating parental rights and a subsequent adoption. As the decision to grant or deny a motion to stay is within the court’s discretion, stays of further proceedings may or may not be applied in a uniform manner. The rules also do not address cases where an appeal is filed but a stay of further proceedings is not requested. A more consistent and effective approach might be to provide for an automatic stay upon the filing of an appeal from an order terminating parental rights. For example, the Rules of Appellate Procedure could provide:

- An order terminating the parental rights of any person that is entered in a proceeding initiated under RCW 13.34 or RCW 26.33 shall be automatically stayed for 30 days after entry of the order of termination. If notice of appeal is filed with respect to the termination order within the 30 days, the automatic stay shall continue until the appeal is complete or the stay is lifted by the reviewing court. If notice of appeal is not filed within the 30 days, the automatic stay shall expire.
- The automatic stay under this rule shall stay the termination order to the extent that it would permit entry of an order of adoption without the parent’s consent or surrender, and shall also stay the termination order with respect to any power granted to a person or agency to consent to an adoption.

¹²⁸ RCW 26.33.260(4).

¹²⁹ Other states have taken this approach to address this issue. For example, see Michigan Laws, Section 710.56(2).

¹³⁰ RAP 7.2(h); RAP 8.3; CR 62.

- Neither the appeal nor the automatic stay of the termination order shall affect the trial court's continuing jurisdiction over the care, custody, visitation and support of the child, and a guardian of the child may take any authorized action other than consenting to the child's adoption.
- The stay of an order terminating parental rights may be lifted when it is clearly in the best interests of the child on motion by a party or by the court.¹³¹

¹³¹ See Illinois Supreme Court Rule, Civil Appeals Rule 305(e).

WHEN CONSIDERING TERMINATION OF PARENTAL RIGHTS, THE COURT MUST FIRST DETERMINE PARENTAL UNFITNESS BEFORE ADDRESSING THE BEST INTEREST OF THE CHILD.

As discussed above, a parent has a constitutional due process right not to have the State terminate his or her relationship with a child absent an express or implied finding that he or she is currently unfit to parent the child.¹³² If a parent is fit to raise their child, both the parent and the child have a fundamental right to family integrity without state interference. In other words, the law presumes that it is in a child's best interest to be raised by a fit parent.

In *In re A.B.*, the State Supreme Court clarified that in determining whether to grant a petition to terminate parental rights, the court must use a two-step analysis. The first step focuses on the alleged unfitness of the parent, which the state must prove by clear, cogent and convincing evidence. Here, the court considers relevant factors such as whether all necessary services that are reasonably available and capable of correcting the parental deficiencies have been offered or provided, and whether parental deficiencies will be remedied in the near future so that the child can be returned to the parent.¹³³ During this initial step, the court does not balance the child's interest in against the parents' interest in raising the child or consider whether the natural parents or proposed adoptive parents would provide the better home. Only after parental unfitness has been established does the court consider the second step: whether or not termination of parental rights is in the best interest of the child.¹³⁴

This distinction is significant not merely for court procedure but to guide all parties in case planning and establishing permanency. Ombudsman complaint investigations have identified confusion over case planning and case goals resulting from the misapplication of a "best interest of the child" standard. For example, cases referred by the department to the Attorney General's Office (AGO) for termination of parental rights based primarily on factors such as the child's bonding with a caregiver, length of time in state care and the best interest of the child, might be declined by the AGO because of insufficient evidence that the parent is currently unfit. This confusion can delay case resolution and harm children, parents, foster parents, and relative caregivers.

State law arguably does not provide adequate guidance to practitioners on the constitutional requirement that current parental unfitness must be established, prior to a best interest of the child analysis. For example, at the permanency planning hearing, state law requires the court to order the department to seek termination of parental rights if the child has been in out-of-home care for fifteen of the last twenty-two months, unless the court documents a "good cause exception" not to do so.¹³⁵ While the statute lists possible "good cause exceptions" it does not specify insufficient evidence that the parent is currently unfit as a basis not to file for termination of parental rights.¹³⁶

¹³² *Santosky v. Kramer*, 455 U.S. 745, 760 (1982); *In re Welfare of A.B.*, 168 Wn.2d 908 (2010).

¹³³ RCW 13.34.180.

¹³⁴ *Santosky v. Kramer*, 455 U.S. at 750; *Troxel v. Granville*, 530 U.S. 57 (2000) ("The court should not enter into a 'best interest of the child' analysis unless parental unfitness is established."). See also RCW 13.34.190.

¹³⁵ RCW 13.34.145(3)(b).

¹³⁶ "... "good cause exception" includes but is not limited to the following: The child is being cared for by a relative; the department has not provided to the child's family such services as the court and the department have deemed necessary for the child's safe return home; or the department has documented in the case plan a compelling reason for determining that filing a petition to terminate parental rights would not be in the child's best interests." *Id.*

Children's Administration policy, however, recognizes that a compelling reason not to file for termination of parental rights includes: "The parents are making significant progress in addressing the problems that brought their children into care, and the social worker expects reunification within six months."¹³⁷

OFCO RECOMMENDATION

To avoid confusion over identifying an appropriate permanent plan and related case delays, the department and other professionals involved in case planning should institute a similar two step analysis as set forth in *In re A.B.* when considering whether to seek termination of parental rights. First examine whether or not the parent is fit, and then only if the facts and circumstances support a determination that the parents are currently unfit, next consider which case outcome is in the child's best interest.

¹³⁷ Permanency Planning Practice Guide for Social Workers, Children's Administration August 2006, page 17.
<http://ca.dshs.wa.gov/intranet/pdf/manuals/PermPlanGuide.pdf>

INTERSTATE COMPACT FOR THE PLACEMENT OF CHILDREN DOES NOT REQUIRE A RECEIVING STATE'S APPROVAL OF A CHILD'S PLACEMENT WITH A PARENT

OFCO RECOMMENDATION

Children's Administration should develop procedures for conducting home studies, background checks and for making placement recommendations for parents residing out-of-state.

The Interstate Compact for the Placement of Children (ICPC) is a statutory agreement between all 50 states,¹³⁸ the District of Columbia and the US Virgin Islands. The agreement governs the placement of children from one state (the "sending state") into another state (the "receiving state"). The purpose of the ICPC is to ensure that: the child is placed in a suitable environment; the receiving state has the opportunity to assess and approve the proposed placement; the sending state obtains enough information to evaluate the proposed placement; and the sending agency or individual remains legally and financially responsible for the child following placement.¹³⁹

The ICPC provides in part that a sending agency must notify a receiving state prior to sending a child for placement in foster care or for possible adoption. The placement may not occur until the receiving state approves the proposed placement and notifies the sending agency in writing that "the proposed placement does not appear to be contrary to the interests of the child."¹⁴⁰

In a recent opinion, the Washington State Court of Appeals (Division I)¹⁴¹ held that the ICPC does not apply to the placement of a child with a parent residing out-of-state. The court reasoned that the scope of the compact is limited to foster care or pre-adoption placements.¹⁴² Application of the ICPC to placement of a child with a parent also usurps the court's authority to act in the child's best interest as the placement decision lies with an administrative agency in another state and not the court. In this case, ICPC requirements created barriers to family preservation as a fit parent was denied approval by the receiving state because the parent's home had too few bedrooms.

In light of this decision, a court may order a dependent child to be placed with a parent residing out-of-state, without an approved ICPC home study and without a mechanism for courtesy case supervision by the receiving state. The department, however, has a duty under state law to supervise dependent children who are placed with a parent, for at least six months before dismissing the dependency.¹⁴³ While this may not be a common occurrence, the department should develop policy or guidelines on how to provide meaningful case supervision and safely place a child with an out-of-state parent, absent courtesy supervision. This might involve contracting with a private agency to conduct health and safety visits, or other case services on a short term basis.

¹³⁸ Washington State enacted the ICPC into state Law in 1971. RCW 26.34.010.

¹³⁹ See *The Association of Administrators of the Interstate Compact on the Placement of Children*, http://icpc.aphsa.org/Home/home_news.asp See also, RCW 26.34.010 article I.

¹⁴⁰ RCW 26.34.010 article III(d).

¹⁴¹ *In the Matter of the Dependency of D.F.-M.*, Court of Appeals (Div. I), No. 63624-3-I, filed August 2, 2010.

¹⁴² *Id* at 10. See RCW 26.34.010 article III(a).

¹⁴³ RCW 13.34.138(2)(a).

CPS AND LAW ENFORCEMENT INTERVIEW OF A CHILD CONSTITUTED AN “UNREASONABLE SEIZURE” IN VIOLATION OF THE FOURTH AMENDMENT

SUMMARY

The Federal Ninth Circuit Court of Appeals held that a joint CPS and law enforcement interview of a child regarding allegations of abuse, occurring at the child’s school, lasting for one to two hours, and conducted without a warrant, probable cause, parental consent, or exigent circumstances, was an unlawful seizure.¹⁴⁴

In response to this decision, Children’s Administration issued an “Urgent Policy and Procedure Update” modifying procedures for conducting child interviews.

BACKGROUND

In Greene v. Camreta,¹⁴⁵ the father of S.G and K.G was arrested for suspected sexual abuse of a seven year old boy. Subsequent allegations arose of sexual abuse of his daughters. Bob Camreta, a DHS worker learned that upon the father’s release from jail, he was having unsupervised contact with his daughters. Three days later, Camreta, accompanied by James Alford, a uniformed deputy sheriff, went to the nine year old daughter’s school to interview her. Camreta requested a private office to conduct the interview. The child’s mother was neither informed of nor consented to this interview. Camreta also did not obtain a warrant or other court order before the interview. The interview lasted one to two hours and was not recorded. Camreta concluded that Greene sexually abused his daughter. In determining that Fourth Amendment protections against unlawful seizure applied, the court noted that the civil investigation of child abuse was intertwined with law enforcement’s criminal investigation.

CHILDREN’S ADMINISTRATION RESPONSE

Shortly after this decision was published, Children’s Administration issued a Policy and Procedure update regarding CPS interviews of children. The new interview procedure requires CPS social workers to ensure that child interviews regarding allegations of abuse are voluntary by:

- asking the child during the introduction if they are willing to talk to the social worker;
- during the interview re-asking the child if it is okay to continue talking or if they want a break; and
- asking school staff, in the presence of the child, where they will be if the child wants to return to class, wants to have a third party present, or wants to ask a question of school staff.

When interviews are not audio recorded, the new procedure requires the CPS social worker to document in the case notes that:

- the above questions were asked and the child’s response;

¹⁴⁴ The Fourth Amendment guarantees individuals the right “to be secure in their persons . . . against unreasonable searches and seizures . . .” by government officials. U.S. CONST. amend. IV.

¹⁴⁵ 588 F. 3rd 1011 (9th Cir. 2009).

- individuals present for the interview;
- where the interview occurred; and
- a near verbatim summary of the questions asked and the responses by the child.

The U.S. Supreme Court will hear this case in the spring of 2011. The Supreme Court's decision may further affect practice in Washington.

PROPOSED AMENDMENT TO "SIRITA'S LAW"

Enacted in 2007, "Sirita's Law" requires that before a dependent child is "returned home" to a parent, the department must identify all caregivers for the child and assess whether they are in need of services.¹⁴⁶ The department may provide services to the caregivers. If the department recommends that the caregiver engage in services, and the caregiver fails to engage in the services, or follow through with the services, the department must notify the court. The court may delay placing the child in the parent's home or make placement contingent upon the caregiver receiving services. The department is also required to conduct background checks on all adults residing in the home and notify the parents that they have an on-going duty while the child is dependent to notify the department of any person who is residing in the home or acting as a caregiver for the child.

When investigating complaints, OFCO has encountered cases where the department has asserted that the provisions of "Sirita's Law" only apply when a child is "returning home," and not when a child is being placed with a non-custodial parent. "Returning home" should be read to include placement with either a custodial or non-custodial parent. The legislature did not intend for there to be a heightened level of scrutiny and protection for children returned to a custodial parent but not for children placed with a non-custodial parent. In fact, the physical abuse leading to Sirita's death was inflicted by the non-custodial father's spouse, after the child was placed in the father's care. A narrow application of this statute is contrary to the legislative intent of this law, contrary to the specific circumstances of Sirita Sotelo's case, and it potentially leaves children at risk of harm.

RECOMMENDATION

The Ombudsman recommends that the legislature amend RCW 13.34.138 to clarify that the department's duties and responsibilities in this statute apply both when a child is returned home to a custodial parent as well as when the child is placed in the home of a non-custodial parent.

¹⁴⁶ RCW 13.34.138(2).

SYSTEM IMPROVEMENT EFFORTS

Because of the Ombudsman's independent perspective and knowledge of the child welfare system, the Ombudsman is often invited to participate in efforts to improve outcomes for children and families. During the past year, these efforts include:

TRANSFORMING CHILD WELFARE SERVICES

2SHB 2106, enacted by the 2009 Legislature, aims to transform child welfare services in a two-phase process with the assistance of a Child Welfare Transformation Design Committee (TDC). During phase one, the Department of Social and Health Services (DSHS) must convert contracts for child welfare services to performance-based contracts by July 1, 2011. During phase two, DSHS must contract with private agencies to provide all child welfare services in two demonstration sites by December 30, 2012. The Governor will decide whether to expand or terminate the phase two privatization of child welfare services based on measurable performance in the demonstration sites. As a member of the TDC, the Ombudsman works to identify possible unintended consequences in this process which could be harmful to children or families and how these issues might be avoided. The Ombudsman also examines the experiences of other states that have undertaken similar initiatives so as to build on their strengths and avoid mistakes.¹⁴⁷

ENHANCED REPRESENTATION FOR CHILDREN IN DEPENDENCY AND TERMINATION OF PARENTAL RIGHTS PROCEEDINGS

When children are provided attorneys in their dependency and termination proceedings, it is imperative to provide them with well-trained advocates, so that their legal rights around health, safety, and well-being are protected. Effective child representation helps ensure that the child's voice is considered in judicial proceedings, engages the child in his or her legal proceedings, helps the child understand his or her legal rights and the consequences of different decisions, and encourages accountability among the different systems that provide services to children.

To this end, the legislature enacted HB 2735¹⁴⁸ which directs the Administrative Office of the Courts (AOC) in coordination with the Washington State Supreme Court Commission on Children in Foster Care, to develop recommendations for attorneys representing children in dependency proceedings. This past fall, OFCO served on a workgroup which developed attorney practice standards, training requirements and caseload standards for attorneys representing children. These recommendations will be reported to the Legislature by December 31, 2010.

¹⁴⁷ More information about 2SHB 2106 and TDC's activities is available online at <http://www.joinhandsforchildren.org/>

¹⁴⁸ Chapter 180, Laws of 2010, effective June 10, 2010.

ENGAGING FATHERS IN DEPENDENCY PROCEEDINGS

Studies show that engaging fathers in dependency proceedings contributes to improved outcomes for children. When fathers are actively involved in their child's case, there is: a higher likelihood of family reunification; reunification occurs more quickly; children spend less time in foster care; and there is a lower likelihood of subsequent allegations of child maltreatment after reunification. A father's involvement and participation in the dependency proceeding is relevant to the three major concerns of the child welfare system: safety, permanency, and well being.¹⁴⁹

However, there are numerous barriers facing fathers within the child welfare system. As noted by the Washington State Child and Family Services Review, these barriers include: preconceived notions regarding fathers' interest in assuming parenting responsibilities; social workers meet less frequently with fathers than with mothers; engagement of the father in the case plan decreased from 51 percent in 2008 to 47 percent in 2009; and inconsistent engagement of fathers and paternal relatives limit placement and visitation opportunities for the child.¹⁵⁰

This past year, OFCO has supported efforts by Catalyst for Kids, Children's Administration, the National Quality Improvement Center, and the University of Washington School of Social Work to strengthen fathers' involvement and participation in the child welfare system.

¹⁴⁹ *More About the Dads: Exploring Associations between NonResident Father Involvement and Child Welfare Outcomes*, Malm, Zielewski and Chen. This report was prepared by the Urban Institute under contract to the Office of the Assistant Secretary for Planning and Evaluation of the U.S. Department of Health and Human Services.

¹⁵⁰ *Washington 2010 CFSR Statewide Assessment*, July 2010.

2010 LEGISLATIVE ACTIVITIES

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

During the 2010 legislative session, the Ombudsman reviewed, analyzed, and commented on several pieces of proposed legislation. OFCO provided written or verbal testimony on the following bills:¹⁵¹

ENACTED LEGISLATION

SHB 2680: GUARDIANSHIP PROGRAM (*Effective June 6, 2010*)

For some children and youth in foster care, return home or adoption are not appropriate or feasible permanency plans. Legal guardianship offers another option. Unfortunately, OFCO routinely receives complaints from relatives and other caregivers who cite the lack of continued financial support as a barrier to pursuing legal guardianship.

SHB 2680 creates a new Chapter under RCW 13.34 which addresses this common complaint by: a) clarifying that guardianships are permanent plans, b) providing for the dismissal of a dependency once the guardianship is entered, and c) authorizing the creation and implementation of a guardianship subsidy program.

HB 2735: DEPENDENCY MATTERS/YOUTH REPRESENTATION (*Effective June 6, 2010*)

OFCO frequently encounters and intervenes in situations where youth have not been informed about their right to request legal counsel. In 2007, we conducted a youth outreach project spoke with youth residing in group homes across the state. Almost 40 percent of these youth reported that they had not been provided with adequate information about their case or their rights. Many youth said they had not been included in case decisions regarding their lives. In OFCO's Group Home Report¹⁵² we recommended to agency officials and policymakers to "...empower youth by engaging them in decision making regarding changes in their case plans and placement... and by ensuring that dependent youth have an attorney or CASA/GAL and know how to contact them."

HB 2735 takes important steps to engage and empower dependent youth in decision-making about their lives by providing them with critical information about their legal rights. HB 2735 requires DSHS, a supervising agency, and the GAL to notify children who are 12 or older about their right to request an attorney and to inquire at least annually (or upon filing of a motion or petition affecting the youth) whether these youth would like to request an attorney. It also requires the Administrative Office of the Courts to issue a report with recommendations for voluntary training and caseload size for attorneys representing children in dependency proceedings.

¹⁵¹ The Ombudsman's written testimony is available at <http://www.governor.wa.gov/ofco/legislation/default.asp>.

¹⁵² Available at: <http://www.governor.wa.gov/ofco/reports/default.asp>

SHB 3124: REPORTING DUI WITH CHILD IN VEHICLE *(Effective June 6, 2010)*

Through our investigation of citizen complaints and our review of child fatalities and near-fatalities, OFCO has noted inconsistent practice around the state regarding law enforcement reports to CPS when an adult is arrested for a DUI and a child is in the vehicle.

For example, in one case, a two year old child is now paralyzed from an accident caused by her mother's drinking and driving. Two months prior to this accident, the mother had been arrested for DUI and reckless endangerment, with a .217 BAC level. Her two children, a newborn and the two year old, were in the car. Law enforcement did not report this to CPS. Agency documentation indicates that the mother had been in court just days prior to the accident which caused the two year old child's paralysis for violating court orders not to drink and drive.

Identifying the need for a directive that law enforcement notifies CPS whenever a driver is arrested for DUI and a child is present in the car, OFCO brought this concern forward during the 2010 legislative session. SHB 3124 provides a clear guideline to law enforcement officers to make a report to CPS whenever a child under the age of 13 is present in a vehicle with a person being arrested for probable cause of a drug or alcohol related driving offense. SHB 3124 does not require law enforcement to take the child into protective custody if a responsible adult or agency is available.

LEGISLATION INTRODUCED BUT NOT ENACTED

HB 2959/SB 6612: Child Fatality Reviews in Child Welfare Cases

SB 6416: Concerning Relatives in Dependency Proceedings

SB 6417: Concerning the Placement of Children with Relatives

SB 6730: Concerning Child Welfare

IV. APPENDIX

APPENDIX A:

Complaints Received by Region 2000-2010

APPENDIX B:

Adverse Findings of the Ombudsman, By Region
and Issue

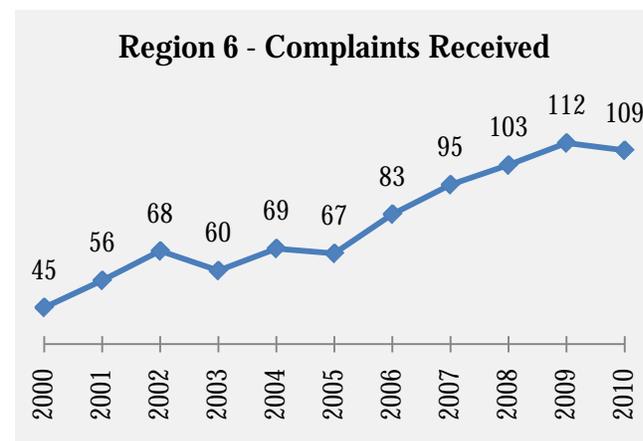
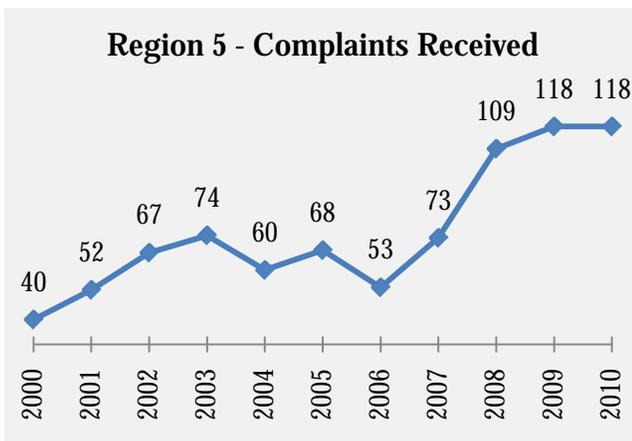
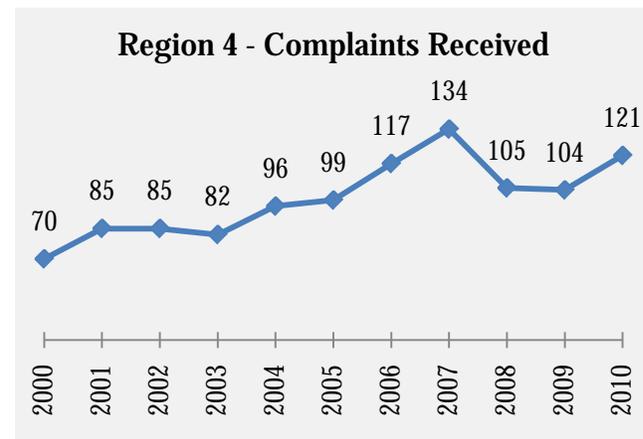
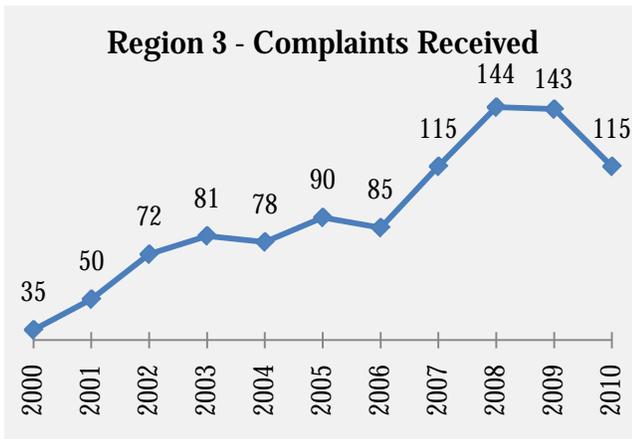
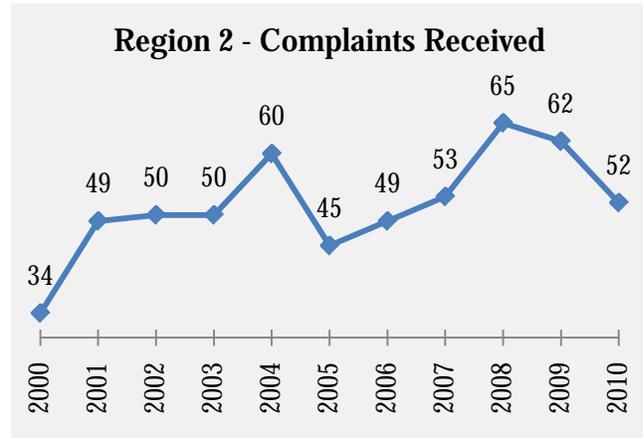
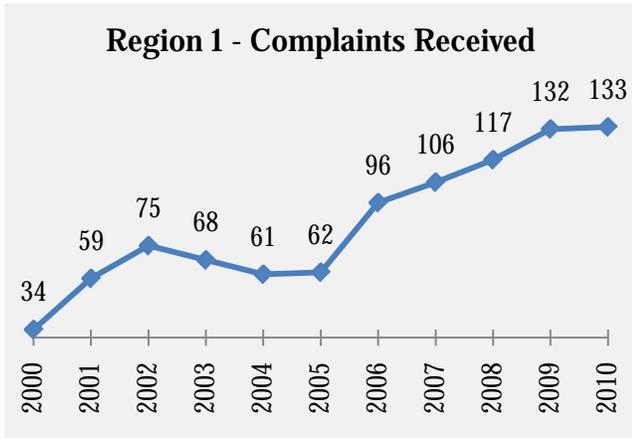
APPENDIX C:

Data Gathered From Child Fatalities and Near
Fatalities Examined By OFCO

APPENDIX D:

Safe Sleep Postcard

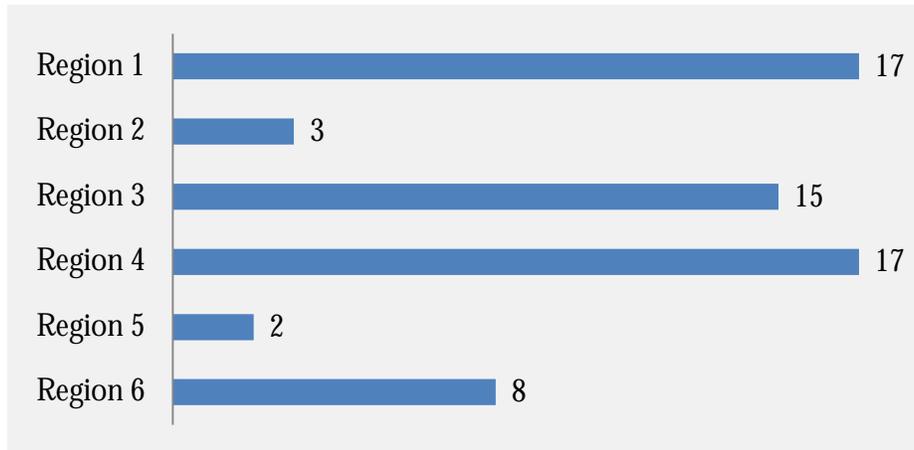
APPENDIX A: COMPLAINTS RECEIVED BY REGION 2000-2010



Source: Office of the Family and Children's Ombudsman, September 2010

APPENDIX B: ADVERSE FINDINGS OF THE OMBUDSMAN, BY REGION AND ISSUE

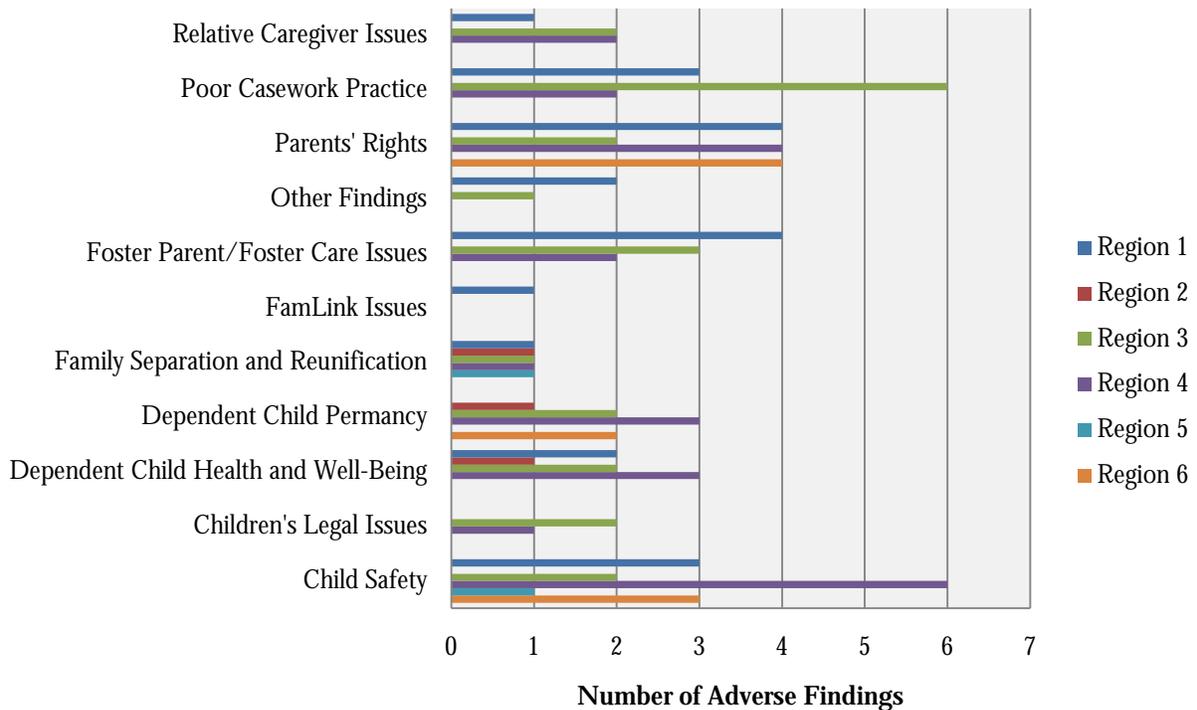
TOTAL COMPLAINTS WITH ADVERSE FINDINGS BY REGION



Source: Office of the Family and Children's Ombudsman, October 2010

ADVERSE FINDINGS, BY ISSUE & REGION

The following table highlights findings across regions by issue category. Meaningful conclusions cannot be drawn from such small numbers; nevertheless, regions may find it helpful to know where their trouble spots were in complaints that were substantiated by OFCO.

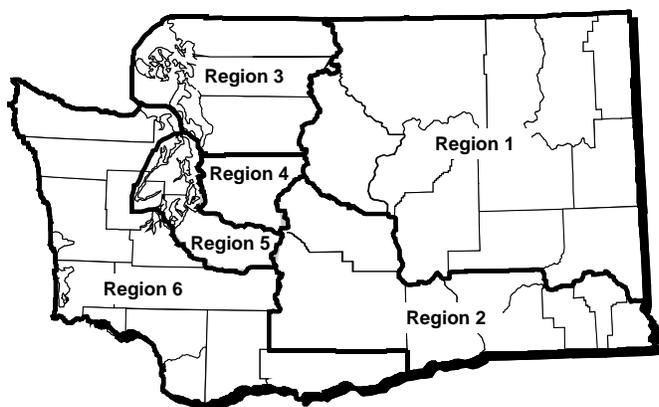


Source: Office of the Family and Children's Ombudsman, October 2010

APPENDIX C: DATA GATHERED FROM CHILD FATALITIES AND NEAR FATALITIES EXAMINED BY OFCO

FATALITIES BY DSHS REGION

There are six DSHS CA regions. The Regional Office and number of children served are provided for context.



Regional Offices:	Children served by CA Region ¹⁵³ :
Region 1 – Spokane	14,739
Region 2 – Yakima	11,331
Region 3 – Everett	16,006
Region 4 – Seattle	18,724
Region 5 – Tacoma	15,189
Region 6 – Vancouver	18,073

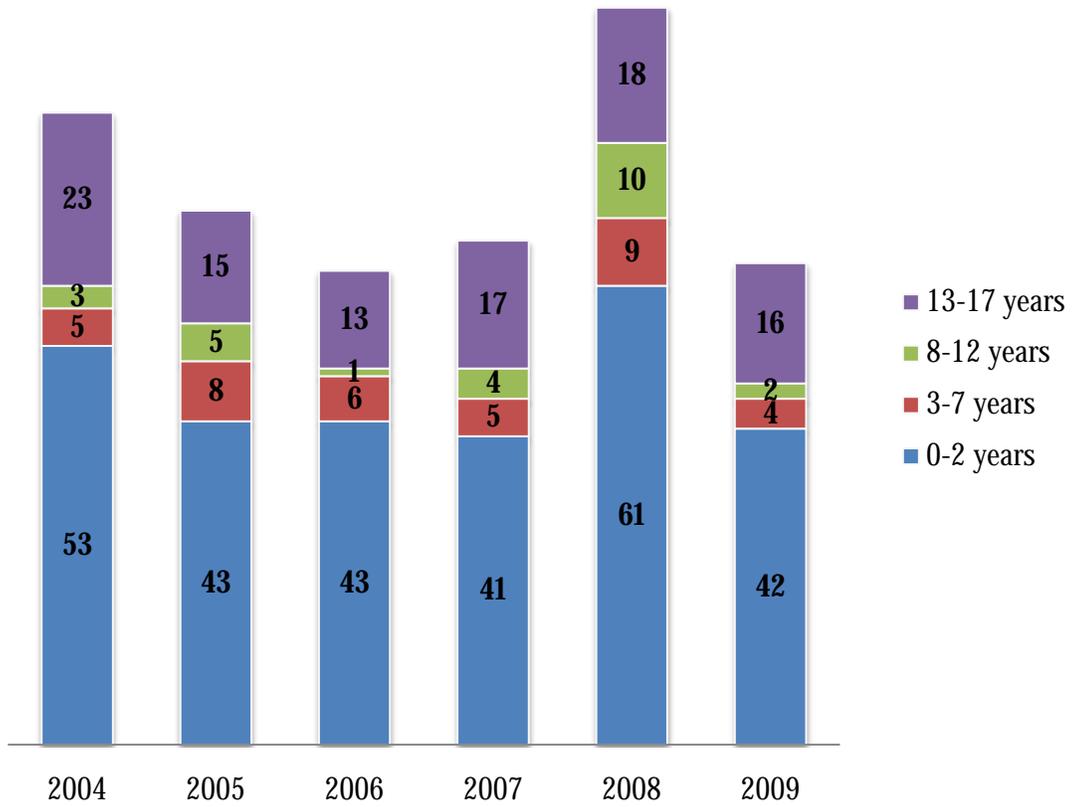
OFCO CHILD FATALITY REVIEWS BY REGION

	2004	2005	2006	2007	2008	2009
Region 1	17	9	9	3	9	13
Region 2	7	10	7	10	15	2
Region 3	14	13	9	16	17	15
Region 4	13	16	13	9	15	17
Region 5	22	7	15	18	23	11
Region 6	14	16	10	11	19	6
Total	87	71	63	67	98	64

Source: Office of the Family and Children's Ombudsman, November 2010, based on analysis of DSHS CA data

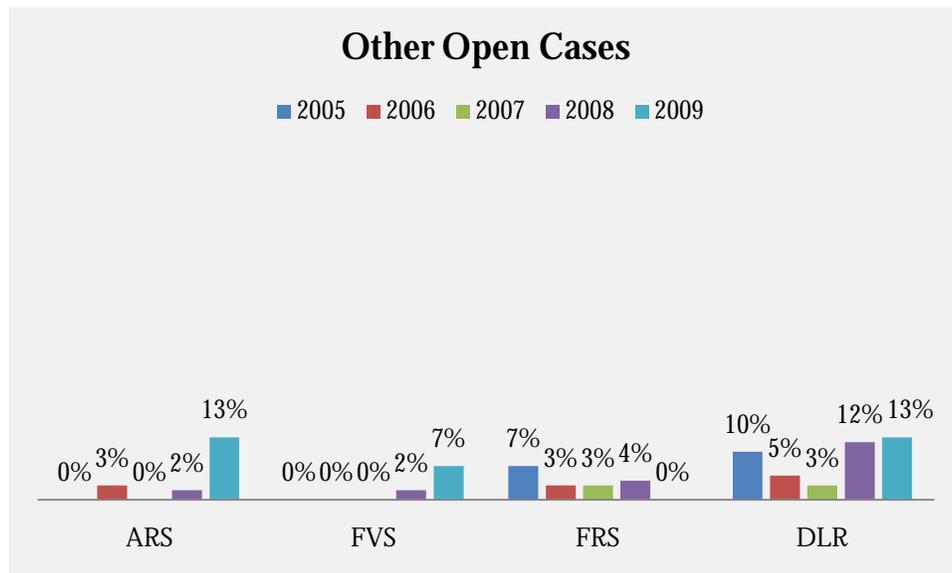
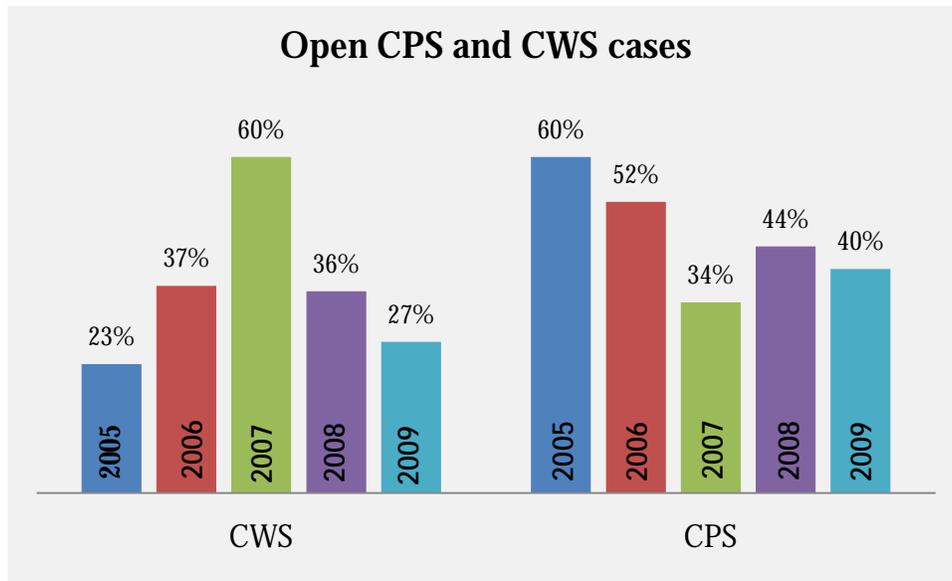
¹⁵³ 2007 data. <http://clientdata.rda.dshs.wa.gov/>

AGE OF CHILD AT THE TIME OF DEATH, 2004-2009



Source: Office of the Family and Children's Ombudsman, November 2010, based on analysis of DSHS CA data

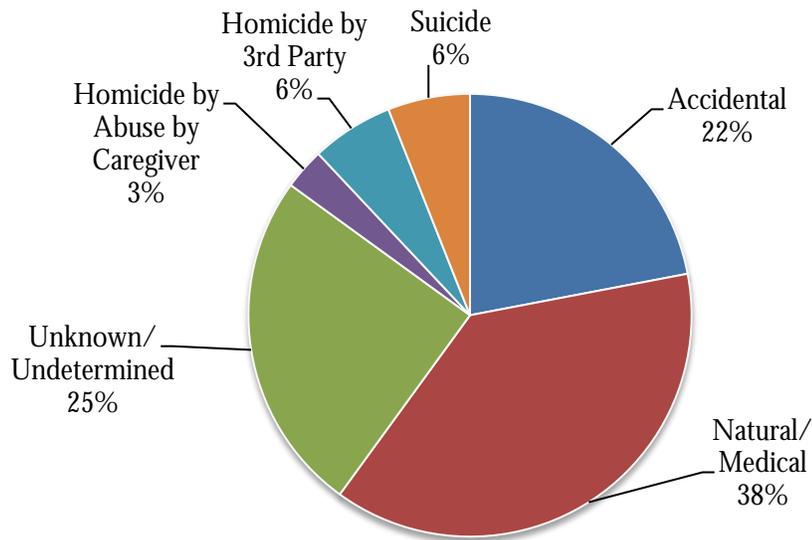
TYPE OF OPEN DCFS CA CASE AT TIME OF DEATH



Source: Office of the Family and Children's Ombudsman, October 2010, based on analysis of DSHS CA data

MANNER OF DEATH¹⁵⁴

The manner and cause of death is determined by a medical examiner or coroner. The manner of death describes the context or circumstances of the death and is assigned to one of five primary categories. These include: 1) unknown/undetermined, 2) natural/medical, 3) accidental, 4) homicide and 5) suicide. Cause of death details how the death occurred. For example, the manner of death is determined as natural/medical when the cause of death is pneumonia, or the manner of death is determined as accidental when the cause of death is a drug overdose. Based on the scene investigation, a death caused by drug overdose could also be determined to have the manner of death as suicide, or unknown/undetermined if it is unclear. The graph below shows the breakdown by manner of death of the fatalities in 2009.



Source: Office of the Family and Children's Ombudsman, October 2010, based on analysis of DSHS CA data

¹⁵⁴ American Family Physician, February 15, 2005 Volume 71 Issue 4 <http://www.aafp.org/afp/2005/0215/p652.html>

CASE EXAMPLES

The following are case examples of child fatalities related to clear physical abuse, clear neglect, or child abuse and/or neglect concerns.¹⁵⁵

Clear Physical Abuse-Related Fatality

- Ø A two year old not dependent child died from head trauma inflicted by the mother's boyfriend. The child's mother was not in the home at the time the fatal injuries occurred and the mother's boyfriend was arrested for physically abusing the child.¹⁵⁶ The boyfriend had CPS history regarding his own children. The mother had an open Alternative Response System (ARS) case and was involved with CA-contracted Early Family Support Services (EFSS). ARS services are designed to serve families with a low risk of child maltreatment in the least intrusive manner likely to achieve improved family cohesiveness, prevention of re-referrals of the family for alleged abuse or neglect, and improvement in the health and safety of the children. EFSS had two face-to-face visits with the mother and her children in the month prior to the child's death. Because ARS services do not investigate allegations of child abuse or neglect, the mother's boyfriend was not investigated for prior CPS or criminal history.

Clear Neglect-Related Fatalities

- Ø A two year old not dependent child died at home. The child had a bruise on his forehead and had been vomiting and feverish prior to death. The child reportedly fell off a bicycle and hit his head while in the care of an unlicensed child care provider and became ill two days prior to death. The child's mother did not seek medical care for the child even though the child's caregiver told the mother to take the child to the doctor three times and the child displayed behavior indicating that he was in severe pain. The Medical Examiner determined that the manner of death was undetermined and the cause to be acute peritonitis (inflammation of the peritoneum, often accompanied by pain and tenderness in the abdomen, vomiting, constipation, and moderate fever.) After investigation, CPS determined that allegations against the parents for not seeking medical attention for the child were founded. The CPS case was closed at the time of death.¹⁵⁷
- Ø A medically fragile one year old child drowned in an infant bathtub at home. The child was tube-fed and delayed in both physical growth and brain development. While bathing the child, the mother reportedly left the room for about five minutes. The Medical Examiner ruled the death to be an accident. The CPS investigation concluded that the allegations of neglect by the parents were founded. There was no open case with DCFS at time of death, but the home was licensed to provide in-home child care through Department of Early Learning.

¹⁵⁵ Children's Administration posts summaries and any recommendations on their website of all fatalities that they review. <http://www.dshs.wa.gov/ca/pubs/fatalityreports.asp>

¹⁵⁶ This fatality was reviewed by an Executive Child Fatality Review Team. The full review is available on the Children Administration's website at: <http://www.dshs.wa.gov/pdf/ca/pottsOrlando.pdf>

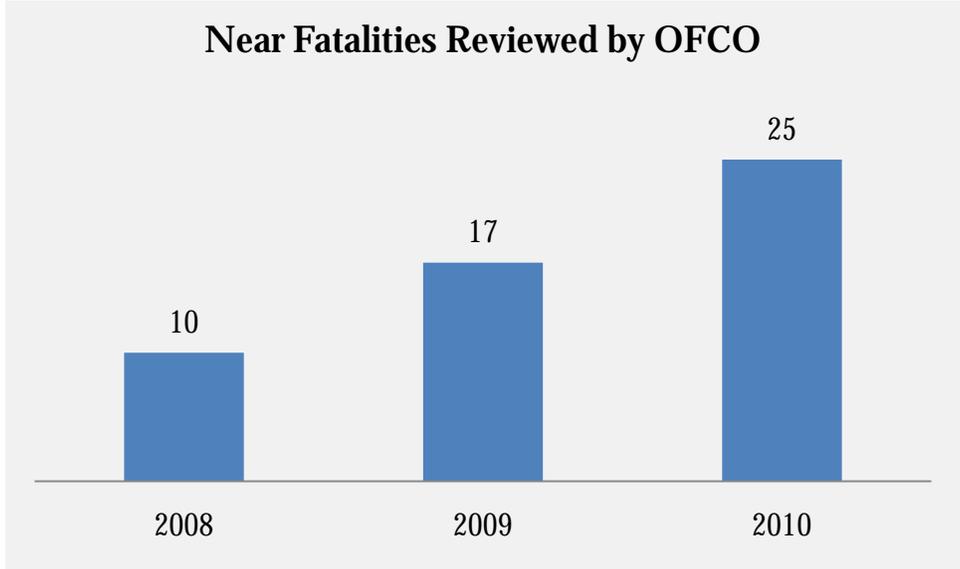
¹⁵⁷ This fatality was reviewed by an Executive Child Fatality Review Team. The full review is available on the Children Administration's website at: <http://www.dshs.wa.gov/pdf/ca/REFinal.pdf>

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Child Abuse/Neglect Concerns

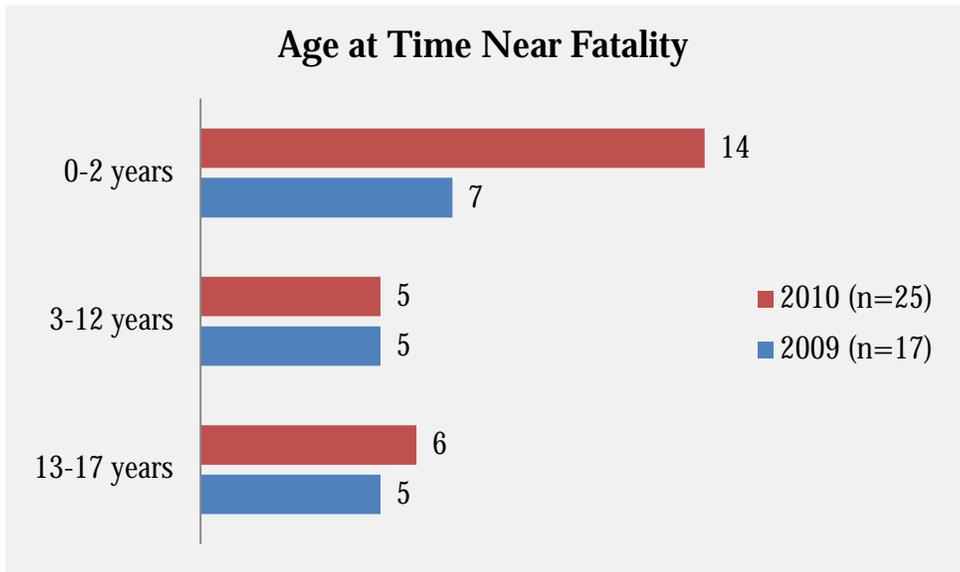
- Ø An eight month old infant was placed on a twin bed to sleep and was found face down on the floor. There was a plastic trash can liner near the infant with a candy substance on the liner that matched a substance found on the deceased infant's face. The Medical Examiner found unexplained injuries on the infant's head and around the eyes. The cause of these injuries could not be determined and the Medical Examiner concluded the manner of death to be unknown/undetermined, and the cause of death to be hypoxic encephalopathy (brain damage due to lack of oxygen). CPS closed its investigation as unfounded for abuse of neglect because there was insufficient evidence.

Near Fatalities Reviewed by OFCO



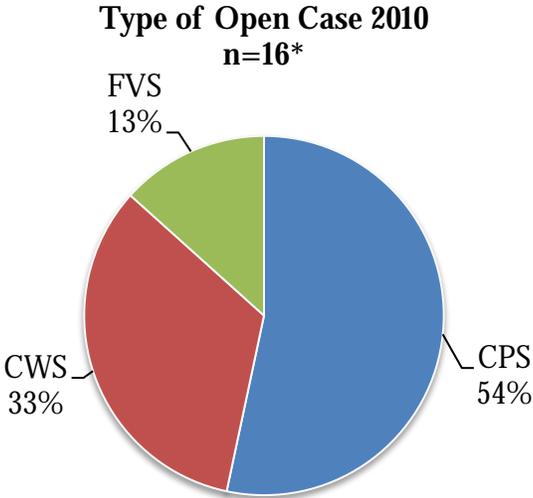
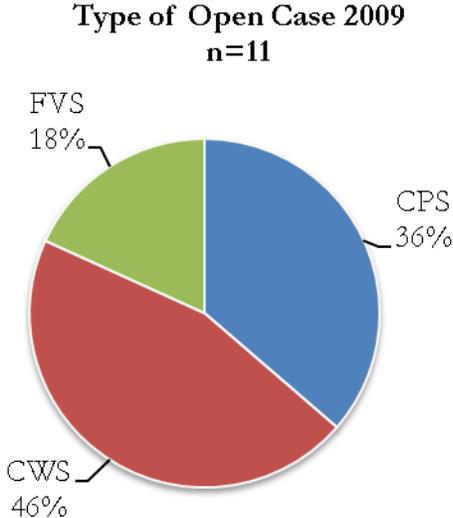
Source: Office of the Family and Children's Ombudsman, November 2010, based on analysis of DSHS CA data

Age at Time Near Fatality



Source: Office of the Family and Children's Ombudsman, November 2010, based on analysis of DSHS CA data

NEAR FATALITY DSHS CA CASE INVOLVEMENT



*One near fatality happened in a licensed DEL facility. This is not included in the DCFS total.
Source: Office of the Family and Children’s Ombudsman, November 2010, based on analysis of DSHS CA data

APPENDIX D: SAFE SLEEP POSTCARD

FRONT

Keep your baby safe while they sleep

Reduce the risk of Sudden Infant Death Syndrome (SIDS)

While snuggling or feeding your baby in your bed is safe and fun babies need their own - safe - sleep space when YOU are sleeping. NEVER let them sleep in adult beds, or on a couch or armchair.

I need my own crib or bassinet

Keep blankets, toys, or clothes away from my face

No bumper pads

Keep me smoke free, no smoking before or while holding me

NO SMOKING

I need a firm mattress and fitted sheet

Put me on my back in the center

Tuck my blanket in no higher than my waist or use a sleep sack

Babies sleep safest in light clothing at 65° -70° degrees and when using a pacifier

BACK

Safe sleep is important to us.

..... This card offers some safe sleeping tips we hope you will consider.

Safe Kids King County South is committed to helping all babies in our region sleep safe and sound. For more information about **Safe Kids** or **Safe Sleep** please visit these websites or call the phone numbers listed below:

- **Northwest Infant Survival and SIDS Alliance**
www.nisa-sids.org or 206-548-9290
- **National Institute for Child Health and Human Development**
www.nichd.nih.gov/SIDS or 1-800-505-CRIB
- **Safe Kids King County South**
www.safekidskingcountysouth.org or 253-372-7729

Center for Childhood Safety

Supporting families at preventing child death

