STATE OF WASHINGTON
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To the Residents of Washington State:

I am pleased to submit the 2014 Annual Report of the Office of the Family and Children's Ombuds. This report provides an account of OFCO's activities from September 1, 2013 to August 31, 2014. OFCO thanks the parents, youth, relatives, foster parents, professionals and others who brought their concerns to our attention. We take their trust in our office most seriously.

During this reporting period, OFCO experienced a sharp increase in the number of complaints received and completed 669 complaint investigations regarding 1,051 children and 635 families. More than one out of every nine complaints was handled as an "emergent investigation" as the allegations involved either a child's immediate safety or an urgent situation requiring timely intervention. As in past years, the separation and reunification of families and the safety of children living at home or in substitute care were by far the most frequently identified issues in complaints. In addition to complaint investigations, OFCO monitors practices and procedures within the child welfare system and makes recommendations to better serve children and families. Systemic issues and recommendations discussed in this report include continued efforts to improve the adoption process and protect children, the implementation status of Child Fatality Review recommendations, and preventable infant fatalities related to unsafe sleep environments.

After serving as Director since 2002 and as an ombudsman since OFCO's inception in 1997, Mary Meinig retired as of November 30, 2014. This report, along with the many other Annual Reports and special reports issued under Ms. Meinig's leadership, reflects her passionate and tireless work to protect and serve the children and families involved with the child welfare system. Ms. Meinig states: "I want to express my appreciation to Governor Inslee who has made protecting children from abuse and neglect, a priority of *Results Washington*[1], as well as to the Legislature, the Department of Social and Health Services, private agencies and advocates who are committed to excellence in child welfare outcomes. I am proud of OFCO's work on behalf of individual children and families and its efforts to facilitate broad-based systemic improvements to keep children safe and strengthen families."

Sincerely,

Patrick Dowd, JD
Acting Director Ombuds

[1] See, http://results.wa.gov/

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The OFFICE OF THE FAMILY AND CHILDREN'S OMBUDS (OFCO) was established by the 1996 Legislature to ensure that government agencies respond appropriately to children in need of state protection, children residing in state care, and children and families under state supervision due to allegations or findings of child abuse or neglect. The office also 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, 2013, through August 31, 2014; OFCO's administrative reviews of child fatality cases (January through December, 2013); and administrative review of near fatalities (January through October, 2014). This report also provides recommendations to improve the quality of state services for children and families.

CORE DUTIES

The following duties and responsibilities of the Ombuds are set forth in state laws:[2]

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

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

System Oversight and Improvement:

- Monitor the procedures as established, implemented, and practiced by the department to carry out its responsibilities in delivering family and children's services to preserve families when appropriate and ensure children's health and safety;
- Review periodically the facilities and procedures of state institutions serving children, and state-licensed facilities or residences;
- Recommend changes in law, policy and practice to improve state services for families and children; and
- Review notifications from DSHS regarding a third founded report of child abuse or neglect, within a twelve month period, involving the same child or family.

Annual Reports:

- Submit an annual report to the Legislative Children's Oversight committee and to the governor analyzing the work of the office including recommendations; and

[2] RCW 43.06A and RCW 26.44.030.

- Issue an annual report to the legislature on the status of the implementation of child fatality review recommendations.

INQUIRIES AND COMPLAINT INVESTIGATIONS

OFCO received 1,349 contacts from families and citizens seeking assistance or information about the child welfare system in 2014. Approximately 53 percent of these contacts were formal complaints requesting an investigation. Between September 1, 2013 and August 31, 2014, OFCO completed 669 complaint investigations regarding 1,051 children and 635 families. As in previous years, the separation and reunification of families and the safety of children living at home or in substitute care were by far the most frequently identified issues in complaints. More than one out of every nine complaints met OFCO's criteria for an emergent investigation as they involved issues of imminent child safety or well-being.

OMBUDS IN ACTION

The annual report describes four main categories of Ombuds action known as "interventions." These include inducing the agency to take corrective action; facilitating resolution of a complaint or an error identified by OFCO; and assisting the agency in avoiding errors, conducting better practice, and preventing future mistakes.

Thirty-nine complaints required intervention by OFCO. In an additional 30 complaints, OFCO provided substantial assistance to resolve the complaint issue. The vast majority of complaints in which OFCO intervened or assisted resulted in the complaint issue being resolved.

In 2014, OFCO made 36 formal adverse findings against the CA. OFCO provides Children's Administration (CA) with written notice of adverse findings resulting from 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 process provides transparency of OFCO's work as well as accountability for DSHS.[3]

REVIEW OF CRITICAL INCIDENTS

The Ombuds conducts administrative reviews of cases of recurrent child maltreatment as well as of all fatalities both involving child abuse or neglect and cases unrelated to child maltreatment, and near fatalities of children whose family had an open case with DSHS within a year prior to the child's death. During this reporting period OFCO conducted 224 administrative reviews of critical incident cases – 61 child fatalities, 17 near fatalities and 146 notifications of recurrent maltreatment. Through these reviews, OFCO identifies common factors and systemic issues regarding these critical incidents. Key points discussed in this section of the annual report include:

- The vast majority of child fatalities related to maltreatment involved children under the age of three years. Unsafe sleep practices continue to be a leading factor associated with infant deaths. The state-wide workgroup (in which OFCO participated) established by CA in June 2013 to improve safety outcomes for this vulnerable group of children has concluded its work, resulting in **significant policy changes regarding casework practice with families who**

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

have an infant. As of November, 2014, caseworkers must assess infants' sleep environment and ensure that families have critical information regarding infant care.

- Neglect continues to constitute the largest number of the founded reports and is more likely to recur than physical or sexual abuse.
- Caregiver substance abuse remains the most prevalent risk factor in cases of recurrent maltreatment.

WORKING TO MAKE A DIFFERENCE

Ongoing Efforts to Improve the Adoption System

OFCO's 2011 Annual Report discussed cases of severe abuse of adopted children. In response, OFCO and CA established a committee to examine this issue in greater detail and make recommendations to improve the adoption process. The committee's report and recommendations were published in September 2012. In February 2014, the Washington State Auditor's Office published its report on *"The Experiences and Perspectives of Washington Families who Adopted Children from Foster Care,"* calling for enhanced post-adoption services for families. OFCO's 2014 Annual Report describes how many of the recommendations made in the 2012 committee report have been implemented in recently proposed changes to regulations governing the adoption process.

Child Welfare Legislation

As part of the Ombuds' duty to recommend system improvements, OFCO reviews and analyzes proposed legislation and testifies before the Legislature on pending bills. This section provides a highlight of those bills for which OFCO provided testimony or those which impact the child welfare system, including bills to improve the adoption process, provide attorney representation for children in dependency proceedings, and extend foster care for youth after age 18.

SYSTEM IMPROVEMENT EFFORTS

Implementation of Child Fatality Review Recommendations

Children's Administration (CA) conducts a child fatality review when the death of a child was suspected to be caused by child abuse or neglect, and the child was in the care of, or receiving services from, the department at the time of death, or in the past year. The purpose of these reviews is to increase the agency's understanding of the circumstances around the child's death and to evaluate practice, programs and systems and make recommendations to improve the health and safety of children. OFCO is required to issue an annual report to the Legislature on the implementation of these recommendations.

This past year, OFCO reviewed the status of 120 recommendations resulting from 32 child fatality reviews conducted between January 2012 and April 2014. OFCO found that 68 percent of the recommendations were either completely implemented or in the process of implementation, while 25 percent were considered, but not implemented. Topic areas identified by these recommendations are: increase training; improve caseworker practices; and strengthen community partnerships. Many of the training recommendations address: child safety; domestic violence; chemical dependency; and mental health issues.

TERMS AND ACRONYMS

AAG	Assistant Attorney General
AIRS	Administrative Incident Reporting System
ARS	Alternative Response System
ARY	At Risk Youth
BRS	Behavioral Rehabilitation Services
CA	Children's Administration
CA/N	Child Abuse and Neglect
CASA	Court Appointed Special Advocate
CDR	Child Death Review
CFR	Child Fatality Review
CHINS	Child in Need of Services
CNFR	Child Near-Fatality Review
CPS	Child Protective Services
CPT	Child Protection Team
CFWS or CWS	Child and Family Welfare Services or Child Welfare Services
DBHR	Division of Behavioral Health and Recovery
DCFS	Division of Child and Family Services
DDD	Division of Developmental Disabilities
DEL	Department of Early Learning
Dependent Child	A child for whom the state is acting as the legal parent
DOH	Department of Health
DLR	Division of Licensed Resources
DSHS	Department of Social and Health Services
ECFR	Executive Child Fatality Review
ECNFR	Executive Child Near-Fatality Review
EFSS	Early Family Support Services
FamLink	CA's Statewide Automated Child Welfare Information System (computerized record-keeping system)
FAR	Family Assessment Response
FRS	Family Reconciliation Services
FVS	Family Voluntary Services
GAL	Guardian Ad Litem
ICPC	Interstate Compact for the Placement of Children
OFCO	Office of the Family and Children's Ombuds
SDM	Structured Decision Making
VSA	Voluntary Service Agreement

I. THE ROLE OF OFCO

"Things wouldn't have moved this quickly and we wouldn't be here if OFCO hadn't stepped in."

~ Foster Adopt Parent, on establishing permanency

THE ROLE OF OFCO

The Washington State Legislature created the Office of the Family and Children's Ombuds[4] (OFCO) in 1996, in response to two high profile incidents that indicated a need for oversight of the child welfare system.[5] OFCO provides citizens an avenue to obtain an independent and impartial review of Department of Social and Health Services (DSHS) decisions. OFCO is also empowered to intervene to induce DSHS to change problematic decisions that are in violation of the law or that have placed a child or family at risk of harm, and to recommend system-wide improvements to the Legislature and the Governor.

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

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

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

- **Credible review process.** OFCO has a credible review process that promotes respect and confidence in OFCO's oversight of DSHS. Ombuds are qualified to analyze issues and conduct investigations into matters of law, administration, and policy. OFCO's staff has a wealth of collective experience and expertise in child welfare law, social work, mediation, and clinical practice and is trained in the United States Ombudsman Association Governmental Ombudsman Standards. In 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.[6]

AUTHORITY

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

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

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

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

including mental health professionals, guardians ad litem, and assistant attorneys general.[7] OFCO operates under a shield law which allows OFCO to protect the confidentiality of OFCO's investigative records and the identities of individuals who contact the office. This encourages individuals to come forward with information and concerns without fear of possible retaliation. Additional duties have been assigned to OFCO by the Legislature in recent years regarding the reporting and review of child fatalities, near fatalities, and recurrent maltreatment.[8]

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

WORK ACTIVITIES

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

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

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

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

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

[7] See also RCW 13.50.100(6).
[8] See RCW 74.13.640(1) (b); 74.13.640(2); and 26.44.030(13).

II. LISTENING TO FAMILIES AND CITIZENS

- Inquiries and Complaints
- Complaint Profiles
- Complaint Issues

"If nothing else, the children's voices have been heard more than they were before, because OFCO has been involved."

~ Foster Parent

INQUIRIES AND COMPLAINTS

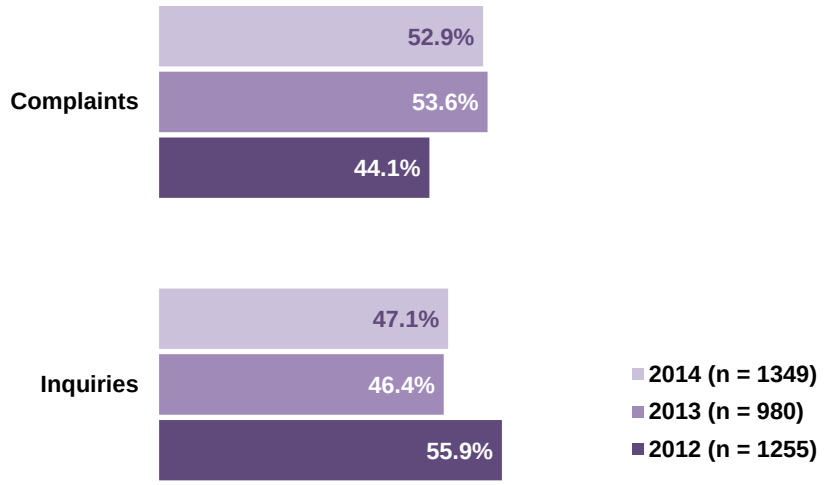
The Ombuds listens to families and citizens who **contact** the office with questions or concerns about services provided through the child protection and child welfare system. By listening carefully, the Ombuds is able to respond effectively to their **inquiries** and **complaints**.

This section describes contacts made by families and citizens during OFCO's 2014 reporting year — September 1, 2013 to August 31, 2014. Data from previous reporting years is included for comparison.

CONTACTS TO OFCO

Families and citizens contacted OFCO **1,349** times in 2014. Of these contacts, over 47 percent were **inquiries** made by people seeking information while nearly 53 percent were formal **complaints** seeking an investigation by an Ombuds. As Figure 1 shows, complaints encompass a majority of contacts to OFCO.

Figure 1: **Contacts to OFCO**
By Reporting Year (September 1st - August 31st)



CONTACTS. When families and citizens contact OFCO, the contact is documented as either an **inquiry** or **complaint**.

INQUIRIES. Persons call or write to OFCO 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. OFCO responds directly to these inquiries, some of which require additional research. OFCO staff refers other questions to the appropriate agency.

COMPLAINTS. Persons file a complaint with OFCO 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. OFCO reviews every complaint that is within its jurisdiction.

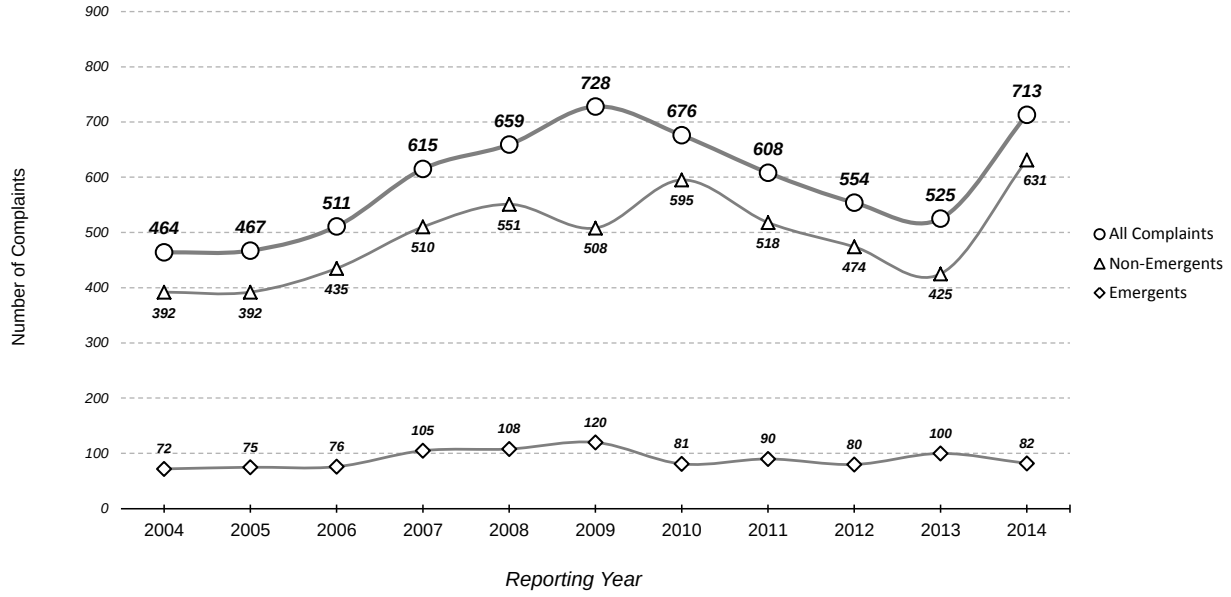
COMPLAINTS RECEIVED

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

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

OFCO received 713 complaints in 2014. Of these, **82 complaints** (**11.5 percent) were emergent.** Emergent complaints most often involve immediate child safety concerns or situations in which timely intervention by OFCO could make a significant difference to a child or family's immediate well-being. Complaints that raised the safety of children as a concern (including safety concerns that OFCO did not see as imminent) numbered 191. The two most common issues identified in complaints involved family separation and reunification; and the safety of children living at home or in substitute care.

Figure 2: **Complaints Received**
By Reporting Year (September 1st - August 31st)



As Figure 2 shows, complaints filed with OFCO decreased steadily between 2009 and 2013, but **increased sharply from 525 in 2013, to 713 in 2014.** A noticeable increase in complaints occurred when OFCO released its **online version** of its complaint form, allowing citizens to complete the form and submit it electronically, on March 25, 2014. Previously, although complainants were able to print the form from OFCO's website, they still had to submit the completed form via mail or fax. The increase in complaints may therefore be explained in part by this improved access to our services. However, the increase in complaints also reflects greater demands placed on the state child welfare system. This year CA experienced an increase in reports to CPS of child abuse or neglect, as well as the number of reports screened in for an investigation. The number of children placed in foster care and with relatives, has also increased, including youth requiring intensive treatment and support programs.[9]

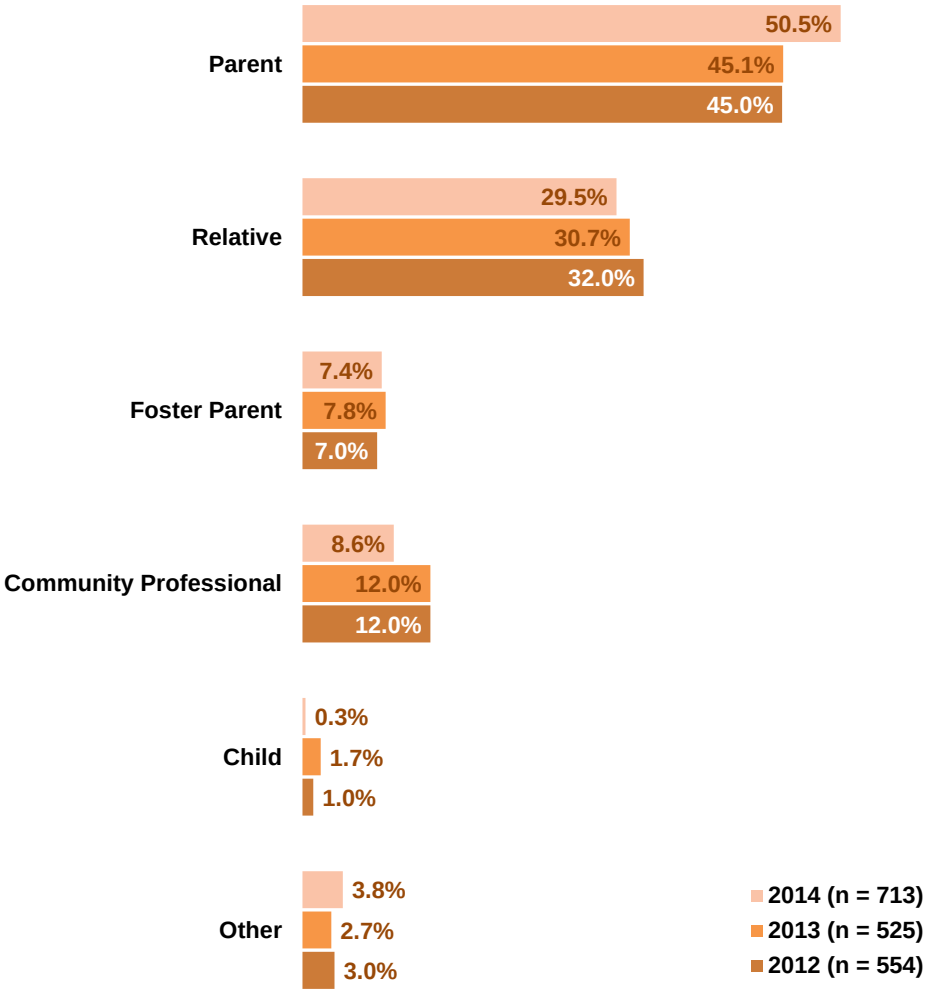
[9] According to data provided by CA, the total number of screened in CPS referrals in 2014 increased by 15% from 2012, and the number of children in out-of-home care increased by 11%.

COMPLAINT PROFILES

PERSONS WHO COMPLAINED

Parents, grandparents, and other relatives of the child whose family is involved with DSHS continued to file the vast majority of the complaints with OFCO. As in previous years, few children contacted OFCO on their own behalf.

Figure 3: **Complainant Relationship to Children**
By Reporting Year (September 1st - August 31st) [10]

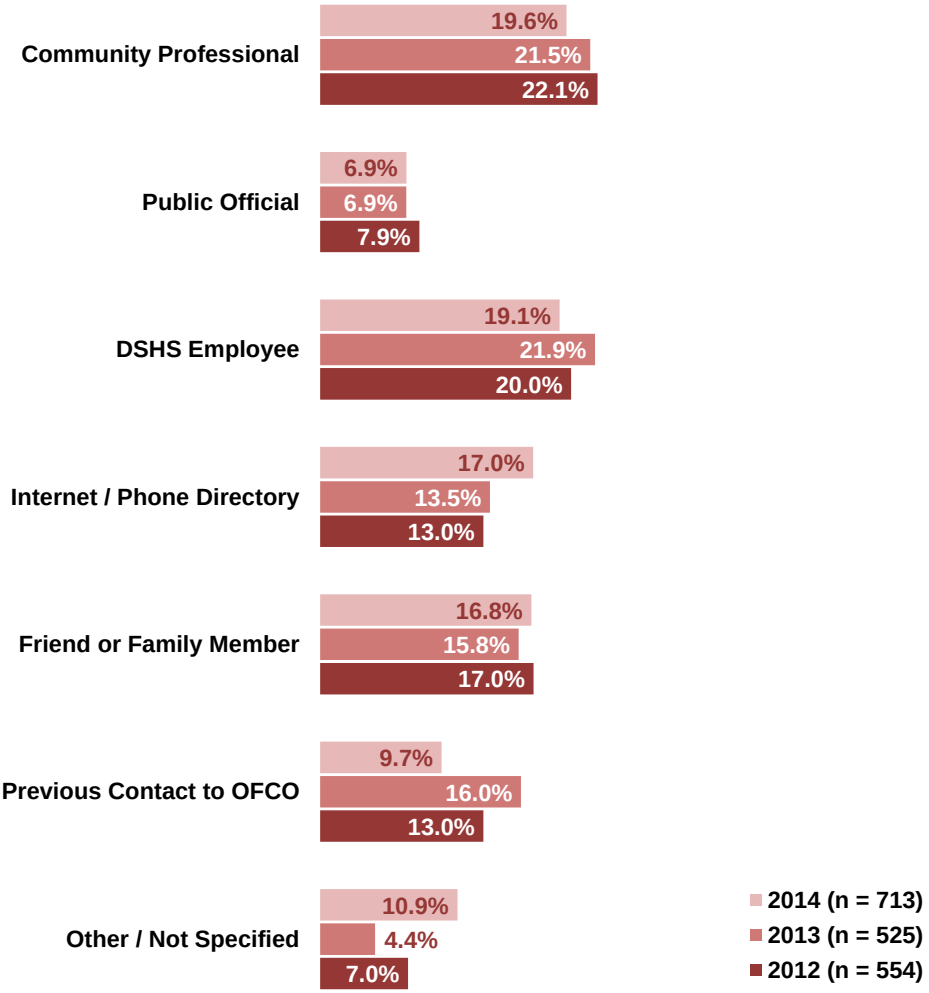


[10] Based on complaints that were received in the reporting year

How Complainants Heard About OFCO

The majority of individuals filing complaints with OFCO indicated that someone else referred them to the office. **Community professionals** (e.g. teachers, counselors, child care providers, doctors, private agency social workers, mental health professionals, attorneys, CASA/GALs) referred nearly one in five complainants to OFCO. Another one in five complainants is referred by a **DSHS employee** (19.1 percent). Complainants have consistently found OFCO through either an **internet search or a phone directory** (17.0 percent); or have been referred by **family or friends** (16.8 percent). A smaller proportion of complainants knew of OFCO from a **previous contact** (9.7 percent). The remaining complainants (11.0 percent) did not specify how they heard about OFCO. The figure below shows how each category has changed in recent years.

Figure 4: **How Complainants Heard about OFCO**
By Reporting Year (September 1st - August 31st)



RACE AND ETHNICITY OF COMPLAINANTS

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

Table 1: **Race and Ethnicity of Complainants**

By Reporting Year (September 1st - August 31st)

	OFCO Complainants*		Comparison Population
	2013	2014	WA State**
Caucasian	74.2%	78.1%	78.7%
African American	8.8%	8.0%	3.5%
American Indian or Alaska Native	4.6%	6.0%	1.4%
Asian or Pacific Islander	1.0%	1.5%	7.8%
Other	1.7%	0.6%	4.0%
Multiracial	4.8%	1.8%	4.6%
Declined to Answer	5.0%	3.9%	-
Latino / Hispanic	8.6%	5.3%	11.2%
Non-Hispanic	91.4%	94.7%	88.8%

* Based on complaints *received (as opposed to closed)* in the reporting year

** U.S. Census Bureau, 2008-2012 American Community Survey 5-Year Estimates

RACE AND ETHNICITY OF CHILDREN IDENTIFIED IN COMPLAINTS

The table below shows the race and ethnicity (as reported by the complainant) of the 1,107 children identified in the 713 complaints received, compared with children in placement through CA and in the general state population.

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

By Reporting Year (September 1st - August 31st)

	Children in OFCO Complaints*		Comparison Populations	
	2013	2014	DCFS Placement**	WA State Children***
Caucasian	66.5%	67.5%	62.6%	71.2%
African American	10.1%	8.1%	8.4%	4.0%
American Indian or Alaska Native	10.8%	9.8%	12.7%	1.7%
Asian or Pacific Islander	0.5%	2.3%	1.6%	7.2%
Other	2.6%	4.2%	0.3%	6.3%
Multiracial	7.9%	7.5%	14.1%	9.6%
Decline to Answer	1.6%	0.6%	0.4%	-
Latino / Hispanic	12.8%	7.6%	16.9%	18.8%
Non-Hispanic	87.2%	92.4%	83.1%	81.2%

* Based on complaints *received (as opposed to closed)* in the reporting year

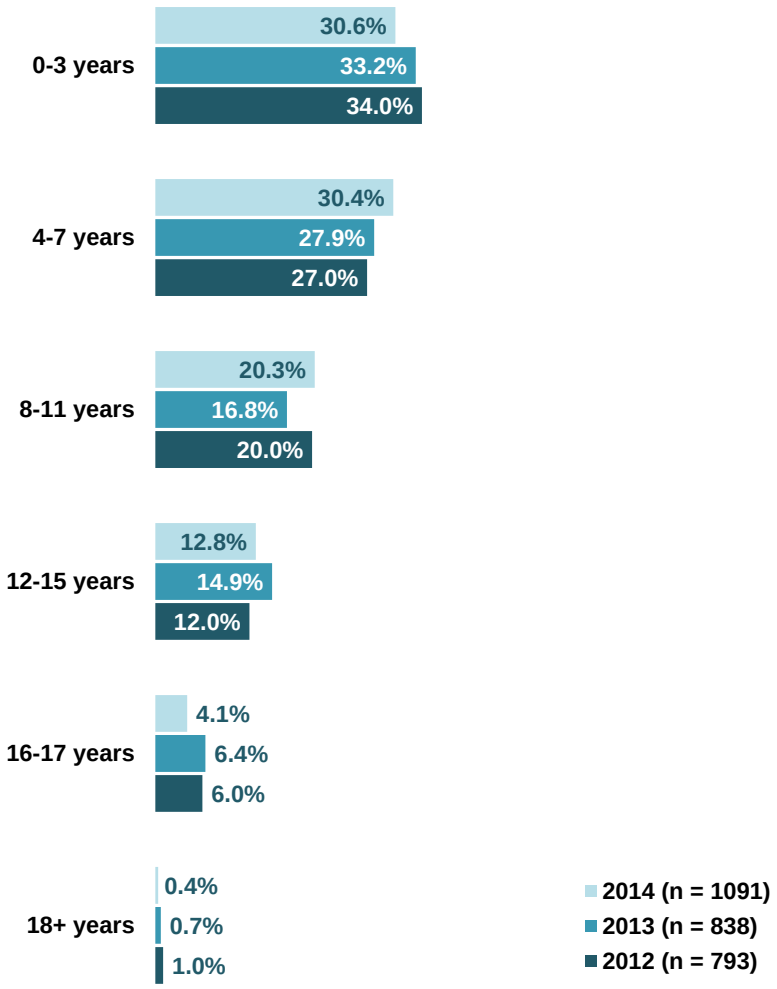
** Data reported by Partners for Our Children (partnersforourchildren.org) 2012

*** U.S. Census Bureau, 2008-2012 American Community Survey 5-Year Estimates

AGE OF CHILDREN IDENTIFIED IN COMPLAINTS

As in previous years, almost two-thirds (61 percent) of the children identified in complaints to OFCO were seven years of age or younger. Conversely, older adolescents continue to be identified in much smaller numbers in the last three years.

Figure 5: **Age of Children in Complaints** [11]
By Reporting Year (September 1st - August 31st) [12]



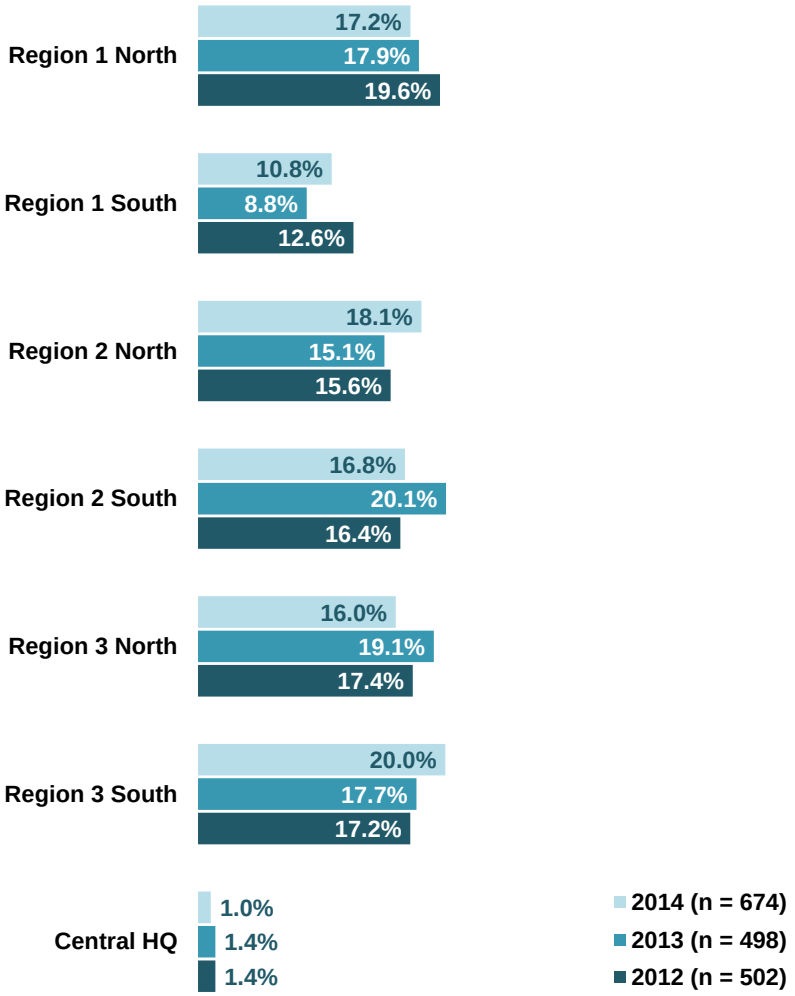
[11] Age information was not collected for 20 children in 2013 and 16 children in 2014; children identified in more than one complaint may be counted more than once

[12] Based on complaints that were received in the reporting year

COMPLAINTS BY DSHS REGION

During the 2014 reporting year, 28 percent of complaints were directed at DSHS Region 1, 34.9 percent at Region 2, and 36.1 percent at Region 3, with the remaining one percent being directed at CA Headquarters. The distribution of complaints concerning individual offices within each region is provided in Appendix A.

Figure 6: **OFCO Complaints by DSHS Region** [13]
By Reporting Year (September 1st - August 31st) [14]



[13] Regional information is not included where complaints involved non-CA agencies (27 complaints in 2013 and 39 in 2014)
[14] Based on complaints that were received in the reporting year

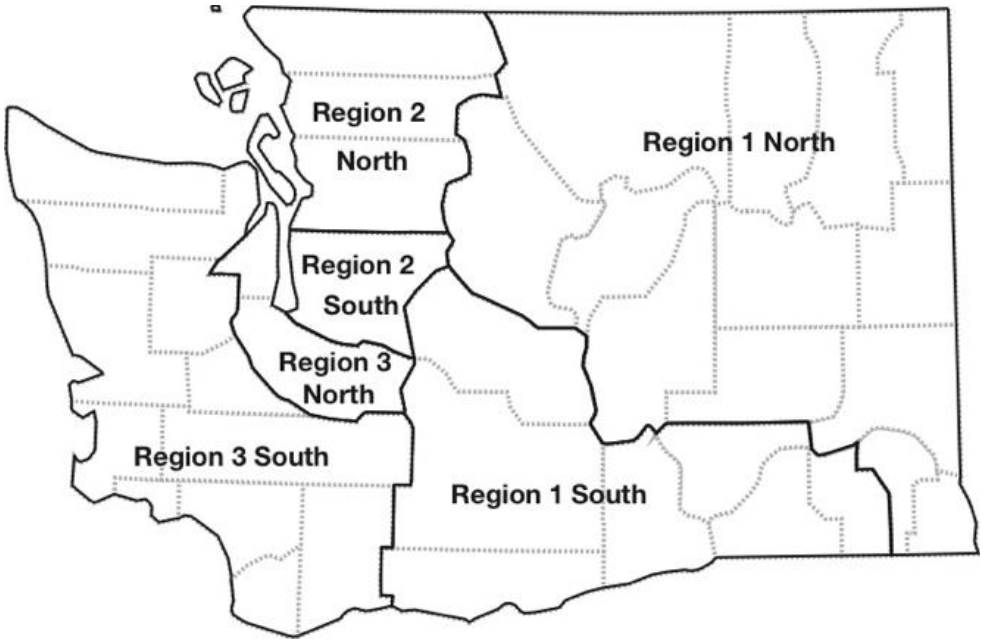


Table 3: **Comparison Populations by DSHS Region**

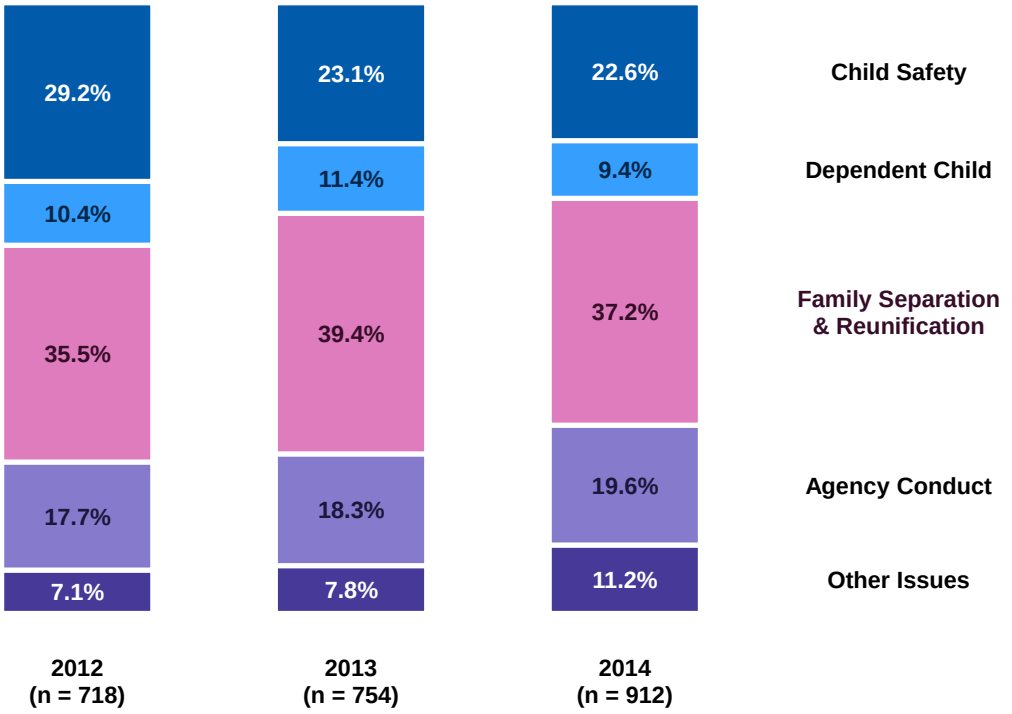
	Population*	CA Clients Served**
Region 1 North (Spokane)	874,391	29,174
Region 1 South (Yakima)	620,663	22,799
Region 2 North (Everett)	1,125,651	34,037
Region 2 South (Seattle)	1,931,249	39,281
Region 3 North (Tacoma)	1,046,358	31,930
Region 3 South (Vancouver)	1,126,228	37,238

* Office of Financial Management (ofm.wa.gov/pop/), 2010
** Children's Administration (www.dshs.wa.gov/ca/), 2010

COMPLAINT ISSUES

As in previous years, issues involving the **separation and reunification of families** (raised **339** times in complaints) and the **safety of children living at home or in substitute care** (raised **206** times in complaints), were by far the most frequently identified issues in complaints to OFCO. Complaint issues involving both **child safety** and **family separation increased** from last year**.**

Figure 7: **Categories of Issues Identified by Complainants**
By Reporting Year (September 1st - August 31st) [15]



The table on the following page shows the number of times various specific issues within these categories were identified in complaints.[16]

[15] Based on complaints that were closed within the reporting year

[16] Many complainants raise multiple complex issues, however only the primary complaint issues are documented in OFCO's complaint tracking database, and reported in the "Issues Identified by Complainants" 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).

Table 4: **Issues Identified by Complainants**

By Reporting Year (September 1st - August 31st) [17]

	2012	2013	2014
Child Safety	**210**	**174**	**206**
Failure to protect children from parental abuse or neglect	118	91	122
- *Physical abuse*	*38*	*22*	*35*
- *Sexual abuse*	*25*	*17*	*23*
- *Emotional abuse*	*5*	*6*	*4*
- *Neglect / lack of supervision*	*49*	*43*	*56*
- *Other child safety issue*	*2*	*5*	*4*
Failure to address safety concerns involving children in foster care or other non-institutional care	51	44	41
Failure to address safety concerns involving child being returned to parental care	27	18	29
Child safety during visits with parent	5	10	10
Children with no parent willing / capable of providing care	7	6	2
Failure by agency to conduct 30-day health and safety visits to child in out-of-home care	1	1	2
Developmentally disabled child in need of protection	1	0	0
Safety of children in institutions / facilities (non-childcare)	2	3	0
Safety of children in childcare facilities (Department of Early Learning)	1	0	0

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

[17] Based on complaints that were closed within the reporting year

Table 4 (cont.): **Issues Identified by Complainants**

By Reporting Year (September 1st - August 31st)

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

	2012	2013	2014
Complaints about Agency Conduct	**127**	**138**	**179**
Communication failures	43	43	44
Unwarranted / unreasonable CPS investigation [16]	19	24	38
Unprofessional conduct, harassment, retaliation, conflict of interest or bias / discrimination by agency staff	4	23	29
Unreasonable CPS findings	28	21	28
Breach of confidentiality by agency	15	14	21
Inaccurate agency records	15	7	9
Heavy-handedness, unreasonable demands on family by agency staff	1	3	3
Failure to close CPS investigation in a timely manner	-	-	3
Poor case management, high caseworker turnover, other poor service issues	2	1	2
Lack of coordination between DSHS Divisions	0	2	2

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

[18] Includes inadequate CPS investigation and delay in completing CPS investigation

Family separation and reunification continues to be the most common category of complaint issues (totaling 339 in 2014). Within this category, the two most common issues are: the unnecessary removal of a child from a parent, and the failure to place a child with a relative. Other common issues include failure to provide parent-child contact, and failure to reunite the family. However, complaints about family reunification have decreased over the past three years. OFCO has not received a significant number of complaints regarding siblings being placed in separate placements or lack of sibling contact.

OFCO investigated 206 complaints involving **child safety.** Over half of these investigations focused on concerns about the *safety of non-dependent children reported for maltreatment in their parents' care.* Approximately twenty percent of the child safety complaints concerned the wellbeing of dependent children in foster or relative care. Additionally, child safety issues during parent-child visits and concerns involving a child returning home are other frequent complaint issues.

Nearly half of the complaints about **agency conduct** alleged unwarranted CPS investigations, unreasonable CPS findings of child maltreatment, or the failure to close a CPS investigation in a timely manner. This includes CPS investigations of child abuse or neglect by a parent as well as investigations of licensed foster parents. The second most common complaint about agency conduct involves *communication failures by agency staff*.

Complaints regarding the **health, well-being, and permanency** of dependent children reflect a steady decrease in issues related to *unnecessary or inappropriate change of placement*. In contrast, complaints regarding the *failure to provide a child with services* have increased each of the past three years.

Other complaint issues frequently raised in complaints include agency *failure to provide parents with services.* Such complaints often involve alleged delays in either referring a parent to a required service or actually beginning those services. Similarly, complainants often identified *lack of support and/or services to foster parents* or *relative caregivers.* Concerns about services and support for parents, foster parents, or relative caregivers comprised well over half of the complaint issues in this category. Other notable issues include: children's legal issues; violations of ICWA; and foster care licensing issues. Few complaints alleged retaliation by the department against a foster parent or relative caregiver.

III. TAKING ACTION ON BEHALF OF VULNERABLE CHILDREN AND FAMILIES

INVESTIGATING COMPLAINTS

- Completed Investigations and Results
- OFCO in Action
- OFCO's Adverse Findings
- Agency Responses to Adverse Findings

"This is exactly why we have an Ombudsman."

~ DCFS manager, in response to a call from OFCO to alert the agency to a casework error which jeopardized a child's safety

INVESTIGATING COMPLAINTS

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

OFCO acts as an impartial fact finder and not as an advocate, 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 OFCO'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.

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

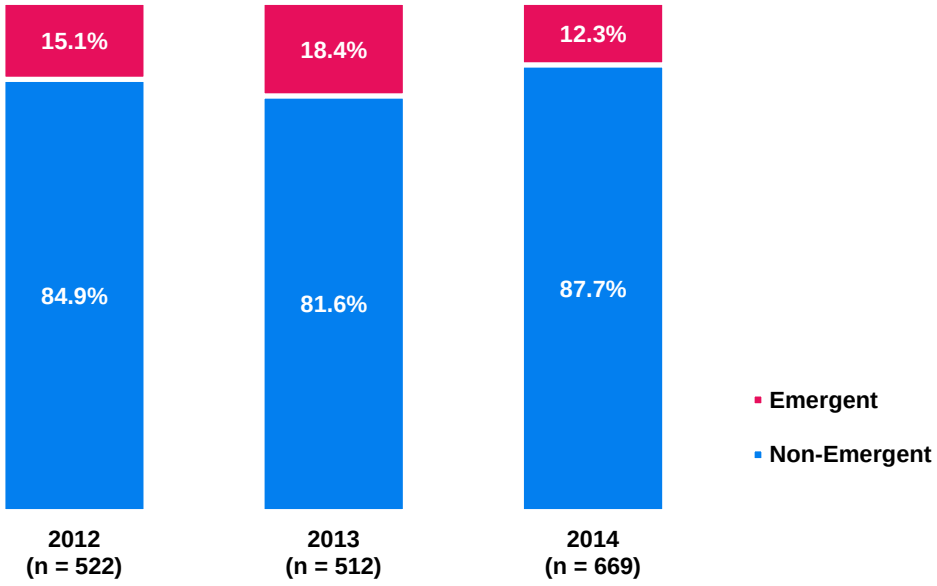
- Where OFCO finds that the agency is properly carrying out its duties with regard to the complaint issue, the Ombuds explains to complainants why the alleged conduct is not a violation of law or policy or clearly unreasonable under the circumstances and helps complainants better understand the role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

COMPLETED INVESTIGATIONS AND RESULTS

COMPLETED INVESTIGATIONS

OFCO completed **669 complaint investigations** in 2014. These investigations involved **1,051 children and more than 635 families**. As in previous years, the majority of these investigations were **standard non-emergent investigations** (87.7 percent). More than one out of every nine investigations (12.3 percent) met OFCO's criteria for initiating an **emergent investigation,** i.e. when the allegations in the complaint involve either a child's immediate safety or an urgent situation where timely intervention by OFCO could significantly alleviate a child or family's distress. Once a call or complaint form is determined to be emergent, OFCO begins the investigation immediately. Over the years, OFCO has substantiated or intervened in emergent complaints at a higher rate than non-emergent complaints. In 2014, **OFCO intervened or provided assistance to resolve concerns in 18.1 percent of emergent complaints**, compared with **9.2 percent of non-emergent complaints**.

Figure 8: **Investigations Closed by Complaint Type**
By Reporting Year (September 1st - August 31st) [20]



[20] Based on complaints that were completed during the reporting year

INVESTIGATION RESULTS

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

- **Intervention:** OFCO 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.

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

- **Monitor:** The complaint issue may or may not have been substantiated, but OFCO monitored the case for a significant period of time to ensure the issue was resolved. While monitoring, the Ombuds may have had repeated contact with the complainant, the agency, or both, and may have offered suggestions or informal recommendations to agency staff to facilitate a resolution.

- **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 Ombuds may have offered suggestions, referred complainants to community resources, made informal recommendations to agency staff, or provided other helpful information to the complainant.

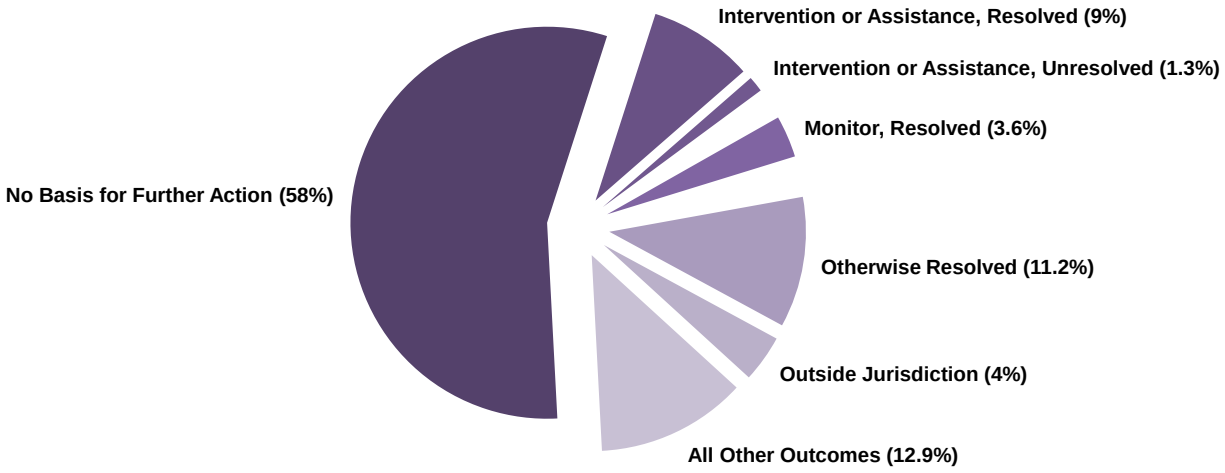
- **No Basis for Intervention:** The complaint was substantiated and OFCO made a finding that the agency violated law or policy or acted unreasonably, but there was no opportunity for OFCO to intervene, usually because the violation occurred in the past. Or, the complaint issue was unsubstantiated, and OFCO found no agency errors in reviewing the case. OFCO 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.

- **Outside Jurisdiction:** The complaint was found to involve agencies or actions that were outside of OFCO's jurisdiction. When possible, OFCO referred complainants to an appropriate office or agency that may be able to assist them with their concern.

- **Other:** The complaint was withdrawn, became moot, or further investigation or action by OFCO was unfeasible for other reasons.

Investigation results have remained fairly consistent in recent years. OFCO **assisted or intervened** to try to resolve the situation in **more than 10 percent of complaints** in 2014—this represents **sixty-nine complaints**. OFCO found **no basis for further action in 58 percent** of complaints this year, fewer than it did in 2013 (64 percent) and far fewer than in 2012 (67 percent).

Figure 9: **OFCO Investigations Outcomes**
By Reporting Year (September 1st - August 31st)



OFCO IN ACTION

OFCO takes action when necessary to avert or correct a harmful oversight or avoidable mistake by the DSHS Children's Administration or another agency. **Thirty-nine complaints required intervention by OFCO in 2014.** This represents 5.8 percent of all complaints, a decrease from 2013, when OFCO intervened in 8.4 percent of complaints.

TYPES OF INTERVENTION BY OFCO

The following tables provide examples of four types of typical interventions by OFCO:

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 **prevent future mistakes.**

Each example summarizes the investigative finding, the action taken by OFCO to address the problem, and the outcome.

OFCO IN ACTION: INDUCING CORRECTIVE ACTION

KEY ISSUE	INVESTIGATIVE FINDING	OFCO ACTION	OUTCOME
Plan to move child from foster-adopt home to out-of-state kin	CFWS planned to place an 18-month-old dependent child with "fictive kin" who reside out-of-state. The child had been in the same foster home since birth, and the foster parent wanted to adopt the child if parental rights were terminated. The foster parents had been facilitating ongoing visits between the child and an older sibling, as well as with relatives residing in Washington State.	OFCO requested a review of the pending placement decision by the Area Administrator (AA), and also contacted CA Headquarters to discuss the potential adverse impact of moving this child to a non-relative across the country. CFWS ultimately determined that it was in the child's best interest to be adopted by the foster parents, and changed the case plan.	Legal parties to the dependency case did not agree on this permanent plan and following a contested court hearing, the court ordered that the child be placed with the "fictive kin" out-of-state.

KEY ISSUE	INVESTIGATIVE FINDING	OFCO ACTION	OUTCOME
Failure to respond to a request for an administrative review of a founded finding for neglect	CPS failed to respond to a parent's request for an administrative review of a founded finding for neglect. Almost a year had passed since the request had been submitted.	OFCO contacted the AA to determine whether the finding had been reviewed, and if so, why the subject of the investigation had not been informed of the result. The AA discovered that no review had occurred. Upon reviewing the case, the AA in consultation with the Assistant Attorney General determined that there was insufficient evidence to support the founded finding.	CPS overturned the founded finding and promptly notified the parent.
Failure to notify a Native American tribe in a timely manner of a CPS investigation involving a tribal family	CPS failed to promptly notify a tribe that CPS was investigating an allegation of physical abuse of an especially vulnerable Native American child. The investigation had been open for 10 days. State law and policy requires "immediate" notification to a child's tribe regarding a CPS investigation.	OFCO contacted the caseworker to request that the tribe be promptly informed.	The CPS caseworker immediately called the tribe and followed up with a letter.

KEY ISSUE	INVESTIGATIVE FINDING	OFCO ACTION	OUTCOME
Failure to consider out-of-state relative for placement	CFWS failed to assess an out-of-state relative for placement of a three-year-old dependent child. DCFS contacted this relative shortly after the child entered care, and the relative expressed interest in being considered for permanent placement, if the child was unable to be returned home. The relative subsequently contacted the assigned caseworker on several occasions to express her continued interest in placement, but received no clear response. Although CFWS later filed for termination of parental rights, the relative was not contacted nor referred for an adoptive home study.	OFCO contacted the CFWS supervisor and requested that the relative be considered for placement.	The supervisor submitted a request for a home study through the ICPC process, approximately one month later. Ultimately, relative placement was not needed as the child was returned to the parent.

OFCO IN ACTION: FACILITATING RESOLUTION

KEY ISSUE	INVESTIGATIVE FINDING	OFCO ACTION	OUTCOME
Refusal to make exception to licensing rules when a regulation conflicted with a doctor's orders for a foster child's medical care	DLR denied a foster parent's request to waive the licensing requirement that all medications be locked away in foster homes. A foster child in the home was experiencing severe seizures, and the doctor had asked the foster parent to keep the child's emergency seizure medication available for immediate administration at the onset of a seizure. The foster parent wanted to carry the medication on her person at all times to avoid any unnecessary prolonging of the child's seizures.	OFCO contacted the DLR Director to express concern about the potential harm to the child. DLR responded that approving such a waiver could result in losing federal funding for the placement. OFCO requested that DLR consult directly with the child's medical providers to fully understand the impact on the child if the medication was delayed.	After consulting with the child's medical providers, DLR approved the waiver to allow the foster parent to carry the child's medication on her person at all times.
Delay in permanency	CFWS failed to finalize a permanent plan of adoption by the foster parents for a dependent child, for more than 18 months after filing a petition to terminate parental rights. Numerous factors contributed to this delay including: several court continuances; ongoing reunification services for the family including an unsuccessful trial return home; reconsideration of a previous relative caregiver; and the relative's failure to complete requirements for a home study in a timely manner.	OFCO contacted the AA to request a review of the case, including whether the unreasonable delay in completing a home study on the relative was creating an avoidable delay in achieving permanency for this child.	The AA and supervisor gave the relative firm timelines for completing home study requirements, which the relative did not meet. Soon after, the parent unexpectedly relinquished parental rights, allowing for adoption of the child by the foster parents.

KEY ISSUE	INVESTIGATIVE FINDING	OFCO ACTION	OUTCOME
Failure to approve attendance at summer camps for a legally free youth	CFWS unreasonably withheld approval for a legally free youth to attend summer camps, which had been requested several months prior. The foster parents had paid for the camps and were not seeking reimbursement from CFWS. The youth's caseworker had informed that approval to attend the camps was conditional upon the youth participating in a visit with a sibling. DCFS filed a motion asking the court for conditional approval or denial of the requested camps based on compliance with the sibling visit and other factors, such as the activities being offered by that camp. Furthermore, the caseworker had informed the foster parents that CFWS could deny permission for the youth to attend camp even if the court approved it.	OFCO contacted the Area Administrator to express concern that the conditions for approving the youth's attendance of summer camps appeared to be arbitrary and capricious, and denied the youth's participation in normal childhood experiences. OFCO also expressed concern about the worker's incorrect communication to the foster parent about the agency's ability to violate a court order.	DCFS allowed the youth to attend both camps, after entering into an agreed court order. CFWS also acknowledged that it could not violate a court order.
Delay in permanency	CFWS withdrew a petition for termination of parental rights, when a parent began participating in services after 15 months of not engaging with the agency or visiting her two children, ages 7 and 6. The children had been in out-of-home care for almost three years, and in the same foster-adopt home for 18 months. After the agency renewed reunification efforts, the children expressed fear of the parent and a strong desire to be adopted in their long term foster home. The children's GAL was not active on the case due to an extraordinarily high workload, and by the fact that the children were placed in a distant region of the state.	OFCO contacted the Area Administrator to request that the agency pursue the appointment of an attorney to represent the children's stated interests, given their strongly expressed wishes and the GAL's inactivity in the case.	DCFS filed a motion to request that attorneys be appointed for the children, but the court denied the motion based on the children's age. The court further opined that the GAL was adequately representing both the children's best interests, as well as their stated interests, to the court.

KEY ISSUE	INVESTIGATIVE FINDING	OFCO ACTION	OUTCOME
Child safety	CPS failed to screen in for investigation a report of neglect of a four-year-old non-dependent child. This report alleged ongoing domestic violence, including a recent incident that occurred with the child present and significant substance abuse by both parents. There was a current open CPS case with the family based on similar allegations, and the parents were not engaging in services to address the concerns.	OFCO contacted the CPS intake supervisor to request a review of the screening decision.	The new referral was screened in for investigation. Based on new information gathered during this investigation, CPS filed for dependency on the child two weeks later.
Failure to provide visits between dependent siblings	No contact was occurring between two dependent siblings (ages 13 and 11) placed in different placements, even though the children were living in the same city just a few miles from each other.	OFCO contacted the CFWS supervisor and discussed concerns about the lack of sibling contact.	CFWS renewed efforts with the children's caregivers to ensure that the siblings maintained contact both by phone and through visits.

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

KEY ISSUE	INVESTIGATIVE FINDING	OFCO ACTION	OUTCOME
Compliance with the Indian Child Welfare Act (ICWA), and consideration of relative for placement	CFWS declined to consider a relative for placement, because the two-year-old dependent child had remained in the same foster home for 18 months, and assessing the relative would delay permanency. The relative had been contacted early in the case but was living out-of-state and declined temporary placement at that time, but indicated an interest in being contacted should the child need permanent placement in the future. Upon learning from other relatives that the state was pursuing termination of parental rights, the relative moved to Washington state and requested placement. Furthermore, OFCO questioned whether the department had made adequate efforts determine the child's Native American status.	OFCO contacted the CFWS supervisor, Area Administrator and AAG to discuss efforts to determine the child's Native American status, potential impact of the ICWA and to assure objective consideration of potential relative placement.	CFWS referred the relative for an adoption home study, and initiated visits between the child and the relative. The agency contacted relatives and communicated with the Tribe to determine the child's enrollment status and the application of ICWA. The relative's home study was approved, and the child was placed with the relative for adoption.
Child safety and well-being	CPS failed to take appropriate action to protect an 11-year-old non-dependent child from neglect by the parent. The parent had taken the child for emergency medical care several times over the course of a few months and made incredible allegations that the child was being sexually assaulted at school. There was no evidence to support these claims and medical providers reported serious concerns about the parent's mental health. OFCO found that although CPS had an open investigation on the family, the caseworker had not seen the child in over two months even though the agency continued to receive reports that the parent was continuing to subject the child to unnecessary hospital visits.	OFCO requested that CPS make immediate contact with the family to assess the child's safety. CPS visited the home and requested a child welfare check by law enforcement. CPS also gathered further information from emergency room providers, which indicated that the parent's ongoing mental health concerns were causing significant harm to the child.	CPS filed a dependency petition, and the child was removed from the parent's care and placed with a relative.

KEY ISSUE	INVESTIGATIVE FINDING	OFCO ACTION	OUTCOME
Failure to address safety of children in relative placement	CFWS left two dependent siblings, ages 5 and 3, in the care of relatives, and was considering transitioning their older sibling into the home, despite the relatives' lack of cooperation regarding a safety plan for the children. The children's 9-year-old sibling had recently disclosed possible sexual abuse by the relatives' adult son during a sibling visit at the relatives' home. OFCO found that following the older child's disclosure, CFWS developed a safety plan for an upcoming sibling visit at the relatives' home, whereby the relatives reluctantly agreed not to allow their adult son to be present. The relatives had also stated that they did not believe the allegations against their son and did not want the child placed in their home if this would result in restrictions on their son visiting the home.	OFCO contacted the Area Administrator to request a review of the case plan based on OFCO's identified safety concerns.	CFWS held an FTDM and subsequently filed a motion to request a change of placement for the two children in the relative placement. The children moved to a new placement within nine days.

KEY ISSUE	INVESTIGATIVE FINDING	OFCO ACTION	OUTCOME
Placement issues	CFWS planned to move a five-year-old legally free, significantly developmentally delayed child from the long term foster home where she had been living for over three years. The foster parents had expressed ambivalence about adopting the child based on her high needs and their concerns regarding a lack of long term supports. As a result, CFWS began a search for an alternate adoptive home for the child. The foster parents then approached CFWS after receiving additional information regarding resources that would be available for the child into adulthood. CFWS informed them that several alternate adoptive homes had been found and a placement committee would be meeting to choose the best home for the child. The placement committee reviewed several adoptive home studies, including a home study on the current foster parents that was several years old. In part due to outdated information in that home study, the committee selected another adoptive home for the child.	OFCO contacted the Deputy Regional Administrator expressing concerns regarding the agency's plan to move the child given the inaccurate information that had been reviewed by the committee, and requested a review of this decision.	CFWS agreed to reconsider the child's current foster parents and referred them for an updated adoptive home study. Meanwhile, after visiting with the child, the family selected by the committee removed themselves from consideration, and the agency began the adoption process with the current foster parents.

KEY ISSUE	INVESTIGATIVE FINDING	OFCO ACTION	OUTCOME
Child safety	CPS delayed in protecting two non-dependent children, ages 8 and 2, from parental neglect related to severe substance abuse. While the parent was initially cooperative with the investigation, and expressed an interest in services, the parent repeatedly failed to follow through with urinalysis monitoring and a chemical dependency assessment. CPS continued to receive reports of repeated neglect.	OFCO monitored the case and contacted the CPS supervisor and caseworker on several occasions to express concerns regarding the safety of the children and explore alternative courses of action. When CPS planned to close the case after the parent repeatedly failed to engage in services offered by the agency, OFCO requested that CPS convene an FTDM to gather further information to better assess the safety of the children.	CPS held an FTDM, and based on the parent's demeanor at the meeting and suicide threat later that day, CPS went to the home with law enforcement that evening. Safety threats observed in the home resulted in the children being placed in protective custody, and they were later placed with a relative.

OFCO IN ACTION: PREVENTING FUTURE MISTAKES

KEY ISSUE	INVESTIGATIVE FINDING	OFCO ACTION	OUTCOME
Inappropriate provision of legal advice to parents	OFCO received a complaint that a CFWS caseworker had allegedly "explained" to the parents of a dependent child why they should agree to adoption, as opposed to guardianship, as the child's permanency plan. The worker was alleged to have given the parents legal advice and encouraged one parent to "not listen to" the parent's assigned attorney. The worker was also alleged to have asked the parent to reveal information that was discussed during privileged conversations with the attorney.	OFCO contacted the Deputy Regional Administrator to ask that the caseworker, who was new, and other new workers in that CFWS office receive training regarding a) the role of the social worker versus the role of parents' attorney in dependency matters; and b) law and policy regarding attorney/client confidentiality and privilege.	The Deputy Regional Administrator confirmed that training on these topics would be provided to all relatively new workers in that office.
Caseworker conduct	OFCO received a complaint that a CPS caseworker allegedly served family court paperwork to a family for whom the worker was providing CPS services. The family court paperwork involved a custody action that had been filed with the court by a third party regarding the parents' child. OFCO was concerned that if the allegation was true, the worker's action would have created the appearance that the worker was acting in an official CPS capacity in a non-CPS matter.	OFCO contacted the Area Administrator to share these concerns.	The AA informed OFCO that this information had been received by the agency, and the matter was being referred for a personnel investigation. (Note: OFCO is not privy to results of personnel investigations.)

MOST INTERVENTIONS RESULT IN AGENCY CHANGING POSITION

As detailed in the complaint intervention examples summarized above, the **majority of complaints** in which OFCO intervened **resulted in the agency changing its position** and the complaint issue being resolved (71.8 percent).

In **11 complaints** in which OFCO intervened, **the agency did not change its position**. In eight of these cases, although the complaint issue remained unresolved, OFCO determined that the agency's decision not to change its position was ultimately acceptable. For example:

PROHIBITION OF CONTACT BETWEEN LEGALLY FREE CHILD AND BIOLOGICAL PARENT

DCFS was refusing to allow contact between a ten-year-old legally free child and his biological parent, based upon the recommendation of the child's therapist. The parent's rights had been terminated at least three years prior, but permanency had not yet been achieved for this child. He had also experienced severe placement disruption, with about 20 placements since entering out-of-home care. The child was expressing a desire to have contact with the parent. While DCFS's decision was not a violation of law or policy, OFCO believed the department's refusal to allow contact between this child and his biological parent may be unreasonable, based upon the child's multiple placements, lack of permanency, and treatment with psychotropic medications, and his regular requests for visits with his parents and with siblings who had already been adopted. OFCO concluded that the appointment of an attorney for this child may be prudent in order to have his wishes directly advocated for in court.

OFCO contacted the Adoptions Supervisor to request that the agency pursue the appointment of an attorney for the child. The supervisor disagreed, stating that the youth had a guardian ad litem who was actively involved in the case, and that both the GAL and the agency believed that appointment of an attorney for the youth at this juncture in the case may be counterproductive. The supervisor reported that the youth was closer to permanency than he had ever been, and the agency was unwilling to jeopardize his stability. The youth was adopted about nine months later.

While OFCO disagreed with the agency's position, OFCO determined that the agency's decision was not *clearly* unreasonable.

In **three complaints,** the agency **did not change its position** despite OFCO's intervention and OFCO determined that the agency's decision not to change its position was problematic. For example:

AGENCY IMPEDES COMMUNICATION OF YOUTH'S WISHES DIRECTLY TO THE COURT

OFCO found that CFWS had acted clearly unreasonably to prevent a 15-year-old legally free youth from having his wishes expressed directly to the court. The court had ordered the agency to arrange visits between the youth and an older sibling, who resided in a different placement, and the agency had made arrangements for visits to begin. However, the youth had told his foster parents and CASA that he did not wish to have any contact with the older sibling at this time, and visits had not yet begun. At an upcoming court hearing, the youth's CASA intended to present the youth's position opposing the visits, and provide information from the youth's therapist supporting the youth's position. The CASA had informed the department of this plan. Unbeknownst to the CASA, the time of the hearing had been changed from the afternoon to the morning, yet CFWS did not take any action to ensure that the CASA was present for the hearing, and the youth's opposition to the visits was not presented to the court. As a result, the court ordered that monthly visits commence within two weeks of the hearing.

OFCO contacted the Deputy Regional Administrator to express concerns that the youth's voice had not been heard by the court, and requested additionally that the agency seek to have an attorney appointed for the youth. Although both the Deputy RA and the Area Administrator informed OFCO that DCFS would request the appointment of an attorney and would also explore the possibility of bringing the case back to court prior to the scheduled sibling visit so that the youth's wishes could be expressed directly to the court, neither of these actions occurred.

OFCO OFFERS ASSISTANCE TO RESOLVE COMPLAINTS

Complaints receiving "OFCO Assistance" are different from complaints in which OFCO intervenes, as the agency's conduct was *not*: a) a clear violation of law or policy; b) clearly unreasonable; or c) clearly harmful to a parent or child. Even so, the complaint warranted OFCO's assistance in trying to resolve the concerns. In 2014, **30 complaints** were resolved by OFCO in this manner by ensuring that *critical information was obtained and considered* by the agency, by *facilitating timely communication* among the people involved in order to resolve the problem, or by *mediating a compromise*.

EXAMPLE 1: AGENCY PLACES UNREASONABLE DEMANDS ON PARENT

DCFS was not planning to transition a two-year-old dependent child home to a parent, despite the parent's completion of services, with reported good progress. OFCO found that DCFS' demands on the parent may be unreasonable. Specifically, that the parent needed to document sobriety for one year after release from incarceration, and that the parent must live independently rather than in shared housing with a support system, before DCFS would consider a transition plan to return the child home. However, after the court granted the parent's motion for increased and unsupervised visits, and after OFCO contacted the Area Administrator to suggest that the current housing situation may be safer and more protective than an alternative independent housing situation, DCFS changed its position to support an immediate transition plan. OFCO participated in two Family Team Decision Meetings to plan the transition, and monitored the case until the child was returned to the full-time care of the parent.

EXAMPLE 2: POOR CASEWORK PRACTICE: PREVENTABLE PROBLEMS

OFCO received a complaint alleging that DCFS failed to provide appropriate mental health services to a 14-year old dependent child, and that the child's placement with a relative had failed as a result. The complaint reported poor communication by the CFWS caseworker with the relative, who felt blamed for the youth's behavior. OFCO found that there had been some delay in referring the youth for mental health services as well as an evaluation to better identify the youth's service and placement needs, but the delay had not been clearly unreasonable. OFCO found that communication difficulties between the caseworker and the relative probably contributed to the relative's request that the youth be moved, as the relative was feeling unable to protect the other children in the home from the youth's volatile behavior.

OFCO had received a previous complaint regarding similar communication issues between this caseworker and another family. OFCO therefore contacted the CFWS supervisor to bring these issues and concerns to his attention. The supervisor acknowledged some concerns with the caseworker's manner, and transferred the case to a different worker due to the conflict that had developed between the relative caregiver and the agency in this case.

During the course of investigating this complaint, OFCO also became aware of some safety concerns regarding the youth in her foster home, based on information provided by the complainant. OFCO contacted the supervisor as the assigned caseworker was aware of these safety concerns, but had not made a report to CPS intake. The supervisor ensured that a referral was made to Intake, which resulted in a DLR licensing investigation of that foster home. OFCO monitored the case for several weeks, until the youth was moved to a new foster home.

COMPLAINTS RESOLVED AFTER MONITORING BY OFCO

Twenty-four complaints this year required monitoring by OFCO to ensure the agency adequately resolved the complaint issue. Many of the complaints monitored by OFCO involved **child safety concerns**, where OFCO could not determine whether the agency was appropriately addressing the child's safety until after monitoring agency action. Another common theme of complaints OFCO monitored were **concerns about a child's transition**, either between placements, or returning home, as described in the following example:

EXAMPLE 1: OFCO ASSISTS IN CASE INVOLVING PROFESSIONAL DISAGREEMENT

While investigating a complaint that CPS was failing to protect a 15-year-old non-dependent youth from medical neglect by the custodial parent, OFCO found that conflict between CPS and a community professional appeared to interfere with communication regarding the concerns about the youth's care. CPS had received a referral from a medical professional reporting that the youth had been hospitalized with cardiac complications a month prior, and the parent was failing to get the youth to follow-up medical appointments. The child's physician stated that failure to comply with medical treatment could have serious health consequences. Due to child safety concerns and the apparent conflict between CPS and one of the providers, who believed that CPS was not holding the parent accountable for ensuring the youth's uninterrupted treatment, OFCO closely monitored the case. OFCO spoke with the provider, the CPS caseworker and supervisor multiple times to assist in ensuring that everyone had the correct information, and monitored the case throughout its duration to ensure that appropriate action was being taken. The family's situation stabilized during the course of CPS services, and although there were still complications related to the youth's health insurance, the youth received follow-up care and the CPS case was closed.

EXAMPLE 2: INAPPROPRIATE PLACEMENT OF LEGALLY FREE CHILD

A complainant alleged that DCFS Adoptions was failing to provide an appropriate placement and evaluation for a nine-year-old legally free child who was exhibiting sexually aggressive and/or reactive behaviors. The child had just been moved to a new foster home, after his supervision and behavior management became too much for his prospective foster-adopt parents, with whom he and his six-year-old sibling had been placed for over two years. A primary concern of the foster parents was that it was becoming increasingly difficult to ensure the safety of the other children in the home. The foster parents, as well as the child's CASA, were advocating that he receive a comprehensive behavioral/mental health evaluation, ideally in an in-patient setting, or in an out-patient setting while the child was placed in a home with no other children. DCFS however was planning to move both siblings to a pre-adoptive home out-of-state. This pre-adoptive family had an especially vulnerable child of their own, and appeared ill prepared to manage the nine-year-old child's behavior.

OFCO found that an evaluation conducted on the child three years earlier had recommended line-of-sight supervision around other children, as well as ongoing mental health counseling. The evaluator had also recommended referring the child for treatment with a provider specializing in treating sexually reactive behavior if the child's sexualized behaviors did not cease over time. OFCO was concerned that DCFS may be minimizing this child's recent sexual behaviors and the risk he may pose to other children, including his sibling, and contacted the supervisor, and later the Area Administrator, to express these concerns. DCFS responded that the child's current mental health therapist was not recommending a new psychosexual evaluation until the child was settled in his new adoptive placement.

After a shared planning meeting to discuss the children's transition to the out-of-state placement, OFCO learned that the pre-adoptive parents planned to have the child share a bedroom with their developmentally delayed ten-year-old child and monitor the bedroom via video camera to ensure the children's safety. OFCO contacted the Area Administrator again to express concerns, as it is a violation of Washington State law for dependent children to be subject to video surveillance in their bedrooms. The plan was then changed so the two children would not share a bedroom.

The children were moved out of-state, but services such as counseling for the children did not begin as planned immediately upon their arrival, and three weeks after the children's arrival, the pre-adoptive parents requested that the nine-year-old child be immediately removed from their home. They reported that the child's behaviors were more difficult to manage than they had realized and that these behaviors were negatively affecting their own special-needs child. They requested that the younger sibling remain in their care. DCFS Adoptions agreed, and returned the nine-year-old to Washington. DCFS sought to place him in a temporary "assessment bed" where his behavioral and other needs could be assessed. However, no such placement was immediately available, and the child spent several days in the DCFS office while being transported back and forth to different foster homes for one-night stays. In the month following the child's return, he experienced four different foster placements. Due to this placement instability, the child did not return to counseling or other supportive services.

The child was eventually placed in group care where he received assessments and treatment, and was later transitioned to a therapeutic foster home. OFCO continues to monitor this child's situation.

COMPLAINTS RESOLVED WITHOUT SIGNIFICANT ASSISTANCE BY OFCO

In 2014, **11.2 percent of complaints were resolved between the agency and the complainant without significant assistance or intervention by OFCO**. In most of these cases, the Ombuds contacts the agency, or reviews agency records, to confirm that steps are being taken to resolve the issue. **Some complainants report that the mere fact of OFCO contacting the agency and asking questions appears to assist in ensuring that any problems are resolved.**

DCFS REVERSES PLAN TO PURSUE TERMINATION OF PARENTAL RIGHTS

OFCO found that DCFS failed to follow departmental practices and procedures regarding case planning in a dependency case in which the agency planned to file a petition to terminate the parent's rights and have the 14-year-old dependent child adopted by the current relative caregiver. Contrary to department policy and practice, DCFS held a shared planning meeting to develop the permanency plan nine days after the permanency planning hearing by the court. The court had therefore not had an opportunity to review the information that came to light during the shared planning meeting, i.e. that the parent had now made significant progress in completing court-ordered services, and the child was opposing the idea of being adopted by the relative caregiver. OFCO found that this practice oversight was due to a relatively new caseworker misunderstanding agency requirements regarding shared planning meetings. OFCO further found that the failure to hold a shared planning meeting prior to the court hearing had little impact on the case as an interim review hearing occurred a month later, in which the court considered both the parent's progress toward reunification as well as the child's reported opposition to adoption.

The complaint was resolved when DCFS decided to no longer pursue termination of parental rights and adoption as the permanency plan for this child. Based on the parent's progress, DFCS planned to reunite the child with the parent within the following 30 days. Guardianship with the relative was considered as an alternate permanency plan.

OFCO FINDS NO BASIS FOR INTERVENTION

In 2014, 58 percent of complaint investigations were closed after OFCO either found no basis for the complaint, or found no unauthorized or clearly unreasonable actions by the agency warranting intervention. If OFCO did find an unauthorized or clearly unreasonable action by the agency, there was no opportunity at the time of the complaint investigation to intervene to change the agency's position, usually because the violation occurred in the past.

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

It is important to note that in some cases, although OFCO found no basis to intervene with the agency to change its position, OFCO made an adverse finding against the agency for violating law, policy, or procedure or acting clearly unreasonably, as in the following example:[21]

DELAY IN MOVING CHILDREN TO A SAFE PLACEMENT

OFCO investigated a complaint that DCFS was failing to move two dependent children, ages two and four, from a relative placement that was unsafe, and was not exploring other relatives who had come forward as alternative placement options. The relative who was caring for the children had a founded finding for child maltreatment, and reportedly was allowing the children to have unsupervised contact with their parent, who was actively using drugs in a dangerous environment. Other relatives who wanted the children placed in their care had submitted paperwork to DCFS multiple times over the course of a year, for a required waiver to provide respite care for the children and ultimately be considered for permanent placement. OFCO found that this unreasonable delay, as well as the agency's four-month delay in filing a motion to remove the children from their current relative placement, was attributable to high caseworker turnover in that DCFS office. The adverse impact on the children included their being left in a marginal relative placement for four months after the agency became aware of child safety concerns, and a major delay in establishing permanency for these children by not processing the waiver for other more suitable relatives to be considered for alternate, and permanent placement.

Because these delays had already occurred by the time OFCO received the complaint, and the current assigned caseworker was actively working on the waiver process and getting the motion regarding change of placement to the court, OFCO monitored the case until the children were placed with a different relative.

[21] See following pages for more details regarding adverse findings.

OFCO'S ADVERSE FINDINGS

After investigating a complaint, if OFCO 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, OFCO 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 OFCO believes that the agency's action or inaction could cause foreseeable harm to a child or family, the Ombuds intervenes to persuade the agency to correct the problem. OFCO 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. When the adverse finding involves a past action or inaction, the Ombuds documents the issue and brings it to the attention of agency officials.

In 2014, OFCO made a total of **36 adverse findings** in complaint investigations.

COMMUNICATION OF ADVERSE FINDINGS TO DSHS

Pursuant to the Inter-Agency Agreement between OFCO and DSHS,[22] OFCO provides written notice to the Children's Administration of any adverse finding(s) made on a complaint investigation. The agency is invited to formally respond to the finding, and may present additional information and request a modification of the finding. In 2014, CA provided a detailed response to OFCO's finding in half of all cases, and requested a modification of OFCO's finding in two-thirds of those cases. OFCO modified its finding regarding just over half (n=5) of these findings.

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 identified by OFCO in the course of investigating the complaint.

[22] Available at ofco.wa.gov/documents/interagency_ofco_dshs.pdf

Table 5: **Adverse Findings by Issue**

By Reporting Year (September 1st - August 31st)

	2012	2013	2014
Child Safety	**14**	**10**	**12**
Failure by CFWS to ensure/monitor dependent child's safety			
· Findings regarding health and safety visits	2	-	-
· Unsafe placement of dependent child	1	1	5
· Failure to provide safe parent-child visitation plan	1	1	-
· Inappropriate plan for transport of dependent child	1	-	-
· Failure to provide foster parent with information about child's needs	1	-	-
· Failure to recognize physical abuse	-	1	-
Failure by CPS/FVS to ensure/monitor non-dependent child's safety	3	-	3
Inadequate CPS investigation/case management	2	4	2
Failure to screen in CPS intake for investigation/other screening errors	-	1	-
Failure to staff case with Child Protection Team prior to return home	1	-	-
Inappropriate CPS or DLR/CPS finding (unfounded)	2	-	1
Failure to notify tribe of CPS intake	-	1	-
Delay in notifying law enforcement of CPS intake	-	-	1
Failure to complete safety assessment	-	1	-

	2012	2013	2014
Family Separation and Reunification	**6**	**5**	**4**
Failure to provide appropriate contact between parent and child	2	-	-
Failure to provide sibling visits	1	-	1
Failure to provide contact with relative/fictive kin	2	1	-
Failure to place child with relative	1	3	3
Failure to conduct relative search	-	1	-

	2012	2013	2014
Dependent Child Health, Well-Being and Permanency	**3**	**10**	**1**
Placement issues (incl. placement delays, inadequacies, unavailability)			
· Unnecessary/multiple moves	-	1	-
· Inadequate transition plan	-	2	-
· Unreasonable threat to move child from long-term relative care	1	2	-
· Inadequate foster home	1	-	-
· Inadequate relative placement	-	1	-
Inappropriate permanency plan for dependent child	1	-	-
Delay in permanency	-	4	1

Table 5 (cont.): **Adverse Findings by Issue**

By Reporting Year (September 1st - August 31st)

	2012	2013	2014
Parents' Rights	**8**	**9**	**13**
Failures of notification, public disclosure or breach of confidentiality	1	4	3
Delay in completing/closing CPS investigation	7	5	7
Failure to provider services to parent	-	-	1
Other violations of parents' rights	-	-	2

	2012	2013	2014
Poor Casework Practice Resulting in Harm to Child or Family	**6**	**12**	**1**
Inadequate adoption home study	1	-	1
Failure to conduct supervisory reviews	2	2	-
Inaccurate, incomplete or delayed documentation	3	2	-
Other poor practice	-	8	-

	2012	2013	2014
Foster Parent / Relative Caregiver Issues	**3**	**1**	**2**
Violation of foster parent rights	2	-	1
Unreasonable licensing delays/other licensing errors	-	-	-
Failure to notify caregiver of move of dependent child	1	1	-
Other relative caregiver issue	-	-	1

	2012	2013	2014
Other Findings	**1**	**2**	**3**
Delay in completing DLR/CPS investigation (licensed daycare)	1	-	-
Violation of ICWA (non-child safety)	-	1	2
Delay in ICPC	-	1	-
Delay in CPS intake (caller wait time)	-	-	1

	2012	2013	2014
Number of Findings	41	49	36
Number of Closed Complaints With One or More Finding	31	34	29

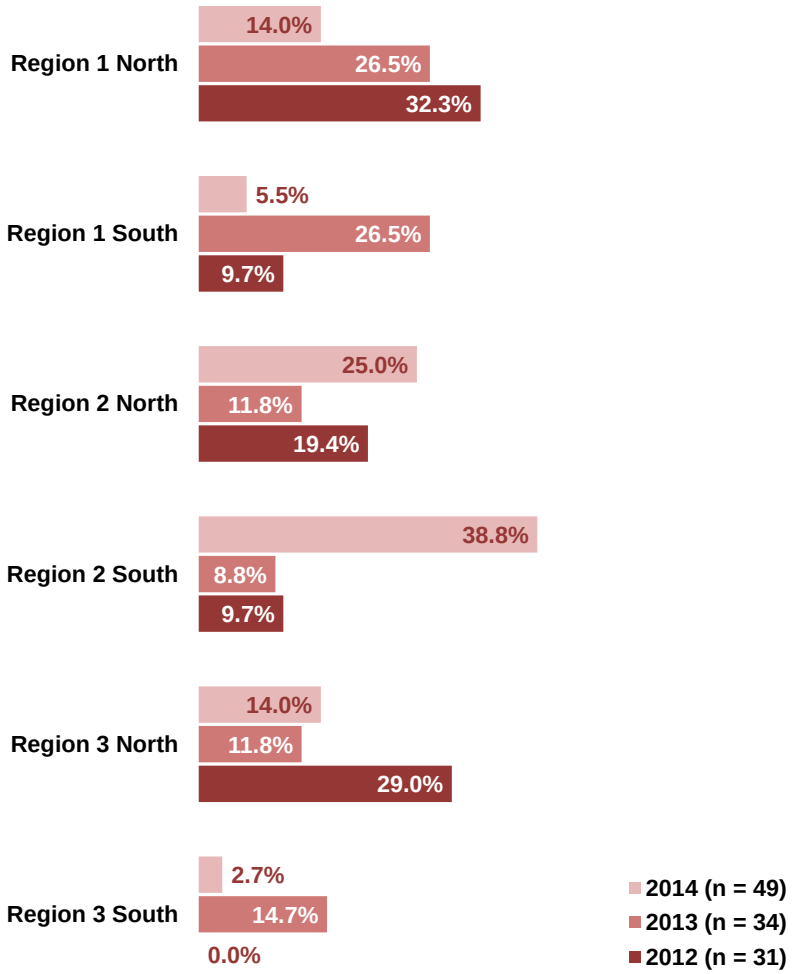
The number of adverse findings against the agency **decreased in 2014** (a total of **36 findings**) from 2013 (49 findings). Findings related to the safety of children, as well as findings involving violations of parents' rights or services to parents, were the two most common issues resulting in adverse findings. One-third of the total adverse findings involved child safety, in which an unsafe placement of a dependent child was most common. Another third of the findings involved parent's rights, with delays in closing CPS investigations representing just over half of the findings in this category.

ADVERSE FINDINGS BY DSHS REGION

This year, the number of complaint investigations resulting in adverse findings by OFCO varied considerably across each of the three larger DSHS Regions. Of the **29 complaints** in which OFCO made a total of **36 adverse findings** against the agency, **findings in Region 2 constituted almost two thirds (23 findings)**. The number of adverse findings in **Region 1 totaled seven (19.5 percent)**, and in **Region 3, totaled six (16.7 percent)**.

Compared with 2013, adverse findings in Region 1 decreased significantly, while findings in Region 2 increased significantly. Findings in Region 3 as a whole remained the about the same; however, Region 3 North accounted for the vast majority of the findings in that region. In the other sub-regions, the largest proportional increase in adverse findings was in Region 2 South, while the largest decrease was in Region 1 South.

Figure 10: **Number of Adverse Findings in Complaint Investigations by DSHS Region**
By Reporting Year (September 1st - August 31st)



Note: 2014 data reflects the total number of adverse findings per region; some complaint investigations resulted in more than one adverse finding. 2012 and 2013 data reflects the number of *complaint investigations* resulting in one or more adverse finding.

AGENCY RESPONSES TO ADVERSE FINDINGS

OFCO provided written notice of adverse findings on complaints to DSHS, to allow the agency to review the findings and respond. OFCO received several responses to these notifications and three of CA's responses included a request for OFCO to modify a finding. OFCO partially modified a finding in these three cases. OFCO withdrew a finding on one case based on additional information provided by CA.

The following summaries of correspondence between CA and OFCO illustrate this process.[23]

CA AGREEMENT WITH ADVERSE FINDING, NO REQUEST FOR MODIFICATION

OFCO FINDINGS

Violation of Policy & Procedure: DCFS failed to conduct a thorough home study at time of child's placement. In August 2009, DCFS conducted a Family Home Study regarding a suitable adult placement. The home study included a DCFS records review. The home study report did not include any notes under the "Recommendation" section, and did not identify any concerning history regarding the caregiver. Based on the approved home study, the child was placed with this individual in 2009.

In July 2013, DCFS completed a second Family Home Study regarding this same caregiver who was then interested in adopting the child. The second home study raised significant concerns about the caregiver and highlighted serious gaps in the 2009 home study. Specifically, the 2013 home study noted that the "home study approved by the Department in September 2009 did not address [the caregiver's] CPS history". The 2013 home study notes that the caregiver's CPS history includes 750 pages of records "related to the investigation of multiple referrals alleging sexual abuse by [the caregiver] of [the caregiver's] children as well as a neighbor's son." The 2013 home study also discussed serious concerns raised by the caregiver's psychosexual evaluation and parenting assessment. Given this information, DCFS filed a motion to remove the child from the caregiver's home, which was granted.

OFCO is concerned that the initial home study failed to address the significant CPS history that was known at the time the child was placed in the caregiver's home in 2009. As a result, the child remained in an unsafe placement for four years.

Violation of Law: DCFS failed to Notify Native American Tribe Regarding a Child in State Care. OFCO could not find any evidence indicating that DCFS made efforts to contact or notify the child's tribe, as required by the federal Indian Child Welfare Act (ICWA). 25 U.S.C. § 1912(a), after it learned in 2010 that the child's biological father asserted tribal membership.

CA RESPONSE

Finding 1: We agree that the initial home study should have addressed the caregiver's CPS history that has now been addressed in the 2013 adoption home study.

Finding 2: We acknowledge that the department did not follow up on recommendations received during Local Indian Child Welfare Advisory Committee (LICWAC) staffing that were held in 2010. In August 2013,

[23] In the interest of brevity and to maintain confidentiality, CA's and OFCO's correspondence have been edited and condensed.

the assigned adoption worker learned of the recommendations and contacted the tribe in September 2013. The department is currently working closely with the tribe identified by the child's father.

CA DISAGREEMENT, OFCO DECLINES TO MODIFY AN ADVERSE FINDING

OFCO FINDING

CPS facilitated placement of an 11-year-old non-dependent child with her non-custodial father. The child's placement with the father was based on an allegation of sexual abuse of the child by an adult sibling living in the mother's home. This placement however, violated the conditions of an existing family court parenting plan restricting the non-custodial father's contact with this child to supervised visits, based on a history of domestic violence. OFCO found that the father had not completed domestic violence treatment, and six months previously, CPS had made a founded finding of neglect against the mother for allowing the children to have unsupervised contact with the father, in violation of the family court order. The adult sibling was subsequently adjudicated and the court ordered no contact between the perpetrator and any minor children, and prohibited him from going to the mother's home. CPS then returned the child to the mother's care.

OFCO concluded that the department's action to facilitate placement with the father, without any modification of the existing parenting plan was clearly unreasonable under the circumstances, as just six months prior, CPS had determined that the mother's failure to follow the parenting plan by allowing unsupervised contact between the father and his children, created a clear and present danger to the child's health, welfare or safety.

CA RESPONSE

CPS requested that OFCO reconsider the adverse finding, stating that CPS's decision to allow the child to live with the father was reasonably based on its assessment that this would be a safe situation for the child. CPS stated that "the decision addressed child safety, was agreed upon by both parents, included community supports, was culturally relevant, and was in alignment with the local agreement between DCFS and the Prosecutor's Office/Law Enforcement regarding separating siblings during sexual abuse/molestation/rape investigations."

CPS pointed out that the mother did not appear to believe the child's disclosure of abuse by the older sibling, and was allowing the older sibling to have unsupervised contact with the child. The parents had mutually agreed to change their residential time with the children and already had a scheduled court hearing in family court to propose modifications to the existing parenting plan. CPS had met with the mother, community members, and Elders, and received input from the father, to develop a safety plan" to ensure the child's safety during the investigation while being minimally invasive and allowing [the child] some degree of normalcy and continuity of connections." The safety plan involved community members checking on the child, and was approved by Elders "who had cultural and spiritual authority for this and other families" in that community.

CPS reiterated that before being returned to the mother's home, the child had been in the care of the father for approximately 45 days, and had been well cared for, supported by the community, and maintained connections with school, culture, and the community.

OFCO RESPONSE TO REQUEST FOR MODIFICATION

OFCO responded that the agency's efforts to avoid further trauma to this 11-year-old child were appreciated, but OFCO maintained that the agency did not have the authority to facilitate the temporary placement of the child with the non-custodial father, in violation of the parenting plan.

OFCO stated that the modification of a parenting plan restricting a parent's contact with a child is governed by RCW 26.09.260 which provides that:

> *"A parent whose residential time with the child is subject to limitations may not seek expansion of residential time unless that parent demonstrates a substantial change in circumstances specifically related to the basis for the limitation; and*
>
> *A parent who is required by the existing parenting plan to complete evaluations, treatment, parenting, or other classes may not seek expansion of residential time unless that parent has fully complied with such requirements."*

OFCO further stated:

We were unable to locate authority that under these circumstances, parents may mutually agree to informally change their residential time with their children. In fact, Child Protective Services also concluded that the mother lacked the authority to ignore restriction on the father's contact with this child set forth in the parenting plan. In February 2013, CPS determined that an allegation of neglect by the mother was founded, based on her "knowing violation of the terms of [the] supervision plan between the children and their father."

We also recognize the department's collaborative efforts to work with this family, the [cultural] community and Elders to establish a safety plan and ensure the child's well-being during the CPS investigation. However, we disagree that the alternative of filing a dependency petition would have necessarily resulted in the removal of this child from her family and community and placement in foster care. The juvenile court hearing a dependency matter has concurrent jurisdiction with the family court over parenting plans, and could have considered the temporary placement of this child with her father.

OFCO therefore declined to modify its adverse finding in this case.

CA DISAGREEMENT, OFCO MODIFICATION OF AN ADVERSE FINDING

OFCO'S ORIGINAL FINDING

Violation of Law and Policy/Practice Concern: CPS failed to make reasonable efforts to provide services to a parent of dependent children, by failing to make a referral for a psychological evaluation for this parent. OFCO found that:

- Services for the mother, identified in a Dependency Order, include a "psychological evaluation with a parenting component." The order also provides that "Services shall be commenced within 30 days unless otherwise specified."
- A psychologist was identified and agreed to by all parties to conduct this parent's court ordered evaluation, but the evaluation did not occur because the department did not submit referral information to the psychologist.

Four months after this evaluation was ordered, it has still not been provided to this parent. OFCO concluded that the department's failure to provide this service in a timely manner was clearly unreasonable under the circumstances. Delays in the provision of services to families have an adverse impact on reunification efforts and permanency for dependent children.

CA REQUEST FOR MODIFICATION OF FINDING

DCFS responded that the assigned caseworker had, in fact, worked with the parties in this case to agree upon a provider to conduct the evaluation, within the 30 days following the court's order, and had arranged a date for the evaluation with that provider, but had failed to send the actual referral with the supporting documents needed by the psychologist to proceed with the evaluation. Once this was discovered, the supervisor quickly found a new provider who would be able to conduct the evaluation promptly, and sent the appropriate referral to that provider.

The Area Administrator added that this instance would be used as a training opportunity in an all staff meeting in that office to remind staff to ensure they are reviewing court orders thoroughly, following timelines and writing and submitting complete and timely referrals.

OFCO'S MODIFIED FINDING

Although the actual finding remained unchanged, OFCO agreed to modify the factual basis for the finding, by including information about the efforts made by the caseworker to arrange the evaluation and the error that was made.

OFCO WITHDRAWAL OF AN ADVERSE FINDING

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

OFCO'S ORIGINAL FINDING

Practice Concern: Subject of child maltreatment not identified in allegations in CPS intake report. CPS received an intake alleging negligent treatment of a four-year-old non-dependent child. The referrer reported that the child had a quarter-size burn on his thigh that looked like a car cigarette lighter, that it was the third burn in five months, and suspected the paternal grandmother was burning the child. Under "caregiver characteristics", the intake noted that the child resides with the father and grandmother, and that while the father is at work, the grandmother cares for the child. Under "additional risk factors", the intake noted that two months earlier there was an unfounded finding on an intake regarding a burn to the child's chest and that the grandmother was watching the child at the time of the injury.

The current intake was screened in for investigation, but only the child's father was listed as a suspected perpetrator. OFCO was concerned that the intake report failed to include the grandmother as a subject despite the information provided in the intake narrative, the recently completed investigation regarding another burn with the grandmother as the subject, and the fact that the grandmother reportedly lived in the home.

During the CPS investigation, the CPS investigator did not identify the grandmother as a subject, nor was the grandmother interviewed. The investigation resulted in an unfounded finding against the father for negligent treatment.

OFCO does not dispute CPS's finding. However, OFCO is concerned that both the intake worker and the CPS investigator failed to investigate the grandmother as an additional suspected perpetrator of maltreatment. OFCO contacted the CPS Intake supervisor, who stated that the grandmother should have been included as a subject given the information provided in the intake report. The supervisor also noted, however, that the CPS investigator could and should have later corrected the error.

OFCO'S WITHDRAWAL OF ADVERSE FINDING

CA's detailed response included information that the incident address shown on the later intake was the address of the father, and that at the time of this intake the father and child were living separately from the grandmother and there was no indication that the grandmother was acting in loco parentis. Furthermore, based on information gathered during the CPS investigation, the investigator did not suspect the grandmother as an additional subject. CA believed that the father was listed correctly as the primary caregiver and subject of the second investigation.

OFCO responded that its original finding was based on the fact that the later intake report, as well as other demographic information in FamLink, listed the grandmother as having the same address as the father. Based on the agency's clarification to OFCO that the intake worker incorrectly identified the father and the grandmother as residing in the same home, OFCO agreed that the grandmother did not in fact meet the definition of a person acting in loco parentis. OFCO therefore withdrew its adverse finding in this case.

LACK OF AGENCY RESPONSE TO OFCO ADVERSE FINDINGS

As mentioned earlier in this section, CA did not respond to approximately half of the notifications send by OFCO regarding an adverse finding. It should be noted that according to the Interagency Agreement between OFCO and DSHS, CA is not required to provide a response, and if no response is received within 10 working days of the agency receiving OFCO's notification, the finding becomes final. However, a number of OFCO's findings to which the agency did not respond left unanswered questions regarding what, if any, action the agency was taking to address the concerns identified in the finding.

Some examples are:

1. **Violation of law and policy**: CPS failed to conduct an adequate investigation into allegations of physical abuse of a 7-year-old child by a parent. OFCO found that CPS failed to conduct (or failed to document) an interview with the child, and did not make any collateral contacts to gather information to assess the safety of the child. A new report of physical abuse was received over 5 months later, after the child was seen covered in bruises. The child disclosed being beaten by her parent with an extension cord, and she and her siblings were placed in protective custody.

2. **Violation of policy and procedures**: DCFS failed to inform a parent of a two-year-old dependent child that the child sustained an injury (elbow fracture) and was treated at a hospital emergency room. The injury was reported to DCFS, and despite telephone contact with the parent between the time the worker became aware of the injury and the parent's next visit with the child six days later, the parent only discovered the injury at the visit. OFCO concluded that the agency's failure to inform the parent of an injury to the child was unreasonable under the circumstances, and this communication failure had an adverse impact on this case as it likely fueled the parent's suspicion that the child's injury resulted from abuse or neglect by the foster parent, and/or that the agency was intentionally withholding this information from the parent.

3. **Violation of policy and procedures**: DCFS failed to conduct a home study on a relative caregiver of a now-four-year old legally free child who had been placed with this relative at birth. DCFS had conducted background checks at the time of placement, and found that the relative had a founded finding of physical abuse of a child in her CPS history, as well has criminal history. The relative also had a child care license, and had received a waiver from the Department of Early Learning (DEL) to be granted the license despite this founded finding. DCFS had located the DEL waiver and placed it in the DCFS file, without seeking its own waiver or conducting a home study. When the child became legally free and the relative was referred for an adoption home study, a waiver was submitted by the Adoption caseworker. The waiver was denied, as was the home study. The agency is exploring another relative who lives out-of-state, but there have been numerous delays in completing the ICPC home study, and the child remains with the relative caregiver, who sought and passed an adoption home study conducted by a private agency. It is unclear what placement decision will be made in this case.

4. **Violation of law and policy**: CPS failed to notify law enforcement in a timely manner of a reported crime against a child. CPS received a report of sexual abuse of a 15-year-old youth by her father, and interviewed the youth, who confirmed the reported incidents. The CPS investigator informed the youth that she would be following up with law enforcement, and the

youth expressed anxiety about returning home after what she had reported. Two days later – and five days after the CPS intake had been received - the youth's school called CPS intake to report that the youth was experiencing high anxiety about when her father would be informed of the investigation. CPS intake responded by notifying law enforcement of the reported abuse later that day. Law enforcement interviewed the youth and a sibling the following day, and arrested the father. The children were allowed to remain in the care of the mother. A week later, CPS received another intake reporting that the youth was suicidal and afraid to return home since the mother had bailed the father out of jail and was blaming the youth for the father's arrest. OFCO monitored the CPS case, and although CPS took steps over the following two-and-a-half months to protect the youth from further abuse and provide for her safety and welfare, OFCO was concerned that insufficient efforts were being made to ensure her safety, particularly after the agency became aware that the father had moved back into the home, and the mother was defending him while exhibiting reluctance to protect her daughter. OFCO contacted the Area Administrator, and based on further information gathered by CPS, a dependency petition was filed and the children were removed from the home.

5. **Violation of law:** DCFS failed to notify a Native American Tribe that two siblings reported to have tribal heritage were in state care, as required by the Indian Child Welfare Act. The family had reported their Native American heritage early on in the dependency case. Soon after establishing dependency, the department sent inquiries to four tribes and received a response from one of the tribes confirming the children's eligibility for membership. However, the Tribe did not receive the required notice that these children were in state custody until about 18 months after the children entered state care. This deprived the Tribe of their right to intervene in the legal proceedings, to provide input into case planning and placement, or to request that the case be staffed with a Local Indian Child Welfare Advisory Committee. The children were ultimately returned to the parent's care.

6. **Violation of law and policy**: A DCFS Family Voluntary Services (FVS) caseworker failed to report suspected physical abuse of a six-year-old non-dependent child by a parent. The parent had admitted to the worker that she spanked the child with a belt "excessively". The mother reported that she may have left bruises on the child, but thought they were going away. The FVS worker spoke with the Family Preservation Service therapist involved with the family, who confirmed receiving the same information from the parent and told the FVS worker she would "continue to monitor and update". Neither of these mandated reporters reported the suspected abuse to CPS intake. Responding to a subsequent call from a concerned citizen, law enforcement placed the child in protective custody after seeing the child's bruises. Law enforcement reported the information to CPS intake approximately 48 hours after the FVS worker learned of the abuse. The CPS investigation resulted in a founded finding of abuse against the parent. In its notification to the agency of an adverse finding in a complaint, OFCO expressed concerns that, particularly in light of the implementation of the Family Assessment Response program, a DCFS caseworker and a DSHS-contracted provider who were working with an at-risk family did not appear to have a full understanding of their mandated reporter duties and the importance of assessing child safety.

7. **Violation of policy**: A CPS investigator reported being unable to complete a CPS investigation of allegations of physical abuse of a 16-year-old non-dependent youth by his father, and the investigation was closed 13 days after the intake was received. OFCO found that the investigator closed the investigation with the rationale that he was unable to interview the alleged victim, after the youth failed to return two phone calls to the investigator. This was clearly unreasonable, as the CPS investigator was aware that a Family Reconciliation Services (FRS) caseworker had direct and ongoing contact with the youth during this period of time, while assisting the youth with filing a Child in Need of Services (CHINS) petition with the court. OFCO expressed concern that CPS closed the investigation without having seen or interviewed the alleged victim despite the victim's availability.

IV. IMPROVING THE SYSTEM

PART ONE: WORKING TO MAKE A DIFFERENCE

- Ongoing Efforts to Improve Adoptions
- Family Assessment Response

PART TWO: OFCO CRITICAL INCIDENT CASE REVIEWS

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

PART THREE: IMPLEMENTATION STATUS OF CHILD FATALITY REVIEW RECOMMENDATIONS, 2012-2013

PART FOUR: 2014 LEGISLATIVE UPDATE

"I have contacted ombudsman before and I normally wouldn't give them two cents. But you have proven to be a good resource. I feel like you really got things moving. I feel you are an asset."

~ Foster Parent

PART ONE: WORKING TO MAKE A DIFFERENCE

ONGOING EFFORTS TO IMPROVE THE ADOPTION SYSTEM

The Division of Licensed Resources Proposes Rules to Improve the Adoption System

OFCO's 2011 Annual Report[24] documented cases of severe child abuse and neglect occurring in adoptive or pre-adoptive placements. What is particularly disturbing in these cases is that the child abuse and neglect occurred in homes that had been scrutinized and approved by child welfare agencies, and or by the court, as safe and appropriate adoptive homes for the children.
In February 2012, Children's Administration (CA) and OFCO convened a statewide committee to address these concerns and recommend changes to the adoption process. Members of the committee represented various professions and organizations within the child welfare and adoption system including: CA; private child placing agencies who conduct domestic and international adoptions; the Office of the Attorney General; the court; public defense attorneys; the Governor's Office; researchers; and medical professionals. The recommendations made in The *Severe Abuse of Adopted Children Committee Report* [25] (hereinafter "Severe Abuse Report") aimed to strengthen the adoption system and provide greater safeguards to protect children and strengthen families.

In August 2014, the Division of Licensed Resources (DLR) filed new proposed rules governing child-placing agencies and adoption services with the Office of the Code Reviser.[26] These rules implement many of the recommendations made in the *Severe Abuse Report*, and address the following topics:

Training and Post Adoption Support Services

1. Training and preparation for prospective adoptive parents.[27] Specific topics include:
    - The rights and responsibilities of adoptive parents;
    - Potential risks and challenges inherent in adoption;
    - The needs and characteristics of children available for adoption;
    - Attachment, separation and loss issues for children;
    - The importance of a child's cultural and ethnic identity;
    - The effects of adoption on the child and family; and
    - Training related to the particular child being adopted such as the child's: cultural, racial, religious, ethnic and linguistic background; medical, social birth and developmental history; and educational data.

[24] Available at http://www.governor.wa.gov/ofco/reports/2011/ofco_2011_annual.pdf
[25] Report released in September 2012. Available at: http://www.governor.wa.gov/ofco/reports/Severe_Abuse_Adopted_Children_Report.pdf
[26] Proposed rules available at: http://www.dshs.wa.gov/ca/fosterparents/laws.asp
[27] Proposed WAC 388-147-1725

2. Training requirements for child placing agency staff,[28] including:
    - Potential short and long term effects of prenatal exposure to alcohol, drugs and poor nutrition;
    - Potential effects of separation and loss by the child in respect to their family of origin;
    - Developing emotional ties to an adoptive family;
    - Attachment and post-traumatic stress disorders;
    - Normal child and adolescent development;
    - Issues of race and culture;
    - Acculturation and assimilation issues including those that arise from race, ethnicity, religion and culture;
    - Ethical considerations in inter-country adoptions; and
    - The effects of having been adopted internationally.
3. Information provided to potential adoptive families must include post-adoption supports available, including financial support.[29]

Assessing Prospective Adoptive Families

1. Establishes minimum requirements for adoption home studies[30]- Required activities and topics addressed include:
    - Individual interviews with each applicant parent and with each member of the household;
    - On-site evaluation of the applicant's home and property;
    - Suitability and fitness of each applicant;
    - Identification of child characteristics for which the applicant(s) are best suited;
    - Concept of adoption as a lifelong process and commitment;
    - Relevance and potential benefit of the child's relationship with siblings;
    - Disclosure to the child of adoption and the child's possible questions about birth parents and relatives;
    - Relevance of a child's racial, ethnic and cultural heritage;
    - Whether the applicant(s) previously applied for an adoption home study and the outcome of the application; and
    - A supervisor must sign for approval or denial of the adoption home study.

2. Minimum requirements for post-placement reports[31]- Required activities and topics include:
    - Face to face post placement contact with each child and adoptive parent at least once every thirty days until the adoption is finalized.
    - All reasonably available information about the child's physical and mental condition, home environment, family life, and facilities where the child has resided;
    - Information on the child's cultural heritage, including membership in any Indian tribe or band;
    - Collateral contacts with professionals involved with the family or child;
    - Follow up contacts with personal references;

[28] Proposed WAC 388-147-1665
[29] Proposed WAC 388-247-1675
[30] Proposed WAC 388-147-1695
[31] Proposed WAC 388-147-1730; and proposed WAC 388-147-1685

- A review of the family's discipline practices;
- Documentation of home visits including one within the first thirty days of placement; and
- If the placement appears likely to disrupt, documentation of efforts to provide services to preserve the placement and if disruption occurs, documentation of efforts to provide a new placement for the child.

3. Ensure that all adoption home studies (pre-placement reports) are, are filed with the court as required by state law.[32]

Placing a Child for Adoption

1. Plan to identify children needing adoptive placements, the diverse needs of those children, and how children will be matched to families.
2. Locate and provide information about the child and the birth family to the prospective adoptive family.
3. Develop a transition plan for the child into the family and preparing for adjustment issues as related to the child's background.

Qualifications for Individuals Conducting Pre- and Post-Placement Reports

Proposed WAC 388-147-1695 requires: "*A supervisor must sign for approval and denial of the adoption home study."* However, this proposed WAC does not describe qualification requirements for the supervisor, or for the individual conducting the home study. At a hearing on these rules, OFCO requested that the requirements recommended in The Severe Abuse of Adopted Children Report, be incorporated into this rule:

Recommendation:
WAC 388-147-1695(5) *Individuals conducting an adoption home study must be supervised through a Washington State child placing agency and the supervising agency employee must possess the following qualifications:*

- *A master's or doctorate degree from an accredited program in social work, psychology, guidance and counseling, or a similar subject area.*
- *Two years of experience in family and children's services, one year of which must include providing adoption services.*
- *And if the agency provides intercountry adoption services, the supervisor must have experience in intercountry adoptions."*

A supervisor must sign for approval and denial of the adoption home study.

[32] WAC 388-147-1700

Washington State Auditor's Office Report[33] *Highlights Need for Post-Adoption Services*

In February 2014, the State Auditor released its report titled *The Experiences and Perspectives of Washington Families who Adopted Children from Foster Care.* This report focused on three questions:

- To what extent are the service needs of families who adopted children from foster care being met?
- What are adoptive parents' experiences working with DSHS and CA to negotiate benefits?
- What can we learn from other states' programs to help improve services for families in Washington?

The Auditor surveyed 1,686 adoptive parents, gathered information from national experts, and examined practices in eight other states with populations similar to Washington.

The study reinforced findings of previous reports, specifically that:

- The children and families with the greatest need were less likely to obtain or benefit from services.
- Some parents unable to access services felt unsafe and reported concerns that their children are at risk of harming themselves or others.
- Nearly half of parents surveyed said they had difficulty finding information on how to access crisis intervention and residential care services.
- Other parents said they needed assistance finding counselors who could help their children, and that they also wanted information on additional services available for their children.

The report recommends that DSHS develop a plan to enhance post-adoption services for families adopting children from foster care and that this plan include strategies to inform adoptive parents about accessing available services.

In response to the State Auditor's report, CA has initiated work with the National Resource for Adoption to create a more informative post-adoption website to help adoptive families identify resources and services available in their community for the special needs of children adopted from foster care. The department will also develop a list of experienced and knowledgeable counseling providers for adoptive families. In partnership with stakeholders and nonprofit organizations, CA is working to enhance resources for post adoption services.

[33] Performance Audit *The Experiences and Perspectives of Washington Families who Adopted Children from Foster Care.* Available at: www.sao.wa.gov.

FAMILY ASSESSMENT RESPONSE

Background

In March 2012, Engrossed Substitute Senate Bill 6555[34] was signed into law. This law required Children's Administration (CA) to implement a differential response system that provides an alternative to the traditional Child Protective Services investigative pathway for families with low to moderate abuse or neglect allegations. The Family Assessment Response (FAR) pathway is Washington State's differential response system.

FAR offers greater flexibility to CA in engaging families and effectively addressing concerns regarding child maltreatment. FAR generally involves conducting a comprehensive assessment of the safety of the child, as well as the family strengths and needs, and providing services and concrete supports. Key features of FAR include:

- A family's involvement is voluntary. Parents can refuse the FAR pathway and instead opt for a CPS investigation if they choose.
- A formal determination or substantiation (i.e. "founded" or "unfounded") of abuse or neglect is not made.
- Based on new information that a different type of response is needed to ensure child safety CPS may change its response from FAR to the investigative pathway.
- FAR provides an avenue to engage parents more effectively to understand the conditions that impact child safety and the factors that need to be addressed to strengthen the family unit and improve child and family well-being.
- FAR tends to be less adversarial. There is a focus on partnering with the family to identify concrete resources and services in an effort to prevent future maltreatment.

Other states have found that FAR has had a positive impact on their child welfare system.[35] Specifically that FAR has resulted in:

- Increased access to services for families in distress;
- Fewer subsequent child maltreatment reports; and
- A reduction in the removal and placement of children in out-of-home care

[34] Available at: http://apps.leg.wa.gov/billinfo/summary.aspx?bill=6555&year=2011
[35] See, *Siegel & Loman, Extended Follow-up Study of Minnesota's Family Assessment Response- Final Report,* (2006). Available at: http://www.iarstl.org/papers/FinalMNFARReport.pdf

Implementation

FAR is being implemented incrementally across the state, allowing CA to provide focused support and monitoring to a small group of offices at any one time. CA began implementation in January 2014 in three offices: Aberdeen, Lynnwood, and two zip codes in Spokane. CA began offering FAR to families in five additional offices in mid-July 2014, and another eight offices in October 2014. An additional seven offices are in the process of being prepared for FAR implementation in January 2015. Complete implementation of FAR statewide will occur by January 2016.

Early FAR Data

CA reports that between January 1 and August 31, 2014, FAR social workers have responded to 1,263 intakes.[36] Families have engaged in services including Positive Parenting Program (Triple P), Crisis Family Intervention (CFI), chemical dependency services, mental health services, and Project Safe Care. FAR social workers have helped families address a variety of identified needs including childcare, transportation, clothing, utility bills and household items including safety equipment such as baby gates or other childproofing items.

FAR workers filed dependencies due to child safety concerns in the home in less than 2 percent of cases. Approximately five percent of FAR intakes were reassigned to investigations because of safety concerns, or because the family chose an investigation instead of FAR. One reason why some families choose not to participate in FAR is because they are engaged in child custody issues. Some of these families believe that an investigation with an unfounded outcome will help in their custody case. [37]

CA has been monitoring CPS intake trends since January 2014, and if FAR was available state-wide, approximately 70 percent of intakes would be screened to the FAR program. Although it is early to assess and identify trends in FAR offices, it is reported that there has been in a clear increase in the number of FAR families voluntarily participating in services during a FAR intervention. TriWest, the agency contracted by CA to evaluate the FAR program, will be tracking data on repeat referrals, disproportionality, and other outcomes for families engaged in the FAR pathway.

[36] Available at http://www.dshs.wa.gov/pdf/ca/FARNewsletterFall2014.pdf
[37] http://www.dshs.wa.gov/pdf/ca/far-semiannual-Jan2014.pdf

Table 6: **Early FAR Data Reported by CA** [38]

Calendar Year 2014	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	TOTAL
Intakes assigned to FAR	126	126	130	138	106	101	243	293	**1263**
FAR cases transferred to Investigations due to safety or risk concerns	4	3	6	8	4	2	6	2	**35**
Families who declined to participate in (transferred to investigations)	6	5	1	2	1	2	7	3	**27**
Percent transferred to Investigations total	7.94%	6.35%	5.38%	7.25%	4.72%	3.96%	5.35%	1.71%	**5.07%**
Dependencies filed	1	0	4	4	3	0	3	7	**22**
Percent dependencies filed	0.79%	0.00%	3.08%	2.90%	2.83%	0.00%	1.23%	2.39%	**1.74%**

Source: CA FAR Newsletter, Fall 2014 Issue.

OFCO and FAR

OFCO has developed an internal system to identify complaints that involve the FAR pathway. In 2014, OFCO did not receive any complaints involving FAR. For the majority of OFCO's reporting year (September 2013 to August 2014), FAR was mainly implemented in just three CA offices. As FAR is implemented throughout the state, OFCO will continue to document any complaints regarding FAR, and will report on issues concerning families engaged in the FAR pathway. Additionally, OFCO will watch for child safety issues that may arise, particularly related to decisions whether or not to conduct a CPS investigation.

When the FAR program began, OFCO Director Mary Meinig requested to participate in a "ride-along" in order to observe the differences in practice in FAR cases, compared with CPS investigations. Ms. Meinig accompanied FAR caseworkers in Spokane and Aberdeen, and was impressed by these workers' ability to engage with these families in a constructive way during their initial face-to-face contact with the families.

Ms. Meinig noted the workers were non-intrusive, pro-active, and non-blaming, and kept a clear focus on immediate safety concerns as well as the family's overall needs. FAR caseworkers helped these families identify community resources and secure needed items such as a crib or a stroller. The families welcomed the assistance that was offered, and workers did not encounter the resistance and distrust often encountered by CPS workers when initiating a CPS investigation.

[38] Statewide data since program inception

PART TWO: OFCO CRITICAL INCIDENT CASE REVIEWS

BACKGROUND

OFCO receives notification of the following critical incidents by way of CA's Administrative Incident Reporting System (AIRS) and immediately begins an independent administrative review:

- **Child Fatalities:** When there is an open case on the family at the time of or prior to the fatality or any CA history on the family within twelve months of the fatality, including "information only" referrals; or when the fatality occurred in a CA or Department of Early Learning (DEL) licensed, certified, or state operated facility.

- **Child Near Fatalities:**[39] When the near fatality is a result of alleged child abuse and/or neglect on an open case or on a case with CA history within twelve months; or the near fatality occurred in a CA or DEL licensed, certified, or state-operated facility. A near fatality is defined as an act that, as certified by a physician, places the child in serious or critical condition.[40]

- **Recurrent Maltreatment:**[41] When children in the same family experience recurrent maltreatment— defined as three founded reports of alleged abuse or neglect within the last twelve-month period.

- **Other Critical Incidents -** OFCO is regularly notified of other critical incidents including child abuse allegations in licensed foster homes or residential facilities, high-profile cases, incidents involving CA clients (such as dangerous behavior by foster youth), or incidents affecting CA staff safety. OFCO briefly reviews each of these cases to assess whether there is any unaddressed safety issue, and if so, may conduct a more thorough review.

OFCO treats each fatality, near fatality, and recurrent maltreatment notification as **emergent** in order to assure the safety of any children remaining in the home. In this reporting period, OFCO conducted:

- 61 administrative reviews of child fatalities both involving child abuse or neglect and cases unrelated to child maltreatment;
- 17 administrative reviews of child near fatalities;
- 146 reviews of cases of recurrent maltreatment; and
- At least 400 brief reviews of other critical incidents.[42]

[39] RCW 74.13.640(2) requires the department to promptly notify the Ombuds in the event of a near fatality of a child who is in the care of or receiving services from the department or a supervising agency or who has been in the care of or received services from the department or a supervising agency within one year preceding the near fatality. The department may conduct a review of the near fatality at its discretion or at the Ombuds' request.

[40] RCW 74.13.500.

[41] RCW 26.44.030(13) requires CA to notify the Ombuds of these cases.

[42] Resulting from notifications received from CA.

OFCO'S REPORTING PERIOD FOR VARIOUS CRITICAL INCIDENTS

CHILD FATALITIES: This section discusses **61 administrative reviews of child fatalities conducted by OFCO**[43] both involving child abuse or neglect and cases unrelated to child maltreatment, occurring between January 1, 2013 and December 31, 2013. OFCO's administrative review process is described below. Due to the nature of these cases, investigations and reports by law enforcement, CPS, and the medical examiner can take many months to complete. OFCO's examination of and reporting on these cases is therefore limited to the 2013 calendar year and prior.

CHILD NEAR FATALITIES: OFCO conducted an administrative review of **17 near fatalities** occurring between January 1, 2014 and October 31, 2014, when the family was receiving services from CA at the time of the near fatality, or had history with CA in the prior twelve months.

RECURRENT CHILD MALTREATMENT: For the period September 1, 2013 through August 31, 2014, OFCO reviewed **146 cases** of recurrent maltreatment.

OFCO'S ADMINISTRATIVE REVIEW PROCESS

OFCO has developed a database of child fatalities, near fatalities, and critical incidents 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. OFCO also creates a chronology for each case describing significant events. Through this process, OFCO 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.

When conducting critical incident reviews, OFCO focuses on whether child maltreatment was a contributing factor, and whether there were any opportunities for the child welfare system to assist the family and protect the child prior to the incident. This allows OFCO to not only take any needed action to protect the children involved in the critical incident during the aftermath, but also provides an opportunity to conduct systemic investigations and issue recommendations as needed, to better protect our state's most vulnerable population going forward.

[43] An administrative review by OFCO is a different and less comprehensive process than an Executive Child Fatality Review convened by CA in cases which meet the statutory requirements of RCW 74.13.640.

SUMMARY OF FINDINGS

FATALITY REVIEWS

- In 2013, OFCO reviewed **61 child fatality cases**, both involving child abuse or neglect and cases unrelated to child maltreatment. This represents a 45 percent increase from 2012.
- **Seventeen child fatalities** were directly attributed to **physical abuse or neglect** and of these, **ten** involved **children under the age of three** years.
- **Unsafe sleep environment** continues to be a **leading risk factor** associated with infant deaths.
- Major risk factors in these child fatalities include: **substance abuse** by and/or **mental health problems** of a caregiver; and/or a history of **domestic violence** in the family.

NEAR FATALITY REVIEWS

- OFCO reviewed **17 near-fatality cases** in the first ten months of 2014, a sharp decrease from those reviewed in the full calendar year of 2013 (30 cases).

RECURRENT MALTREATMENT REVIEWS

- OFCO received **146 notifications of recurrent maltreatment** in its 2014 reporting period, a **20.7 percent increase** over the same period last year.
- The vast majority of the founded reports constituted child **neglect** (78.4 percent), which is **more likely to recur** than physical or sexual abuse.
- **Caregiver substance abuse** remains the most prevalent risk factor in these cases (67.2 percent of cases in 2014, a **38.4 percent increase** from last year).

CHILD FATALITY REVIEWS

State law requires DSHS to conduct a child fatality review when the child's death is suspected to be caused by child abuse or neglect, and the child was either in the department's custody or receiving services from the department within the last twelve months.[44] DSHS is required to consult with OFCO to determine if a fatality review should be conducted in any case in which it cannot be determined whether the child's death resulted from suspected maltreatment.[45] The CA fatality review committee is made up of individuals who had no previous involvement in the case, and includes individuals whose professional expertise is pertinent to the case. In 2013, the department conducted **13 executive child fatality reviews**.[46] An additional **two internal fatality reviews** were convened by CA at the request of OFCO.[47] Executive child fatality review reports are distributed to the appropriate committees of the legislature, and are posted and maintained on the department's website.[48]

OFCO examines all fatalities in which the child's family had an open case with CA at the time, or any CA history within twelve months of the fatality, regardless of whether the subject child received services from the department.[49] This includes child fatalities in which the death is suspected to be caused by child abuse or neglect, as well as fatalities unrelated to child maltreatment. OFCO examines these in order to: identify critical factors and patterns; assist policymakers in developing strategies to avoid these tragedies; and to determine whether a DSHS fatality review is required based on suspected child abuse or neglect. In 2013, OFCO examined 61 child fatalities. Because OFCO uses slightly broader criteria to determine whether further examination of a fatality is warranted, data compiled by CA and OFCO regarding these internal administrative reviews may vary.[50]

In past reports, OFCO has presented and analyzed child fatality data by calendar year. Because the number of maltreatment-related fatalities in any given year is too low to reflect significant patterns or trends, OFCO has chosen in this report to present data covering the **four-year period from 2010 through 2013**. The following data describes the profile of the **152 child fatalities examined by OFCO** during this four-year period. It should be noted that the accidental or natural death of a child, unrelated to abuse or neglect, is not included in this data.

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[44] RCW 74.13.640. In 2011, state law modified the department's duty to conduct child fatality reviews. Prior to this change, DSHS was required to conduct a child fatality review of an "unexpected death" of a child. As amended, DSHS must only review those deaths that "are suspected to be caused by child abuse or neglect." This eliminates fatality reviews of a child's accidental or natural death unrelated to abuse or neglect.

[45] RCW 74.13.640(1)(b). This law also states that DSHS may review any near fatality at its discretion, or at the request of OFCO.

[46] Note that due to the time-lag between the death of a child and the review of that death, some of the deaths *reviewed* in 2013 include deaths that may have *occurred* later in 2012, and does not include deaths that *occurred* in late 2013.

[47] RCW 74.13.640(1)(b) also states that DSHS may review any near fatality at its discretion, or at the request of OFCO.

[48] See: http://www.dshs.wa.gov/ca/pubs/fatalityreports.asp (RCW 74.13.640)

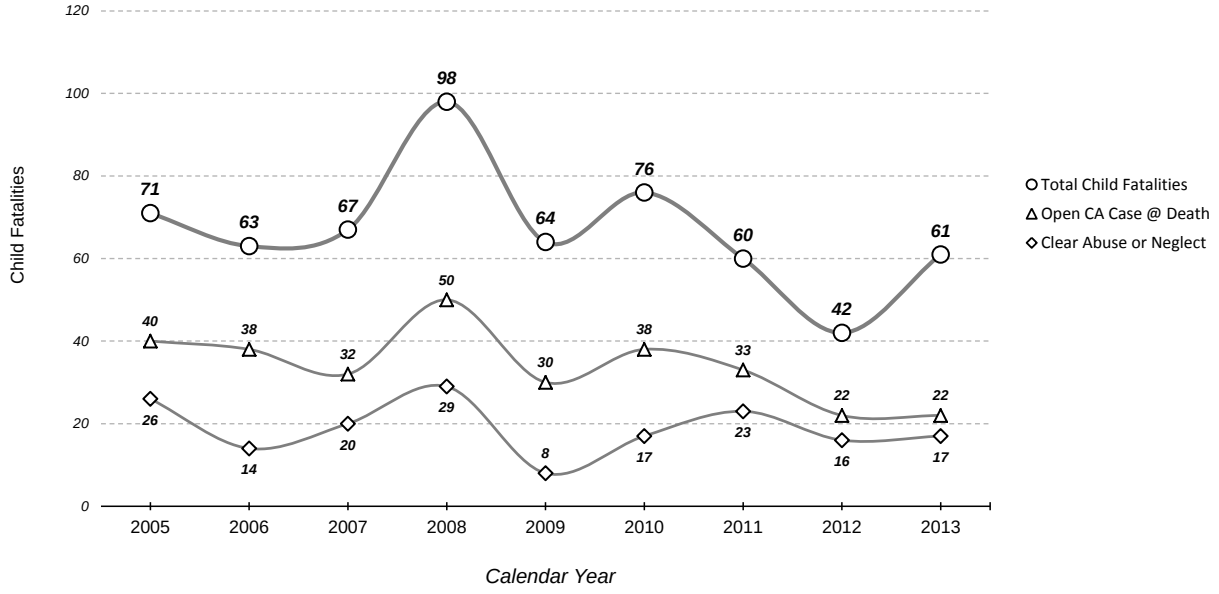
[49] "CA history" may include reports to CPS that were not screened in for investigation.

[50] Like OFCO, CA conducts a brief administrative review of all critical incidents. OFCO conducts a more detailed administrative review of the deaths of children whose family had an open case with CA at the time of death or within one year prior, or whose family was the subject of a CPS report in the year prior. CA also conducts its own internal administrative review of most of these deaths. Neither DSHS nor OFCO reviews child fatalities that were expected due to a medical condition.

CHILD FATALITIES EXAMINED BY OFCO, 2010 – 2013: KEY FINDINGS

- *The vast majority of fatalities related to abuse or neglect—**72.4 percent**—involved children **under the age of 3 years.***
- *Unsafe sleep practices continue to be a leading risk factor associated with infant deaths (77.3 percent).*
- *Fatalities **of Native American and African American children are disproportionally high** relative to their representation in the state population.*
- ***Major risk factors in child fatalities** include **substance abuse** by and/or **mental health problems** of a caregiver; and/or a history of **domestic violence** in the family.*

Figure 11: **OFCO-Reviewed Fatalities by Year**
By Calendar Year (January 1st – December 31st)



In 2013, DSHS CA conducted executive fatality reviews regarding the deaths of 13 children.[51] The department conducts such reviews only when the child's death is suspected to be caused by abuse or neglect. OFCO, however, examines all deaths of children whose family had an open case with CA at the time of death or within one year prior, or whose family was the subject of a CPS report in the year prior. CA conducts its own internal administrative review of most of these deaths also. Neither DSHS nor OFCO reviews child fatalities that were expected due to a medical condition.

[51] CA Child Fatality Review reports are available at: http://www.dshs.wa.gov/ca/pubs/fatalityreports.asp

Infant fatality examined by OFCO, but not meeting criteria for CA Executive Fatality Review

CPS received a report of the death of a three-month old infant while the child's family was receiving CPS Family Voluntary Services. The baby had been placed in bed with the mother, who woke up to find the baby not breathing with some evidence of blood. The autopsy concluded that this was an "undetermined" infant death.

The mother had a significant history of substance abuse. She used street methadone and marijuana during her pregnancy, as well as methamphetamine and a prescription benzodiazepine medication for two months prior to discovering she was pregnant. After entering in-patient treatment, she was prescribed Suboxone[52] , which she was still taking at the time of the baby's death. The father denied drug use and produced clean urinalyses, although a family member reported that he was an alcoholic. There had been two prior CPS reports regarding the family, the last one reporting that the newborn was experiencing withdrawal symptoms due to prenatal substance abuse. The earlier CPS report (a little over a year prior to the birth of this infant) reported that the firstborn child tested positive for methadone and marijuana at birth. The mother was in a methadone treatment program at the time.

The night of the fatality, both parents admitted to drinking alcohol and taking Nyquil. The father had placed the infant in bed with the mother. The infant's death resulted in a "risk-only" report to CPS, and as per CA policy, the CPS investigation did not make a finding regarding abuse or neglect, but rather was focused on future risk to the surviving sibling.

Teen suicide examined by OFCO, but not meeting criteria for CA Executive Fatality Review

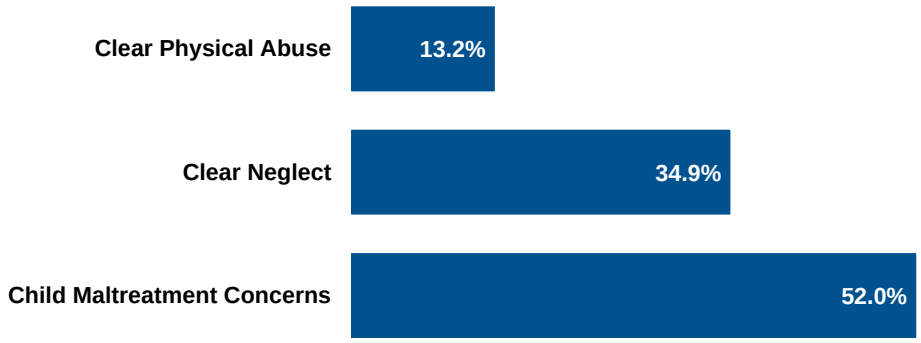
CPS received a report that a 15-year-old youth committed suicide. The report was not screened in for investigation, as no maltreatment was suspected. The youth's family had recently moved to Washington from another state, and had one prior report to Washington CPS less than a month before the youth's death. The reported incident alleged that the father used physical force to get the youth to undergo drug testing, and that the youth ran away. The youth reported to police that he was being abused by his father. The youth had reportedly been taken to the hospital the previous day for evaluation of suicidal ideation. At the time of the youth's death, the CPS investigation of that incident was pending for closure, with an unfounded finding for maltreatment. The CPS investigator found that the family had a history of two prior CPS reports in another state. One involved allegations of domestic violence in the home, and resulted in a "substantiated" finding; the other involved an allegation of physical abuse of the youth by the father and resulted in an "unsubstantiated" finding.

[52] Suboxone treatment is a physician-directed treatment for opioid dependence.

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

OFCO identifies child fatalities that were directly caused by child abuse or neglect, as well as those in which abuse or neglect concerns *contributed to the fatality*. Between 2010 and 2013, child neglect directly caused many more fatalities (53) than physical abuse (20). In 2013 alone, 13 children died as a direct result of neglect, while four children died from physical abuse. OFCO found that child abuse or neglect factors were present and may have contributed to the child's death in an additional 32 cases.

Figure 12: **Fatalities Caused by Child Abuse or Neglect, or in which Child Maltreatment Concerns were Present, 2010 – 2013**
(Total Number of Fatalities = 152)



CHILD MALTREATMENT DEFINITIONS

Clear Physical Abuse: CA records, law enforcement reports, or other documents noted that intentionally inflicted physical injuries caused the child's death.

Clear Neglect: Circumstances of the child's death clearly indicated that neglect by a caregiver (e.g. leaving an infant unattended for 12 hours) caused the child's death.[53]

Child Maltreatment Concerns: Factors associated with child abuse or neglect were present in the family's case history and while not a direct cause, contributed to the child's death. These factors include: substance abuse; domestic violence by the parent in the presence of children; mental health issues that impair a parent's ability to appropriately care for a child; and prior substantiated abuse or neglect of the deceased child or of other children in the family.

[53] In many of these cases, the child's death caused a CPS report to be made, and the CPS investigation resulted in a founded finding for neglect. CA data indicates that 114 deaths resulted in a "founded" finding for maltreatment between 2010 and 2013, 47 of which met the requirements for an Executive Fatality Review (per CA's Quality Improvement Division, reported during conference call on 12/16/2014).

FATALITY CASE EXAMPLES BY MALTREATMENT TYPE

Example 1: **CLEAR PHYSICAL ABUSE**

A three-year-old child was killed as a result of physical injuries inflicted by his mother's boyfriend. The mother had left the child and his 22-month-old sibling in the care of her boyfriend while she went to work a second part-time job. At the end of her shift, the boyfriend contacted her asking that she come home immediately. The mother found the child sitting on the floor complaining of a hurt stomach, and assumed this was due to iron supplements the child had been taking for anemia. After the child began vomiting and unable to walk independently, the mother took the child to the hospital. According to the mother, the child was talkative en route, but became unresponsive by the time they arrived. Medical staff performed cardio-pulmonary resuscitation but the child was later pronounced dead. The autopsy concluded that the death was a homicide caused by blunt force to the head and torso.

A CPS investigation was conducted into the fatality incident. In addition to the above information, CPS found that the child's sibling was covered in bruises around the torso. The mother reported that her boyfriend had been "controlling" and had been aggressive with her and her children in the past, particularly with the surviving sibling. A prior CPS report made by a medical professional almost five months earlier, alleged that the children had received no primary health care (including immunizations) and did not appear healthy (very pale and coughing). The mother was reported to be unable or unwilling to provide health care for the children. Although the report was initially screened in for investigation, the screening decision was subsequently changed to an "alternate intervention response", i.e. for a referral to Early Family Support Services provided by a CA-contracted community agency. The family agreed to voluntary services with this agency, and services were provided over the following two-and-a-half months. The contractor reported good progress, stating in the closing summary that the children "appeared healthy, happy, and clean and bonding with the mother." The CPS case, which had been kept open to allow these services to be provided, was closed five days prior to the fatality.

The CPS investigation into the fatality incident resulted in a finding of physical abuse by the boyfriend, and neglect by the mother. The boyfriend was charged with homicide by abuse.

Example 2: **CLEAR NEGLECT**

A five-year-old dependent child was killed after being hit by a car while crossing the street with the mother and three siblings, ages six, four, and 16 months. The dependency case was established due to drug abuse and repeated incidents of domestic violence by the parents, some of which had resulted in injuries to the children. The children had been returned to the parents almost three months before this fatality. The mother tested positive for methamphetamine at the time of the accident. The father was incarcerated at the time. The CPS investigation conducted into the fatality incident resulted in a founded finding of neglect against the mother.

FATALITY CASE EXAMPLES BY MALTREATMENT TYPE

Example 3: **CHILD ABUSE / NEGLECT CONCERNS**

A two-month-old infant became unresponsive during the night. Police responded to the incident and found the home cluttered with toys and clothes. The mother reported having gone to sleep in the same bed together with the infant and two older siblings, ages four and one year old. The infant was taken to the hospital and later declared clinically brain dead. A CPS investigation of the fatality incident found that the mother had a history of prescription drug abuse, of narcotics prescribed for pain. The mother was also taking prescribed methadone at the time, but her current prescription bottle was empty and the responding police officer suspected that the methadone may have been sold.

There was one prior report to CPS just over three months earlier (during the mother's late pregnancy). The referral alleged that the mother was overusing prescription medications to the point where she would become dysfunctional, reportedly sleeping for many hours at time, day and night. The mother was also reportedly drinking alcohol and smoking marijuana, "partying" on the weekends and leaving the children with friends and family. This CPS referral was screened out and therefore not investigated.

The autopsy determined the infant's death to be accidental, attributed to "asphyxia and overlay." The CPS investigation of the fatality incident resulted in a finding of "unfounded" due to insufficient evidence to support a finding of neglect.

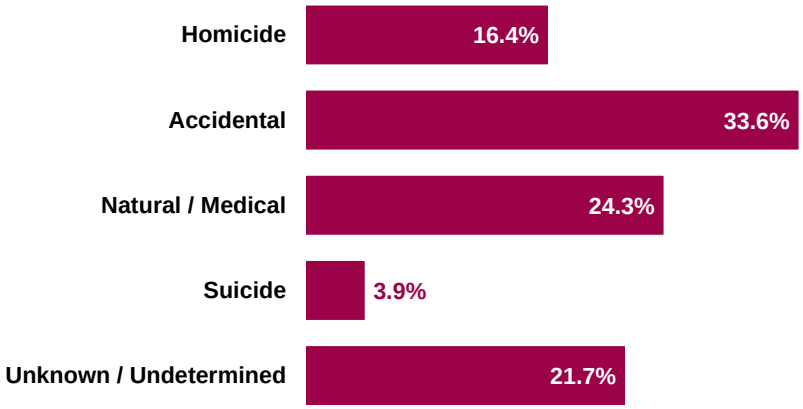
MANNER OF DEATH

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 categories**:

1. natural / medical;
2. accidental;
3. homicide;
4. suicide; or
5. unknown / undetermined.

The 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 and other factors, a death caused by drug overdose could also be determined to be suicide.

Figure 13: **Manner of Death 2010 - 2013**
(Total Number of Fatalities = 152)



Note: Fatalities are reported by calendar year

CHILD FATALITIES AND RACIAL DISPROPORTIONALITY, 2010-2013

Child fatalities directly caused by abuse or neglect, or where child maltreatment was identified by OFCO as a contributing factor, continue to be disproportionally high for Native American and African American children. For example, while Native American children make up two percent of the children in Washington State, they represent more than 23 percent of the child fatalities examined by OFCO. Similarly, African American children make up 4.2 percent of the state's child population yet represent 6.5 percent of the fatalities.

Table 7: **Child's Race and Ethnicity in OFCO-Reviewed Child Fatalities 2010 - 2013**
(Total Number of Fatalities = 152)

	OFCO Fatality Reviews*		Comparison Populations	
	Clear Abuse/Neglect	Maltreatment Concerns	DCFS Placement**	WA State Children***
Caucasian	64.4%	59.5%	62.6%	71.2%
African American	5.5%	7.6%	8.4%	4.0%
Native American	23.3%	20.3%	12.7%	1.7%
Asian or Pacific Islander	1.4%	3.8%	1.6%	7.2%
Other	0.0%	2.5%	0.3%	6.3%
Multiracial	5.5%	6.3%	14.1%	9.6%
Latino / Hispanic	9.6%	7.6%	16.9%	18.8%
Non-Hispanic	90.4%	92.4%	83.1%	81.2%

Note: Fatalities are reported by calendar year

** Includes 2010-2013 child fatalities where maltreatment was identified: clear abuse or neglect (73 cases) or maltreatment concerns (79 cases)*

*** Data reported by Partners for Our Children (partnersforourchildren.org), 2012*

**** U.S. Census Bureau, 2008-2012 American Community Survey 5-Year Estimates*

CHILD'S AGE AT TIME OF DEATH

As in previous years, between 2010 and 2013 an overwhelming majority of fatalities (almost three-quarters) examined by OFCO involved children under the age of three. Infants (children 12 months of age or younger) accounted for almost 60 percent of the fatalities. As in previous years also, the majority of the infant deaths examined are related to unsafe sleep practices (*see Figure 16*).

Figure 14: **Age of Child at Time of Death 2010 - 2013**
(Total Number of Fatalities = 152)

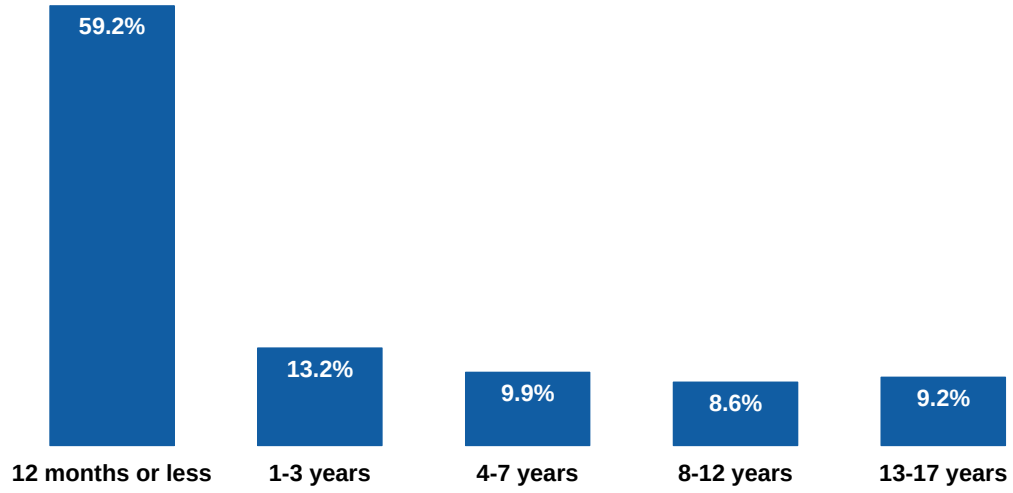
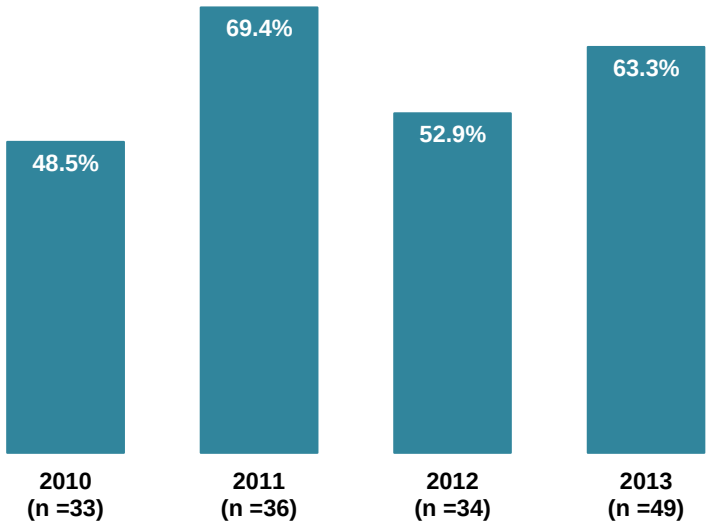


Figure 15: **Fatalities of Infants 2010-2013**
(Total Number of Fatalities = 152)

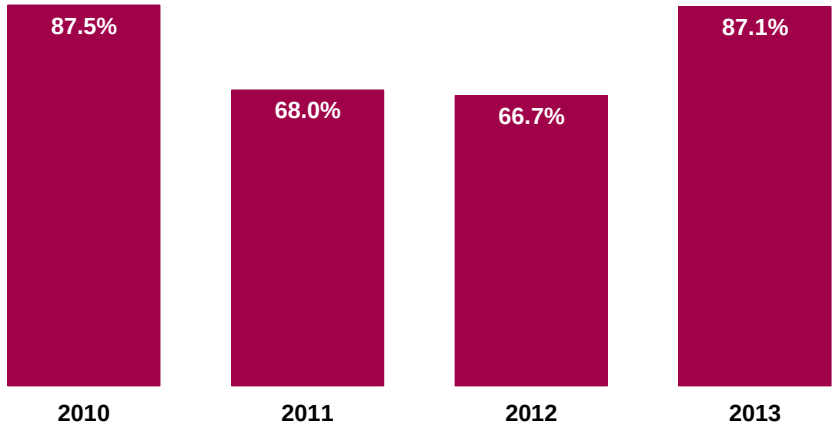


INFANT SAFE SLEEP ENVIRONMENT

An unsafe sleep environment continues to be a major contributor to infant fatalities. Unsafe sleeping practices include: adults, older children, or pets sleeping with an infant; putting an infant to sleep on an adult bed, couch, sofa bed, or other soft surface not designed for an infant; and the presence of soft items such as pillows, blankets or stuffed animals in the infant's crib.

In 2013, the vast majority of the maltreatment-related infant deaths (87.1 percent, or 27 deaths) examined by OFCO involved unsafe sleep practices. Seventeen of these deaths involved a parent or other adult co-sleeping with the child. The average age of infants whose deaths were related to sleep environment was younger than 4 months.

Figure 16: **Unsafe Sleep Environment in OFCO-Reviewed Infant Fatalities 2010-2013**
(Total Number of Infant Fatalities = 90)



Note: Fatalities are reported by calendar year.

UNSAFE SLEEP CASE EXAMPLES

A one-month-old infant died while sleeping on the mother's chest. The mother fell asleep after feeding the infant. The child's two-year-old sibling was also asleep in a high chair nearby. The family was receiving CPS Family Voluntary Services at the time, having had ongoing CPS involvement since the birth of the older child, related to the parent's substance abuse and concerns about neglect of the children. The medical examiner determined the death to be caused by SIDS.

A one-month old infant died while sleeping beside the mother on a futon. The autopsy determined the death was caused by pulmonary distress resulting from airway restriction (accidental). The family had two prior reports to CPS regarding neglect of the mother's older child, age two years. The last report was received just over two months before the infant's death and was closed within 10 days with no founded finding.

A two-month old infant died while sharing a bed with the mother and two siblings, ages two and six years old. The mother had placed the infant to sleep in the bed between herself and the two-year-old sibling. The medical examiner determined the cause of death to be Sudden Unexplained Infant Death (SUID).[54] The family had five prior reports to CPS involving concerns that the children were being neglected, secondary to domestic violence.

[54] Sudden unexpected infant deaths (SUID) are defined as deaths of infants (12 months or younger) that occur suddenly and unexpectedly, in which the cause of death is not immediately obvious prior to investigation. Each year in the USA, about 4,000 infants die suddenly of no immediately obvious cause. About half of these SUID cases are due to Sudden Infant Death Syndrome (SIDS). SIDS is defined as the sudden death of an infant that cannot be explained after a thorough investigation, including an autopsy, examination of the death scene, and review of the clinical history. SIDS is the third leading cause of infant mortality in the USA. Although the overall rate of SIDS in the US has declined by more than 50% since 1990, rates for non-Hispanic black and American Indian/Alaska Native infants remain disproportionately higher than the rest of the population. Center for Disease Control and Prevention, http://www.cdc.gov/sids/aboutsuidandsids.htm

IMPROVING CHILD SAFETY: CHILDREN AGES 0-3 YEARS

Critical incident reviews conducted both by OFCO and CA identify children ages zero to three years as the primary victims of child fatalities and near fatalities. These children are the most vulnerable for maltreatment. CA reports that between 2010 and 2013, 70 percent (84 of 120) of child abuse and neglect related fatalities and near-fatalities were of children under the age of three. The state-wide workgroup (in which OFCO participated) established by CA in June 2013 to improve safety outcomes for this vulnerable group of children has concluded its work, and resulted in **significant policy changes regarding casework practice with families who have an infant**. As of November, 2014:[55]

- for families with newborns, all DCFS and DLR workers **must complete a Plan of Safe Care** if the newborn is substance-affected or born to a dependent youth;
- for families with infants ages 0 to 6 months, all workers **must verify that parents and caregivers have received the Period of Purple Crying** booklet and DVD, and if not, must provide, review and discuss the contents; and
- for families with infants under one year, all workers **must complete a Safe Sleep Assessment**, and engage the parent or caregiver to create a safe sleep environment if one does not exist.

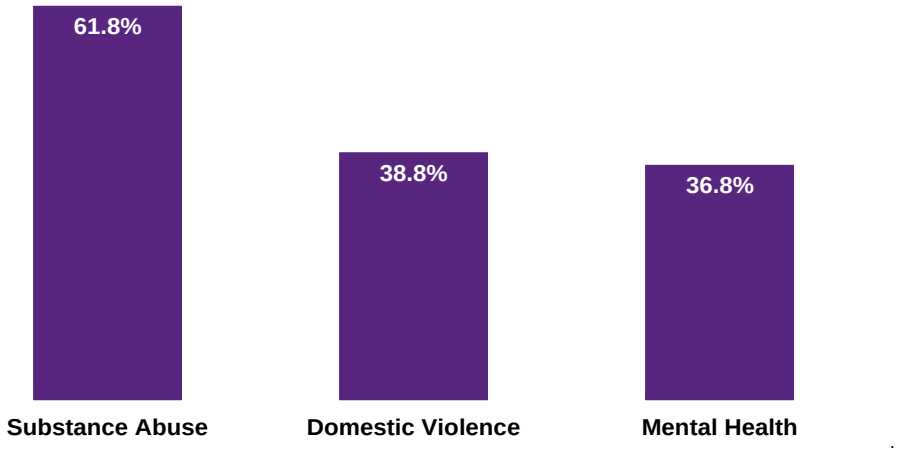
An extensive Infant Safety training titled "Baby 101" has also been incorporated into the core training provided to CA staff through the Alliance for Child Welfare Excellence.[56]

[55] CA Practices & Procedures Manual, Section 1135, Infant Safety Education and Intervention.
[56] Per conversation with Jeff Norman, Health and Safety Program Manager Region 2 South, 11/17/2014. The training is a day and a half in length, a reflection of the importance of this topic in a comprehensive child welfare training curriculum.

FAMILY RISK FACTORS ASSOCIATED WITH FATALITIES

The majority of the children who died (61.8 percent) came from families with a history of drug or alcohol abuse. Domestic violence and mental health issues were also identified as significant risk factors in many of these fatalities. At least one of these three risk factors was present in 82.9 percent of the fatalities examined by OFCO. All three risk factors were identified in 17.8 percent of these child fatalities.

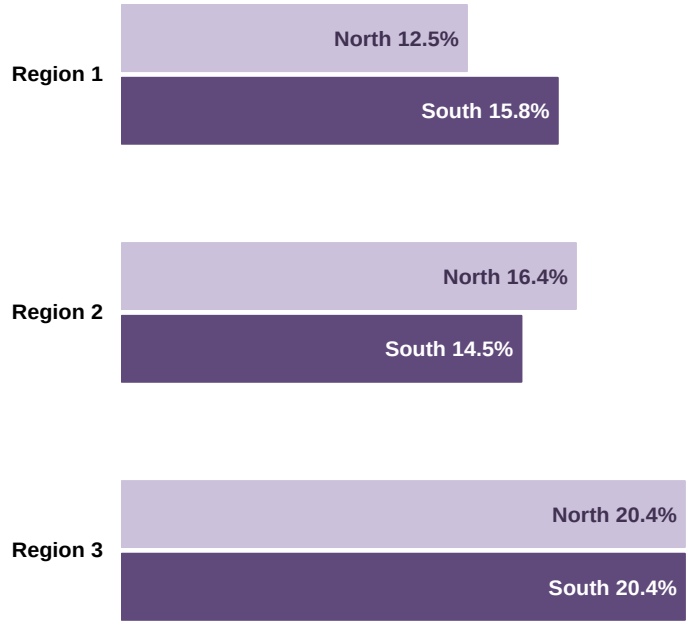
Figure 17: **Family Risk Factors in OFCO-Reviewed Child Fatalities 2010 - 2013**
(Total Number of Fatalities = 152)

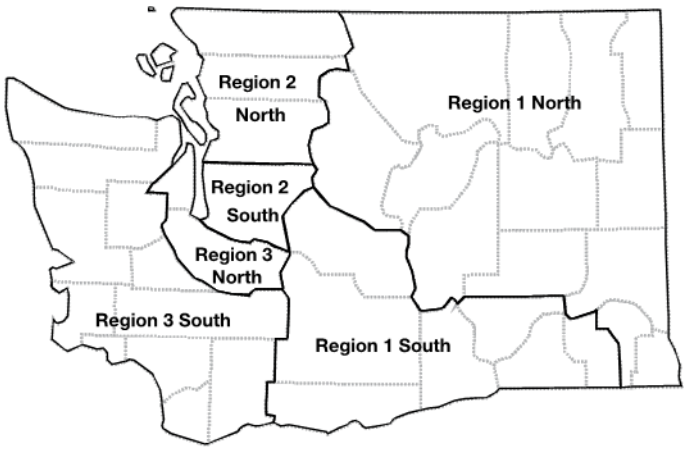


DISTRIBUTION OF FATALITIES BY DSHS REGION

Of the 152 fatalities examined by OFCO from 2010 to 2013, the majority occurred in Region 3 (40.8 percent). Fatalities in Region 1 accounted for 28.3 percent, and in Region 2, 30.9 percent of the total number.

Figure 18: **OFCO-Reviewed Fatalities by Region 2010 - 2013**
(Total Number of Fatalities = 152)





NEAR-FATALITY REVIEWS

State law requires DSHS to notify OFCO of the near fatality[57] of any child who has been in the department's custody, or receiving services from the department, within the last 12 months.[58] DSHS *may* conduct a review of any near fatality at its discretion, or at the request of OFCO.[59] In determining whether to conduct a review of a near fatality, DSHS Children's Administration generally applies the same criteria as mandated for a fatality[60]—that is, CA convenes a near fatality review committee when the near fatality is suspected to be caused by child abuse or neglect and the child received services within 12 months of the near fatality incident. Regardless of whether a near fatality review is conducted, CPS frequently conducts an investigation of the incident to determine whether abuse or neglect occurred, and takes action to protect the child and any other children in the family, where necessary.

OFCO conducts an administrative review of all near fatalities involving child abuse or neglect when the family had an open case with CA at the time of the near fatality or within one year prior, even if the subject child was not the recipient of services from the department.[61] OFCO examines these cases to: identify critical factors and patterns; assist policymakers develop strategies to avoid these tragedies; and to determine whether to request a DSHS near-fatality review.

OFCO examined the near fatalities of 17 children between January 1 and October 31, 2014. Of these, six were selected by DSHS CA to receive a comprehensive Near Fatality Review by a committee.

[57] RCW 74.13.500 defines "near fatality" as "an act that, as certified by a physician, places the child in serious or critical condition."
[58] RCW 74.13.640(2).
[59] Id.
[60] RCW 74.13.640(1).
[61] For example, even if the family had only screened-out intakes within the past year, but no open case, OFCO reviews the intake screening decisions made by CA.

The following are two examples of near fatalities examined by OFCO, but not reviewed through a CA near-fatality review:

NEAR FATALITIES EXAMINED BY OFCO, BUT NOT RECEIVING A CA-CONVENED NEAR FATALITY REVIEW

A 15-year-old dependent youth was hospitalized unconscious after attempting suicide by strangulation. The youth was living in a group home at the time, had experienced multiple out-of-home placements, and had a history of suicidal ideation. OFCO reviewed the near fatality incident as well as recent reports regarding the group care facility, to determine whether lack of supervision of this youth may have contributed to the near fatality. OFCO also reviewed 21 prior CPS reports involving this youth. DLR/CPS conducted a thorough investigation of the concerns that there may have been a lack of supervision of this youth by the facility. Although the finding of the investigation was "Unfounded" for neglect by the facility, several issues and concerns were identified, related to policy and procedures involving youth with suicidal ideation.

A two-month-old infant was hospitalized with a subdural hematoma, requiring brain surgery. The parents had no explanation for the injury, which was suspected to be caused by abuse. CPS had received a report five days earlier, from an anonymous referent, alleging that the infant had bruises on her legs, had a severe diaper rash, was underdressed for the weather and had cried inconsolably for three hours. The parent had reportedly administered three "baby aspirin" to the infant during this time frame. The CPS report had been screened in for an emergent investigation. This was one of two prior reports on these parents; the other report was not screened in for investigation. OFCO reviewed the screening decision on that referral, and the actions taken by CPS following the intake received five days prior to the near fatality. The decision to screen out the earlier referral was appropriate, as it was made while the mother was pregnant with the subject child, and CA's legal authority to accept intakes does not include referrals regarding an unborn child.[62] Regarding action taken by the agency in response to the emergent report screened in for investigation five days prior to the near-fatality, OFCO found that CPS as well as law enforcement had gone to the home the evening the report was received, and found the baby and the home in satisfactory condition. CPS had gone out again the following day and found no evidence to support the allegations made in the referral. It is unclear what further action was planned, if any, but OFCO noted that the assigned caseworker had 12 active investigations open at the time of this referral, and may have had four additional intakes assigned for investigation (including this referral) that day. CA policy regarding caseload size recommends no more than 12 to 15 cases for CPS workers.[63]

[62] RCW 26.44.020 defines a "child" as a person age birth to 18.

[63] See Social Worker Workload report to the Legislature, November 2008, conducted by CA and Washington Federation of State Employees, at http://www.dshs.wa.gov/pdf/ca/SocialWorkerWorkload2008.pdf

CA NEAR-FATALITY REVIEWS

Child near-fatalities offer a learning opportunity for child welfare and other professionals to understand how interventions with families in the context of the child protection system can be more effective in preventing child maltreatment.

CA-convened Child Near-Fatality Review (CNFR) Committees typically include CA staff, OFCO, and community professionals selected from diverse disciplines with expertise relevant to the case, such as law enforcement, chemical dependency, domestic violence, mental health, child health, or social work. Committee members have no previous involvement with the case. The following are two examples of the near-fatality review process and the types of findings and recommendations made in these reviews.

DEPENDENT CHILD PHYSICALLY ABUSED AFTER BEING PLACED WITH OUT-OF-STATE PARENT

A five-year-old dependent child was hospitalized with blunt force trauma, multiple bruises, scratches, cigarette burns, and malnourishment. The child was in critical condition on full life support. The child's non-custodial parent and step-parent were charged with attempted murder. Eight months earlier, the child and a sibling had been removed from their custodial parent due to allegations of child abuse and neglect. At the shelter care hearing, the non-custodial parent, who lived out-of-state, requested placement of the children. Although initial information gathered regarding this parent during a Family Team Decision Meeting and through other collateral contacts did not raise concerns about the suitability of the parent, DCFS requested time to assess this parent through the Interstate Compact on the Placement of Children (ICPC)[64]. The court granted extended shelter care for the children, but the agency later acknowledged that ICPC requirements do not apply to placement of a child with a parent.[65] At the extended shelter care hearing about two months later, the children were placed with the non-custodial parent. The case remained open with DCFS, so that the non-custodial parent could obtain legal custody of the children through family court. No courtesy supervision of the placement was provided by the other state.

Following the children's placement out-of-state, the assigned caseworker began receiving reports from the non-custodial parent and step-parent that the five-year-old exhibited difficult behaviors and was causing a great deal of turmoil in the household, and the agency advised the family to access mental health services. The near fatality incident occurred almost six months after the children were placed with the non-custodial parent.

[64] The Interstate Compact on the Placement of Children (ICPC) is a uniform reciprocal law that governs the interstate placement of foster children. The Compact prohibits states from sending a dependent child to live with an out-of-state caregiver without first obtaining approval from the receiving state's child welfare agency following a home study and other assessments of the caregiver. Washington compact is enacted in Chapter 26.34 RCW.

[65] *In re Dependency of D.F.-M.* , 157 Wn. App. 179, 236 P.3d 961 (2010)

CA convened a Near Fatality Review of this case in August, 2014, in which OFCO participated. The review committee's discussion focused on three core topics:

1. Sufficiency of efforts to gather information about the non-custodial parent

The Committee reviewed and discussed the information about the non-custodial parent gathered by the Department and challenges of vetting placement with an out-of-state parent when ICPC requirements do not apply.

2. The non-custodial parent's legal motion for placement of the children

The Committee reviewed the court transcript and documents related to the court order placing the children with the non-custodial parent, who had no pre-existing relationship with the children. The Committee considered selective bias in the processing of the limited information about the non-custodial parent including: endorsement of this placement by the custodial parent and relatives; and concluding that the non-custodial parent's willingness to travel from out-of-state and participate in court hearings indicates parenting ability and commitment to the children. The committee also noted that the department had few options to oppose placement or assert that the non-custodial parent was unfit.

3. Post-placement activities by the department

The Committee reviewed the efforts by the department to follow-up with the non-custodial parent and to provide case management once the children were placed out-of-state. The committee noted the challenges involved in supervising a child and parent residing out-of-state and arranging any needed services.

Findings from this near fatality review include:

Because the ICPC did not apply, the department was not required or able to conduct extensive vetting of the out-of-state parent. However, inquiries could have been made about this parent's financial situation, employment history, mental health history, and ability to parent a child with significant behavioral issues.

Keeping this case open for the purpose of establishing a parenting plan in family court put the department in an untenable position as the department could not effectively provide services, monitor the placement, or ensure child safety with the children placed out-of-state.

INFANT SUFFERS ABUSIVE HEAD TRAUMA DURING AN OPEN CPS INVESTIGATION

A two-month-old non-dependent infant was hospitalized with a significant brain hemorrhage, bilateral subdural hematomas, and retinal hemorrhages in one eye. The injuries were caused by non-accidental trauma. At the time of the near-fatality, the family consisted of two parents and five children ages zero to five years. A CPS report was screened in for investigation 11 days earlier, alleging that the parents were constantly yelling at the children, and that it sounded as if children were being thrown against the wall by the father. The report also alleged that the home was filled with garbage, maggots, and rodent carcasses. This CPS referral was screened in for a non-emergent investigation, requiring an investigator

to make contact with the family within 72 hours. The family had a history of five prior CPS reports over the previous five-and-a-half years, all alleging neglect of the children. Two of these had been screened in for investigation, with "unfounded" or "inconclusive" findings. During a previous investigation, CPS offered services to the family, but the family declined and the case was closed as the home environment was determined to be acceptable. Two other CPS referrals were screened for an "alternative response", which at that time constituted a letter referring the family to community resources. The remaining report was screened out due to the allegations not meeting the definition of neglect.[66]

Following the recently screened-in CPS report, the assigned caseworker attempted to call the family on the day the report was received, but the contact number was no longer functioning. The worker made unsuccessful attempts to visit the family two days later, and again three days later, leaving a card at the door and on the family vehicle. Although the supervisor twice issued extensions of the 72-hour response time, no additional attempts to contact the family were made prior to the near-fatal incident, which occurred 11 days after the CPS report was received. A CPS intake reporting the near-fatality noted that the infant's father had called 911 because the infant had stopped breathing, and emergency responders described the home as uninhabitable due to piles of garbage throughout the home. All the children were placed into protective custody due to the conditions of the home.

CA convened a Near-Fatality Review to examine the department's practice and service delivery to the child victim and the family. The Committee found that the CPS supervisor failed to follow CA policy regarding the granting of extensions to locate and initiate face-to-face contact with the alleged child victim/s in a CPS investigation. The supervisor is required to review any extension every five business days after it is granted, which was not done in this case. The Committee found that the CPS report in question had been received ten days before Christmas, and both the assigned worker and supervisor began a scheduled vacation the day after the second extension of time to see the child victim had been approved. The Committee recommended that the CA policy regarding extensions of time for face-to-face contacts in CPS investigations should be reviewed with all supervisors in that DCFS office. The committee recognized that this CPS unit was significantly understaffed and experienced high caseloads at the time of the incident, and consequently also recommended that CA management utilize the LEAN process to review how coverage is provided for caseloads and units when supervisors and caseworkers are out of the office.[67]

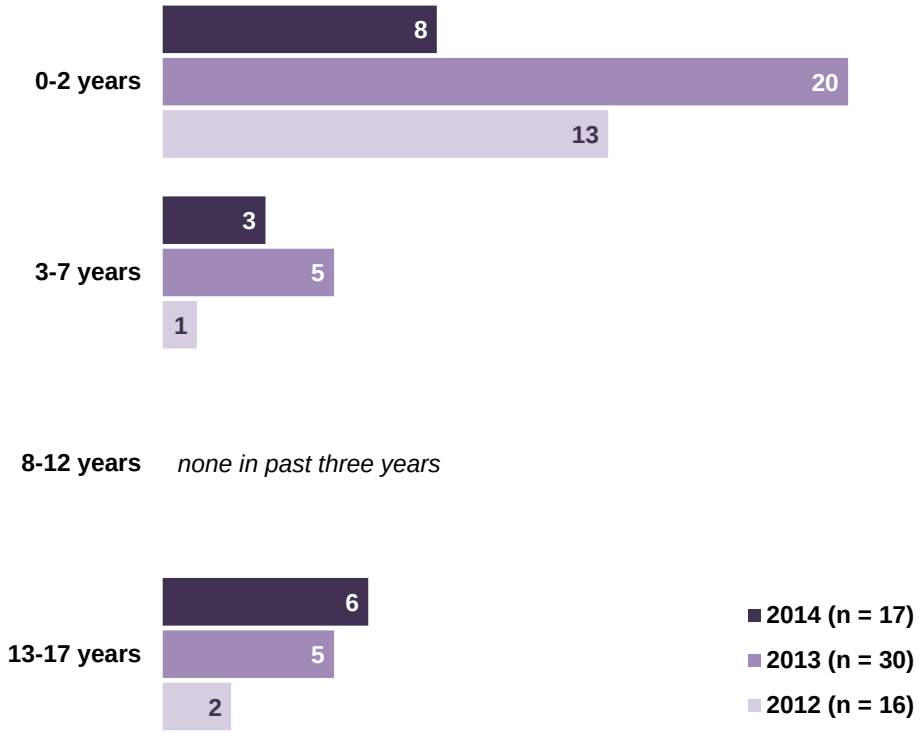
[66] As defined in RCW 26.33.020

[67] The LEAN process provides proven principles that help Washington State government create a culture that encourages respect, creativity and innovative problem solving, continuously improves and eliminates waste from government processes, aligns efforts across state agencies and delivers results that matter to Washingtonians. See http://www.results.wa.gov

CHILD'S AGE AT TIME OF NEAR FATALITY

Nearly one-half of the near fatalities examined by OFCO in 2014 involved children under the age of two years old, and close to two-thirds were under age seven. In contrast to fatalities, where the majority of *fatalities* reviewed of infants are related to unsafe sleep practices, a majority of *near fatalities* of infants are related to physical abuse (often resulting in abusive head trauma). As in the previous two years, none of the near fatalities involved children between eight and twelve years old. Near fatalities of adolescents are often suicide attempts.

Figure 19: **Child Age at Time of Near Fatality**
By Calendar Year for 2012 and 2013; for 2014 data, reporting period is January 1 through October 31.



SYSTEMIC INVESTIGATION: RECURRENT MALTREATMENT

The Children's Administration is required to notify OFCO of all families or children who experience three or more founded reports[68] of alleged abuse or neglect within the last twelve month period.[69] This notification requirement enables OFCO to review potentially 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 and inform practice.[70]

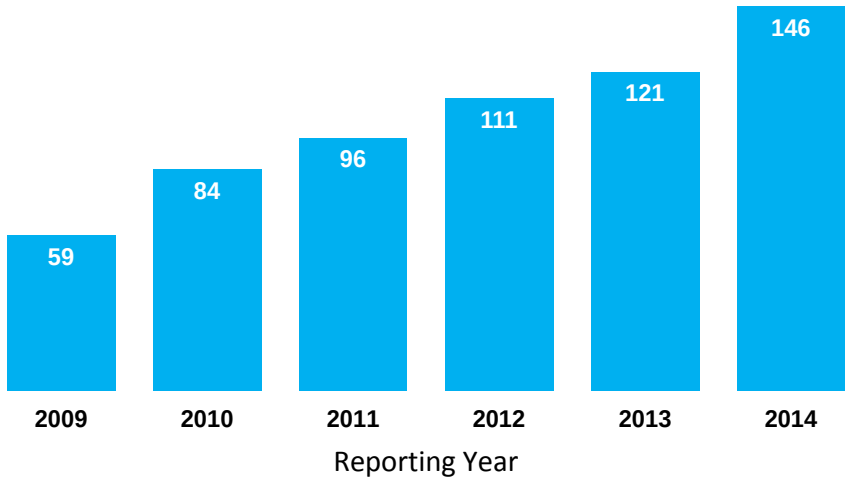
Governor Inslee's *Results Washington* initiative brings increased attention to recurrent maltreatment. A leading indicator under Goal 4 of this initiative, to build "Healthy and Safe Communities" is to decrease the percentage of children with a founded allegation of abuse or neglect who have a new founded allegation within six months, from 7.9% to 6% by December 31, 2015.[71] Although this is a different measure than three or more founded reports within the last twelve months, the common goal is to reduce the number of children experiencing recurrent maltreatment in Washington.

[68] "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). In this context, "report" means a "referral" to Child Protective Services, which DSHS/CA calls an "intake."
[69] RCW 26.44.030(13).
[70] "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.*
[71] http://www.results.wa.gov/whatWeDo/measureResults/documents/communitiesGoalMap.pdf

NOTIFICATIONS OF RECURRENT MALTREATMENT

For the period of September 1, 2013 through August 31, 2014, **OFCO received a total of 146 notifications, an increase of just over twenty percent** from the same period last year. The number of cases meeting the criteria of three founded reports of alleged abuse or neglect within the last twelve month period **has risen substantially since notification began in 2008**. During OFCO's 2009 reporting year, OFCO received a total of 59 notifications—just over 40 percent of the total notifications received in 2014. A variety of factors may have contributed to this increase, including a change in the law which eliminated "inconclusive" determinations of abuse or neglect by child protective services.[72] The implementation of CA's differential response system, Family Assessment Response (FAR), which began in 2014 in pilot sites and will continue to be implemented statewide through 2016, has as yet had no impact on the steady increase in recurrent maltreatment.[73]

Figure 20: **Notifications of Recurrent Maltreatment**
By Reporting Year (September 1st - August 31st)

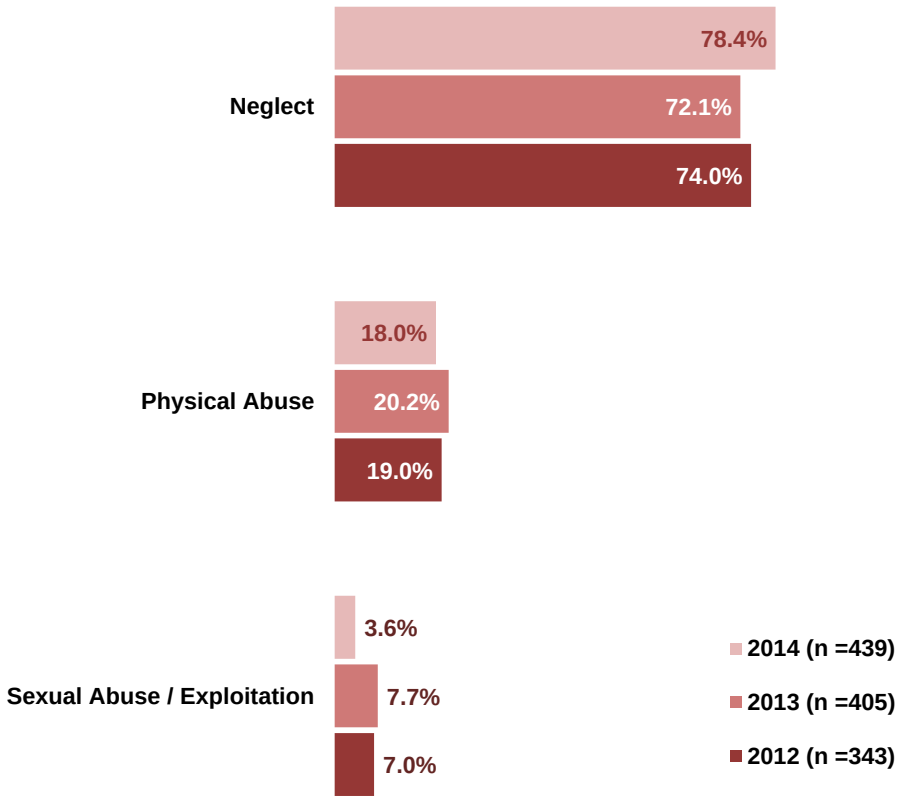


[72] RCW 26.44.020(10); WAC 388-15-005.
[73] RCW 26.44.260.

TYPE OF CHILD MALTREATMENT IN RECURRENT MALTREATMENT CASES

The graph below summarizes the type of maltreatment substantiated in the first, second, and third founded reports.[74] **Consistent with previous years, neglect is—by far—the most common type of maltreatment experienced by children in these recurrent cases**, comprising 84.9 percent of all founded reports reviewed by OFCO.

Figure 21: **Type of Child Maltreatment**
By Reporting Year (September 1st - August 31st)



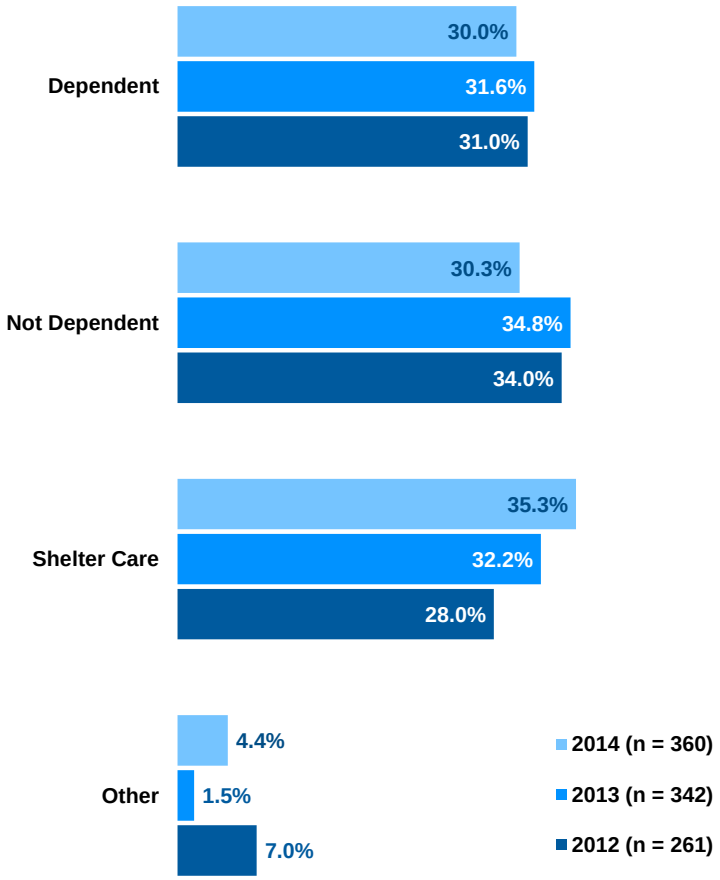
While it is encouraging to see a decreasing trend in recurrent sexual abuse of children, as well as a slight decrease in recurrent physical abuse, neglect continues to be the most likely recurring type of maltreatment of children in our state child welfare system.

[74] 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 Child Maltreatment."

AGENCY ACTION: LEGAL STATUS OF CHILDREN AT TIME OF NOTIFICATION

For almost two-thirds (65.3 percent) of the cases reviewed, the agency had already taken affirmative legal action – either through an in-home or out-of-home dependency – to ensure the safety of the children who were the victims of three or more founded reports.[75]

Figure 22: **Legal Status of Children** [76]
By Reporting Year (September 1st - August 31st)

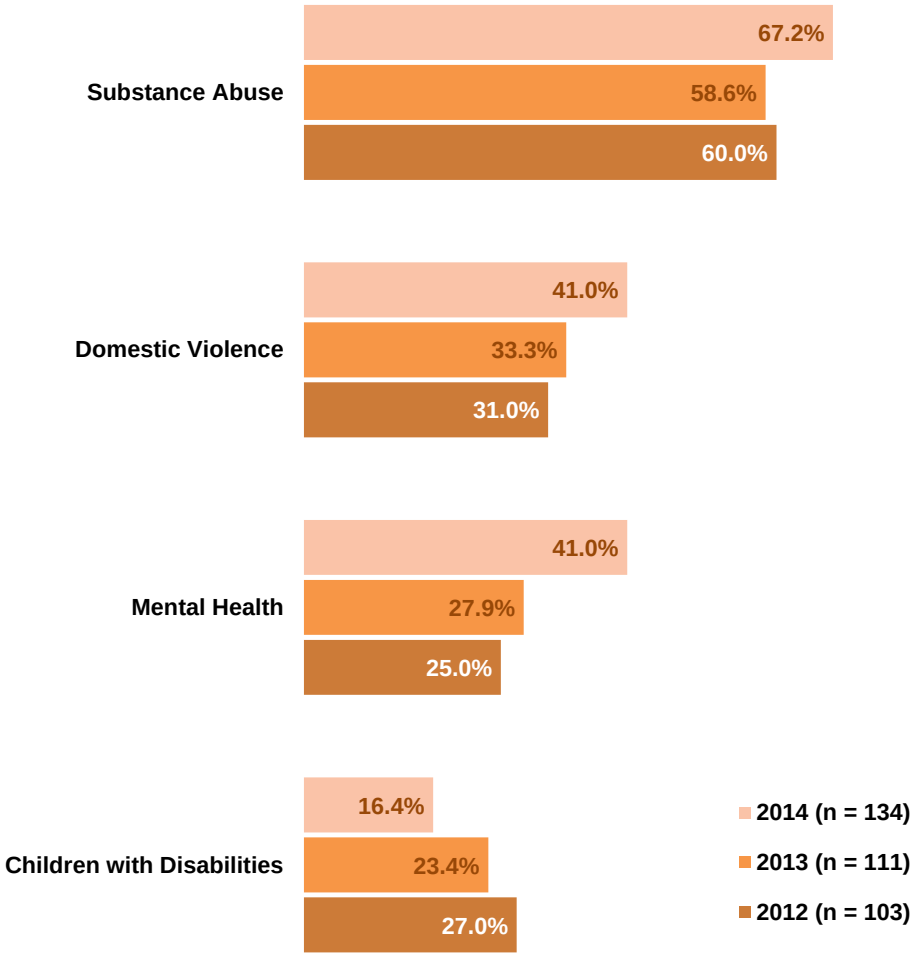


[75] Because of the time lag between when CPS receives an intake and when OFCO is notified of the third founded report, when the CPS investigation is complete, CA has usually has sufficient time to determine whether or not legal action will be taken.
[76] "Other" category may include: voluntary placement agreement; Child in Need of Services; or At Risk Youth proceeding.

RISK FACTORS IN RECURRENT MALTREATMENT CASES

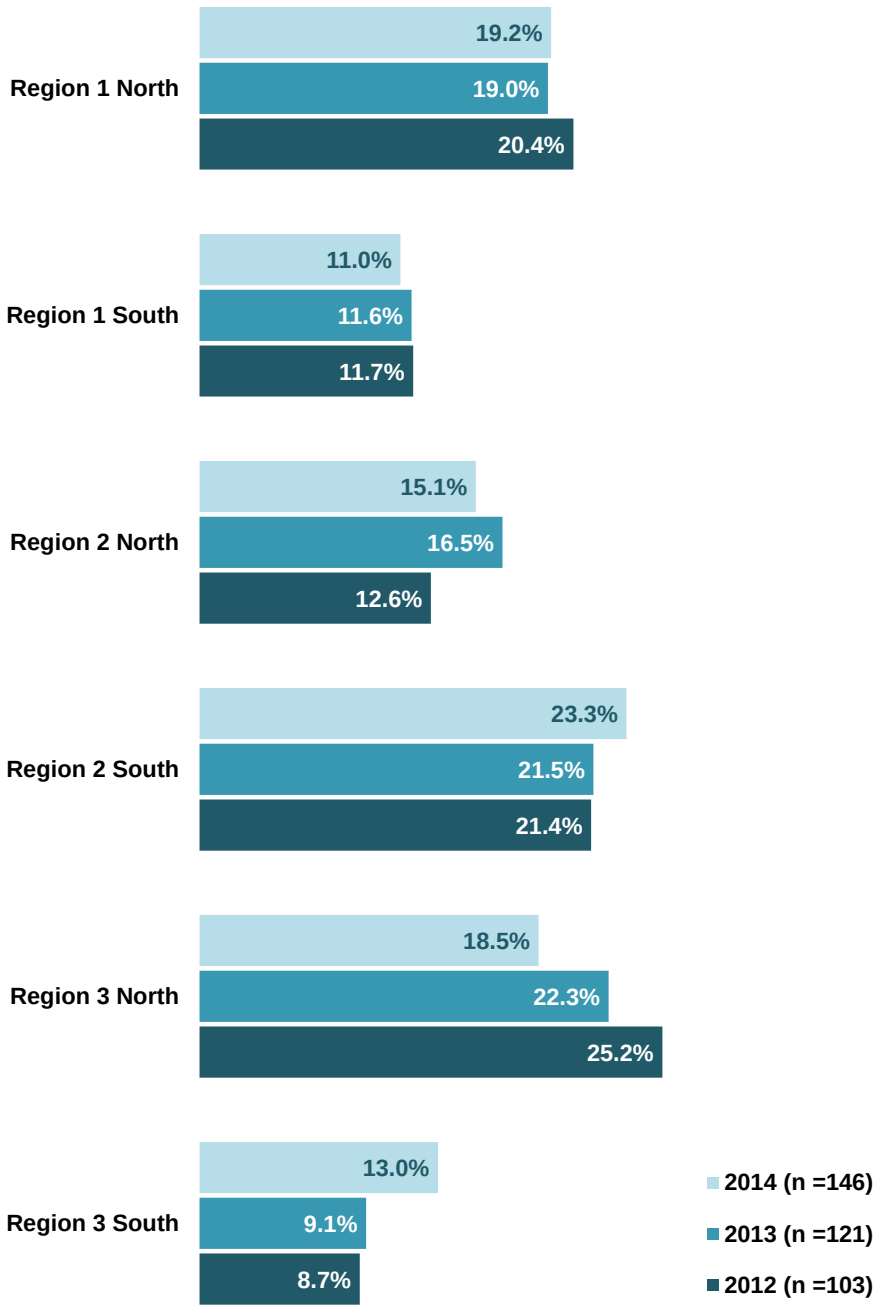
Caregiver substance abuse is consistently the most prevalent risk factor associated with children experiencing recurrent maltreatment cases – substance abuse was identified as a factor in **over two-thirds of cases. Domestic violence** and **mental health problems** of a caregiver continue to be the other two strongest risk factors associated with recurrent maltreatment, while **over one in seven cases** indicated the presence of **all three of these risk factors (i.e. substance abuse, mental health, and domestic violence)**. A fourth risk factor prevalent in these cases is that the child victim of maltreatment has a disability. In contrast to the three most common risk factors, which have increased steadily in these cases in the last three years, the number of cases involving a child with a disability has decreased, from over a quarter of cases in 2012 to 16.4 percent of cases in 2014.

Figure 23: **Family Risk Factors**
By Reporting Year (September 1st - August 31st)



RECURRENT MALTREATMENT CASES BY DSHS REGION

Figure 24: **Recurrent Maltreatment by Region**
By Reporting Year (September 1st - August 31st)



OFCO Adverse Findings in Recurrent Maltreatment Cases

OFCO carefully reviews each of the recurrent maltreatment cases to identify trends as well as case-specific or systemic practice issues. In some cases, OFCO will contact the agency to correct a problem or request or suggest action to better ensure the safety or well-being of the children. OFCO did not intervene in any cases of recurrent maltreatment during this reporting period. When intervening with the agency to change a problematic action or inaction is no longer feasible, OFCO can make an adverse finding to bring the concern to the attention of agency management. In 2014, OFCO made adverse findings **in two of the recurrent maltreatment cases** reviewed, as described below.

CPS Failure to Locate Young Victims of Reported Neglect Delays Protective Action

OFCO FINDING

Violation of Policy & Procedure: DCFS Child Protective Services (CPS) failed to conduct the initial face-to-face contact with the alleged child victims within the required investigative timelines, and there was no extension granted by the supervisor.

CPS received four reports over an approximately 40 day period alleging neglect of two non-dependent children, ages 14 months and 4 months, by their mother. CPS accepted the first intake for investigation with a response time of 72 hours. Thereafter, two extensions for the initial face-to face contacts were granted by the supervisor because CPS was unable to locate the two children due to the family reportedly moving. Case notes indicate that the initial face-to-face contacts with the two children occurred 15 days after the first intake was received. The children were in the care of a babysitter at that time.

A month following this report, CPS received a second report, screened in for investigation within 72 hours. The referrer, the mother's roommate, reported that the mother does not feed the infant and toddler enough and ignores their cries of hunger. Four days later, a different CPS investigator attempted to locate the children, but no one appeared to be home.

Six days after the second intake was received, CPS accepted a third intake for investigation, also within 72 hours. The referrer, a frequent babysitter of the children, reported that the infant was spitting up a lot and looked underweight, with his rib cage visible. The referrer described the infant as "skin and bones."

Three days later, CPS accepted a fourth intake for investigation, again within 72 hours. This time, law enforcement had temporarily placed the children with their grandparents after finding the mother drinking with underage friends outside the home, while the children were unattended in a dark room in the home. Law enforcement noted that there was no power or heat in the home, and the refrigerator was filled with rancid food, and a bottle was found with very little formula.

The assigned CPS investigator made initial face-to-face contact with the children at the maternal grandparents' home two days after the fourth intake was received. The case record documented that at that time, "the infant appeared to be somewhat thin and the social worker observed him to be spitting up frequently." The grandparents were also concerned that the infant appeared to have lost weight since last residing with them and said the infant's stiff, curled up position caused concern that he'd been left in [a] car seat."

No extensions were granted for the initial face-to-face contacts for the second and third intakes received despite the fact that initial contact was not made with the victims until 11 days and 5 days respectively, after the intakes were received, leaving an infant and toddler at serious risk of ongoing neglect.

CA RESPONSE

CA did not respond to OFCO's notification of this adverse finding.

CPS Fails to Assess Child Safety after Receiving a New CPS Report in an Open Case

OFCO FINDING

Poor Practice: CPS failed to conduct home visits or any other follow up with a family involved in two open CPS investigations of neglect allegations, after receiving a new CPS report that the mother had given birth to another child.

In July 2013, CPS initiated two investigations into allegations that the mother of an 8-year-old non-dependent child was leaving the child home alone for long periods of time. Similar allegations had been investigated and founded for neglect a year earlier.. The law enforcement report from these incidents indicated that the mother's partner is a registered sex offender due to a conviction for child molestation. The case note documenting the CPS investigator's initial face-to-face interview with the 8-year-old child and subject interview with the mother indicated that she was pregnant with a due date in mid-August 2013.

In mid-August, the investigator spoke with the 8-year-old child's father, who expressed deep concern about his son as the mother had told him that she was relying solely on donations for her livelihood. Several days after this conversation, CPS received a referral from a hospital social worker alleging that: the mother had given birth; the father of the newborn was a registered sex offender; the mother admitted to having an open case with CPS; and that the CPS case had been closed because she had a babysitter for her 8-year-old. This intake was not screened in for

investigation. The CPS investigator closed the two open investigations as "Founded" for neglect, noting that leaving the child unsupervised for long periods of time "seems to be an ongoing issue."

OFCO found that CPS made no attempt to contact the family after receiving a new report from a mandated reporter, to assess and address safety concerns related to ongoing child neglect, the birth of a new baby, and the presence of a registered sex offender in the home. OFCO determined that this was clearly unreasonable under the circumstances and notified CA of this adverse finding.

CA RESPONSE

The Area Administrator responded by informing OFCO that "I have reviewed this case and have met with the supervisor and social worker regarding OFCO's adverse finding. Beginning in October 2013, the office implemented a quality assurance practice measure regarding intakes and child safety to ensure that all screened out intakes are reviewed by the CPS supervisors and a case note entered regarding the screening decision; previously, the field CPS supervisors reviewed only screened in intakes. Since arriving in [this] office, I have been made aware of practice areas needing improvement around child safety. I have reviewed cases of concern and recognize the areas of concerns with the ongoing assessment of the health and safety of the child, and the newborn child during the investigation of this open case.

[The above practice change] will allow supervisors to discuss with their workers all screened out intakes on open cases, further assess the safety of children in these homes, and document these efforts and decisions. It is anticipated that this change will also ensure supervisor review of practices such as those identified in this adverse finding.

This office is committed to providing high quality CPS interventions and partnering with parents, caregivers and the community to serve the needs of children and families."

PART THREE
IMPLEMENTATION STATUS OF CHILD FATALITY AND NEAR FATALITY REVIEW RECOMMENDATIONS 2012-2014

INTRODUCTION

The Department of Social and Health Services (DSHS) Children's Administration (CA) conducts a child fatality review when the death of a child was suspected to be caused by child abuse or neglect, and the child was in the care of or receiving services from DSHS/CA at the time of death, or in the year prior.[77] If it is not clear whether a child's death was the result of abuse or neglect, the department must consult with the Office of the Family and Children's Ombuds (OFCO) to determine if a review should be conducted. The CA Assistant Secretary convenes an Executive Child Fatality Review (ECFR) team comprised of professionals with relevant expertise who have no prior involvement in the case. Additionally, the department may conduct a review of any near fatality at its discretion, or at the request of OFCO.[78]

The purpose of reviewing child fatalities and near fatalities is to increase the agency's understanding of the circumstances around the child's injury or death and to evaluate practice, programs and systems to improve the health and safety of children.[79] DSHS must issue a report on child fatality review results within 180 days following the fatality, unless granted an extension by the Governor.[80] These reports are subject to public disclosure and must be posted on the department's public website. The department is authorized to redact confidential information contained in these reports to protect the child's privacy.[81]

The recommendations made by representatives from the community, OFCO, and Children's Administration participating in child fatality and near-fatality reviews are forwarded to a Children's Administration's administrator or Children's Administration's Continuous Quality Improvement Committee for review and prioritization. At regular intervals, administrators are required to report on the progress of implementing a recommendation or provide a written response when a specific recommendation was not implemented.[82] In order to promote accountability and the consistent implementation of recommendations from fatality reviews, the Ombuds is required to issue an annual report to the Legislature on the implementation of recommendations made in child fatality reviews.[83]

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[77] See RCW 74.13.640. Prior to the passage of SHB 1105 in 2011, CA was required to review any unexpected deaths of children who were in the care of or receiving services from CA, or had received care or services in the last year.
[78] RCCW 74.13.640(2)
[79] See DSHS CA Operations Manual, Section 5200 at http://www.dshs.wa.gov/ca/pubs/mnl_ops/chapter5.asp#5200
[80] Id.
[81] Individual child fatality reports are available at: www.dshs.wa.gov/ca/pubs/fatalityreports.asp.
[82] Per conversation and e-mail received from CA Program Manager Ronda Haun, 12/17/2014.
[83] RCW 43.06A.110. OFCO reports are available at: www.ofco.wa.gov

This report describes the implementation status of recommendations made in child fatality reviews and near fatality reviews conducted by the Children's Administration (CA). During this reporting period, from January 1, 2012 to April 31, 2014, CA completed 32 fatality reviews of the deaths of 33 children. These reviews resulted in 72 recommendations. Additionally, CA conducted 17 near fatality reviews resulting in 47 recommendations. Some of these recommendations aimed to address state-wide issues, while other recommendations were tailored to remedy regional or local office concerns. Based on information provided by CA, OFCO found that 68 percent of the recommendations were either completely implemented or in the process of implementation, while 25 percent were considered, but not implemented.[84]

Table 8: **Implementation Status of Child Fatality and Near Fatality Review Recommendations**

	Statewide	Region	Office	Total	
Implemented	37	2	12	51	43%
Implemented by Legislature	2	-	-	2	2%
In Process	25	5	3	33	28%
Not Implemented	33	-	-	33	28%

As in past years, the most prominent topic areas identified by fatality recommendations were:

- ✓ Training for caseworkers, supervisors, or community professionals (36 percent of recommendations);
- ✓ Casework practice (29 percent of recommendations); and
- ✓ Partnerships with community professionals (13 percent of recommendations).

Part I of this report takes a closer look at recommendations concerning these three major themes:

- Training;
- Casework practice; and
- Partnerships with community professionals.

Part II examines why certain recommendations were considered, but not implemented.

Part III discusses select recommendations worthy of further consideration

[84] No implementation status was reported for five percent of the recommendations, and two percent of the recommendations were reported as "not yet considered".

PART I: MAJOR THEMES IDENTIFIED IN RECOMMENDATIONS

The majority of recommendations aimed to improve training, casework practice or CA's partnerships with community professionals. Training topics identified in recommendations include: safety assessment and planning; domestic violence; and mental health/chemical dependency. Recommendations regarding casework practice spanned a wide range of topic areas and appeared to be more challenging to implement. Recommendations addressing CA's partnerships with community professionals identified the need to improve communication and clarify roles and responsibilities between CA and community partners such as law enforcement, medical facilities, other state agencies and Native American Tribes. Most of these recommendations are reported to have been implemented or are in the process of implementation.

A. Training for Caseworkers, Supervisors or Community Professionals

Forty-three recommendations (36%) address training issues for caseworkers, supervisors or other professionals involved with the child welfare system. Thirty-six of these recommendations have been implemented or are in the process of implementation. Seven recommendations were considered, but not implemented. As discussed below, many of the training recommendations concerned the same topic. The most prevalent training topics identified in these recommendations were: Safety Assessment and Planning; Domestic Violence; and Mental Health/ Chemical Dependency.

Safety Assessment and Planning- Sixteen recommendations identify the need for increased training on child safety assessment and planning. Fifteen of these recommendations have been implemented or are in the process of implementation. One recommendation regarding training of foster parents was considered, but not implemented. Common themes in these recommendations are:

- Social workers should demonstrate a strong understanding of the safety assessment and safety planning process at the completion of Regional Core Training, and prior to carrying cases. Social workers should also receive an annual refresher training regarding safety planning. -*Completed*
- Training should emphasize the importance of gathering information throughout the life of a case when assessing and planning for child safety. A review of the Child Safety Framework should be provided to all staff. –*In Process*
- Provide infant safe sleep training to CA staff. The training curriculum should be standardized and include information on how to evaluate an infant's sleep environment, how to engage caregivers in a discussion about safe sleep, and risk factors known to increase the risk of Sudden Unexpected Infant Death (SUID) and Sudden Infant Death Syndrome (SIDS). -*Completed*
- Develop a concise guide of what to look for when completing an initial home visit and subsequent health and safety checks. –*In Process*
- Develop and provide social workers and foster parents with training on the risk and prevention of childhood injuries. –*Training for SW- In Process; -Training for foster parents- Not Implemented*

Domestic Violence- Because of the high co-occurrence of domestic violence and child maltreatment, the identification of domestic violence is critical when making case decisions intended to increase safety for children. Six training recommendations focus on the need for training on domestic violence. All six of these recommendations are reported to be either implemented or in the process of implementation. Specific issues identified in these recommendations include:

- Invite a local domestic violence advocacy center to join CPS at a unit meeting and discuss the different forms and patterns of domestic violence. -*Completed*
- Provide on-going training and regular consultation on domestic violence for social workers in addition to existing training on how to use the *Children's Administration's Social Worker's Practice Guide to Domestic Violence. –In Process*
- Invite a team of professionals from a variety of disciplines such as law enforcement, medicine, mental health and domestic violence to participate in the development of a training curriculum and to participate at training events. The training should also promote the benefit of partnerships between CA and domestic violence agencies and encourage social workers to consult with domestic violence advocates when working with families impacted by domestic violence. –*In Process*

Mental Health and Chemical Dependency- Five training recommendations concern mental health or chemical dependency issues. Four of these recommendations are reported to be either implemented, or are in the process of implementation. One training recommendation concerning safety inspections of secure time out rooms in licensed facilities has not been implemented. The department reasoned that there are only three facilities statewide using secure time out rooms and safety issues are addressed through the administrative licensing process. Common topics regarding mental health and chemical dependency training are:

- Trainings should emphasize the need to include detailed collateral information when making a referral for mental health or chemical dependency assessment or treatment. –*In Process*
- CA should review the existing substance abuse training curriculum to ensure staff receive current information about methadone and assessing the safety of young children in the care of methadone using (prescription or illicit use) caretakers. -*Completed*

B. Casework Practice

Thirty-five recommendations aim to improve casework policies, procedures or practices. Seventeen of these recommendations are reported to be implemented or in the process of implementation. Sixteen recommendations have not been implemented and no implementation status was reported for two recommendations. These recommendations touch on a wide range of topics such as: procedures for conducting home studies; storage of prescription medications in unlicensed homes; rules and policies regarding water safety in foster homes; and the appeal procedures for a finding of child abuse or neglect. While casework practice recommendations do not readily fall into specific categories, more than one recommendation concerned:

- Caseloads- the assignment, supervision, staffing, weighting difficult cases, and coverage of cases. –*Not Implemented*
- Prioritize the hiring and retention of social workers, and particularly Spanish speaking workers. *-Completed*
- Background Checks- Easier access to a subject's criminal history and prior contacts with law enforcement. –*Not Implemented*
- Documentation of the worker's case activities. *-Completed*
- Locating Chemical Dependency Professionals in CA field offices to provide case consultation, guidance for client engagement, and information on community resources. – *Not Implemented*

Two casework practice recommendations address concerns frequently identified in OFCO complaint investigations and relate to case planning and decisions whether to place a child with a parent. The first recommendation aims to improve placement decisions at shelter care, when there is little information, positive or negative, about an out-of-state parent's ability to care for a child.

Recommendation: *"More guidance is needed for workers with cases involving non-offending out-of-state parents not under an ICPC but who are placement options for their non-dependent child involved with DCFS. It is recommended that CA, in collaboration with legal consultation with the AGO, develop guidelines to provide clarity as to (1) what system search activities are authorized, (2) what other strategies for information gathering may be used (e.g., internet searches, social media sources), and (3) what other criminal and CPS history should be sought."*

CA Response: -*In Process "This recommendation is being reviewed and considered at this time. ICPC Program will review with AAG."*

The second recommendation relates to case planning and placement decisions when a child suffers non-accidental injuries and it is unclear if one or both parents are responsible.

Recommendation: *"In conjunction with representation from the State Attorney General's Office, CA should review how the department proceeds with recommendations to the court in cases where one or both parents are believed to have caused a serious non-accidental injury to a young child and for which no accountability is established. While the Committee concludes that the department should not generally recommend reunification in such cases, it is open to the development by CA of more precise guidelines for such decisions."*

CA Response: -*In Process "Will discuss this with AAG."*

C. Partnerships with Community Professionals

Sixteen recommendations discuss the need to strengthen communication and partnerships with community professionals, other agencies (both public and private), and Tribal governments. Most of these recommendations address improved communication, sharing of information, and clarifying roles and responsibilities. Ten of these recommendations have been implemented, five are in process, and one was considered, but not implemented. These recommendations aim to:

- Improve communication and coordination between the department and local law enforcement when there is a dependency or CPS case and a related criminal investigation. – *Completed*
- Update or establish a formal Memorandum of Understanding between Native American Tribes, and Children's Administration, to enhance coordination and cooperation between the Tribes and CA, and to clarify the roles and responsibilities of tribal social services and CA social workers. –*In Process*
- Improve information sharing between CA and private organizations such as child placing agencies, and medical facilities. –*Completed*
- Update a working agreement between CA and the Department of Corrections to establish protocols for issues such as: case staffing, eligibility screening for services, child caretaking arrangements for pregnant inmates, information sharing between CA and DOC, and the roles and responsibilities of CA and DOC staff. –*Completed*

Table 9: **2012- 2014 Child Fatality and Near Fatality Review Recommendations by Topic** [85]

Provide Training	43	36.1%
Effective Interventions with Families	1	0.8%
Intake Screening Decisions	1	0.8%
Safety Planning and Risk Assessment	9	7.6%
Casework Practice	35	29.4%
Community and Family Education	1	0.8%
Effective CPS Investigations	5	4.2%
Partnerships with Community Professionals	16	13.4%
Child Fatality Investigations and Reviews	2	1.7%
Services / Other	6	5.0%

[85] Previous reports have organized recommendations under these categories.

PART II: RECOMMENDATIONS CONSIDERED BUT NOT IMPLEMENTED

Twenty-eight percent of all child fatality and near fatality recommendations were considered by CA, but not implemented. OFCO examined each of these recommendations to determine why, and found that most often this was either due to: workload, insufficient resources or lack of funding; the recommendation being inconsistent with law or policy; already in place; or not considered a priority.

Listed below are some of the recommendations considered, but not implemented for these reasons.

A. Workload, Insufficient Resources, or Lack of Funding

Recommendation: *"At the time of initial licensing and licensing renewal, require foster parents to complete training on the risk and prevention of childhood injuries. The Committee recommends the training include information on the proper use of safety equipment such as bicycle helmets, car seats and personal flotation devices."*

Agency Response: *"The department does not have the capacity to require this of all providers. Recommendation is being forwarded to the Alliance as a suggested in-service training or on-line training available to satisfy in-service training requirements. We have also identified some reputable websites with good childhood injury information and those hyperlinks have been uploaded to the DSHS Foster Parent website."*

Recommendation: *"Currently, CA policy provides CPS social workers with discretion in deciding when to access the National Crime Information Center (NCIC) database for subjects of CPS investigations and other adults related to an investigation. The Committee recommends, if permissible by law, a change in policy to require social workers to access the National Crime Information Center (NCIC) database during the course of a CPS investigation."*

Agency Response: *"At this time, there are insufficient resources in the NCIC unit to provide for the existing demand of Purpose Code C requests. Requests are approximately 5 days out for a worker to receive a response. If there were more resources to support the demand, this could be implemented."*

B. Recommendation Inconsistent with Law or Policy

Recommendation: *"The Committee recommends WAC 388-148-0120 require foster parents, private agency licensors, and case managers to report incidents as soon as they have reason to believe a child is experiencing suicidal ideation or attempted/completed suicide. All reports should be made to the child's assigned social worker, CA intake, and the private agency case manager if a child placing agency program places the child."*

Agency Response: *"The purpose of a report to intake is to refer for an investigation. This may result in either a CA/N investigation or a licensing investigation. An intake of this nature would screen out for investigation. An appropriate plan regarding a youth with suicidal ideation should be made directly to the social worker, who can develop the appropriate response plan. The licensor would defer to the child's social worker who is aware of the dynamics of the case and the specific needs of the child."*

Recommendation: *"CA is encouraged to re-assess and consider modifying the Child Safety Framework safety plan policy that does not currently allow a child to remain in relative care with a safety plan if a safety threat meets the criteria of an "unsafe child." There may be situations in which a Safety Plan could be initiated within the relative home so that placement disruption (whether temporary or longer term) does not need to immediately occur."*

Agency Response: *"Safety plans are not created in out of home care situations."*

C. Recommendation Addressed Through Current Policies and Practices

Recommendation: *"CA should incorporate the following practice issues into any future "Lessons Learned from Child Fatalities" presentations for CA staff: (1) making purposeful effort to find out why a parent does not have care and/or custody of other biological children, including making contact with the custodial parent or relative caregivers; (2) giving deliberate consideration to referring a marijuana using parent for substance abuse assessment when that parent has any past diagnosis for substance abuse/chemical dependency issues, especially if they co-occur with mental health and DV issues."*

Agency Response: *"LL does emphasize comprehensive investigations that would address these issues."*

Recommendation: *"The Committee believes WAC 388-148-0205 should be modified to specify all medications be kept in a locked container or another storage area made of strong, unbreakable material when not in use similar to the WAC for firearm and ammunition storage."*

Agency Response: *"The WAC concerning guns was written in the manner it was written, such that glass display cases are not used for gun storage. The WAC written requires locked storage for medication, this naturally would be made of a strong material. The medication in this case was in a locked file cabinet, which would qualify both as a locked container, as well as a container of strong unbreakable material. DLR would not allow a locked medication box that could be easily broken."*

D. Recommendation Not Considered a High Priority

The following recommendations were "not ranked as priority" by the department.

Recommendation: *"Pre-CAPTA appeals should be reviewed and approved at a level higher than an Area Administrator when the subject of the finding is appealing so they may provide care for children of vulnerable adults. If a pre-CAPTA founded finding is reversed the electronic record should include the reason for the reversal."*

Recommendation: *"Children's Administration should provide a written reminder to all case-carrying social workers about case transfer protocols. The reminder should address both transfers between social workers working in the same office and transfers between offices."*

PART III: RECOMMENDATIONS WORTHY OF FURTHER CONSIDERATION

Six year-old A.A. died from blunt force injuries caused by his biological father with whom he was living in Idaho. Six months earlier, in September 2011, Washington State CPS had removed A.A. from his mother's care and filed for dependency due to allegations of child maltreatment. The father, who had no prior relationship or involvement with A.A., was contacted and informed of the dependency proceeding. CPS had no information about his fitness or unfitness as a parent, or any information regarding his partner. In January 2012, the father appeared for a court hearing in Washington State, and requested that A.A. be placed with him. The department did not offer evidence that the father was unfit, reported that background checks had been completed on the father and his live-in girlfriend and neither had disqualifying information, and that the father had been cooperative. The court granted the motion allowing A.A. to immediately leave for Idaho with his father. Thirty days later the dependency petition was dismissed, ending the department's supervision or authority regarding A.A.

In April 2012, the father struck A.A. in the head, knocking his son to the floor where he hit his head and became unconscious. The father waited two hours before calling for an ambulance. A.A. was airlifted to a Hospital where he was placed on life support. He died three days later, and the father was charged with First Degree Murder.

Fatality Review and Recommendations

This case was reviewed by an executive child fatality review committee. The committee concluded that the department did not obtain available information that may have slowed down the child's placement in the father's care and that this was reflective of a significant practice deficit. Most significant was the lack of any discernible effort to seek Idaho CPS history on the father or on his domestic partner and her children, which would have likely influenced the court's decision to place the child with the father. The committee noted several factors in this case that contributed to confusion about the department's authority to pursue more information regarding the father and his partner. Specifically, the department did not have evidence that the father was unfit; dependency had not been established as to A.A.; requirements under the ICPC, which would have assessed the appropriateness of placing the child with his father, did not apply; and the circumstances of this case did not permit use of the National Crime Information Center (NCIC) database to obtain criminal background information.

Recommendation: *"More guidance is needed for workers with cases involving non- offending out-of-state parents not under the ICPC but who are placement options for their non-dependent child involved with DCFS. It is recommended that CA, in collaboration with legal consultation with the Attorney General's Office, develop guidelines to provide clarity as to (1) what system search activities are authorized, (2) what other strategies for information gathering may be used (e.g., internet searches, social media sources), and (3) what other criminal and CPS history should be sought."*

Agency Response: *"This recommendation is being reviewed and considered at this time. ICPC Program will review with AAG."*

Recommendation: *"CA should review the current statutory and policy requirements for vetting parents and their partners prior to placement of dependent child (e.g., Sirita's Law) and consider how these standards might be applied when children who are not yet dependent are placed with an out-of-state parent, as occurred in this case. The key aspect of this recommendation is to strengthen practice such that the department identifies the risks associated with placement with an out-of-state parent when the department lacks information about that parent, their partner and/or their living environment, rather than presenting this situation as neutral, with no evidence of unfitness."*

Agency Response: *Considered, Not Implemented - "Parents have an intrinsic right to parent their children. We have to look through the pieces of information we have and work with the other state to obtain and help determine fitness of the parent."*

Both of these recommendations are closely related as they ask the department to develop guidelines for gathering information and to strengthen practice for assessing a non-offending parent, while respecting a parent's intrinsic rights. The department reports that one recommendation is in process, while the second recommendation, referencing current laws and policies related to dependent children, was considered, but not implemented.

These recommendations provide an opportunity to examine how the child welfare system should effectively assess child safety, prior to placing a child with a non-offending parent. As in A.A.'s case, it is not uncommon that the non-offending parent has little or no existing relationship with the child, and the department has scant information about this parent's ability to care for the child. Sometimes the non-offending parent requests placement at shelter care, in other cases the parent comes forward and seeks placement after dependency is established. A.A.'s case was complicated by the fact that the father lived out-of-state. However, cases where the parent resides in-state can also pose challenges when assessing the suitability of placing a child with a non-offending parent.

The department should examine both the specific facts and circumstances presented in A.A's case as well as the broader issues that confront caseworkers when considering placement with a non-offending parent including:

- Standards for placing a child at shelter care versus a dependent child;
- Protocols for obtaining information from –agencies from other states; in state agencies; court records; and other publicly available documents related to the parent's ability to care for the child; and
- The assessment of other caregivers residing in the parent's home.

DO THE REQUIREMENTS OF "SIRITA'S LAW" APPLY WHEN PLACING A DEPENDENT CHILD WITH A NON-CUSTODIAL PARENT?

"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.[86] 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 must 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 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. OFCO believes "Returning home" should be read to include placement with either a custodial or non-custodial parent, and that the legislature did not intend 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, and leaves children at risk of harm.

[86] RCW 13.34.138(2).

PART FOUR
2014 LEGISLATIVE UPDATE

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. Consistent with statutory requirements and OFCO's role, the Ombuds remains neutral when providing testimony on proposed legislation.

During the 2014 legislative session, OFCO reviewed, analyzed, and commented on several pieces of proposed legislation aimed at strengthening Washington's child welfare system. Many of the issues addressed in proposed legislation were areas of focus in previous OFCO reports. OFCO provided written or verbal testimony on bills related to the following legislation.

LEGAL REPRESENTATION FOR CHILDREN IN DEPENDENCY CASES [87]

Legislation was passed and became law in 2014, requiring the court to appoint an attorney for a child in a dependency proceeding six months after granting a petition to terminate the parent and child relationship. The same attorney may represent more than one child in a sibling group as long as such representation is not prohibited by the rules of professional conduct. Subject to the availability of appropriated funds, the state must pay the costs for legal representation of children[88] in these cases as long as representation meets the standards of practice, training, and caseload limits recommended by the statewide children's representation workgroup.

OFCO supported the intent of this legislation as children have at least the same due process right to counsel as do indigent parents subject to dependency proceedings.[89] OFCO also noted that State law currently provides a child with the right to an attorney in At Risk Youth and Child in Need of Services cases[90] where a child does not face the possibility of termination of the parent-child relationship. However, whether or not a child is represented by an attorney in a dependency proceeding lies with the discretion of the court, and depends largely on local practices in the county where the child's case is heard. As a result, a child in one county may have an attorney advocating for the child's stated interests and protecting the child's legal rights while in another county a similarly situated child is not represented by an attorney. This legislation will assure that an attorney will be appointed for dependent children when a permanent plan for the child has not been established within six months of termination of parental rights. This is a significant step towards protecting the child's rights and interests, particularly as to the fundamental issue of establishing a permanent placement for the child.

STATUS – This legislation was signed into law by Governor Inslee.[91]

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[87] SB 6126

[88] The Office of Civil Legal Aid (OCLA) administers state funding of child representation under this legislation. Prior to disbursing state funds, OCLA must verify that the appointed attorneys meet the standards of practice, voluntary training, and caseload limits.

[89] *In re the Dependency of MSR and TSR.*

[90] RCW 13.32A.192 and RCW 13.32A.160

[91] Chapter 108, Laws of 2014

BACKGROUND CHECKS AND SCREENING FOR EMPLOYMENT OR PLACEMENT [92]

OFCO frequently receives complaints from individuals who were denied placement of or access to a child, or find their eligibility for employment is impacted by results of a background check.[93] In many cases, the negative conduct or action occurred many years ago, and the individual is unaware that it now prevents them from working as a nurse or social worker, or caring for a dependent child. Under CA policy, CA staff must disqualify persons from being authorized to provide care for children based on criminal history and negative actions (such as a finding of abuse, neglect, exploitation, or abandonment of a vulnerable adult or child), that are set forth in the DSHS Secretary's List of Crimes and Negative Actions[94]. Federal law[95] also prohibits federal Title IV-E funds or adoption support funds from being used to support placements of children with persons who have a history of certain crimes. However, some crimes identified in the DSHS Secretary's List, are not listed under federal law.

Legislation that passed and became law in 2014 loosens restrictions on employment and unsupervised contact with children. This legislation allows an agency operating under contract with CA to hire a person who would be precluded from employment with DSHS based on a disqualifying crime or negative action. DSHS would not be liable for harm to a child or DSHS client attributable to such person. This legislation also prohibits the department from denying or delaying a license or approval of unsupervised access to children based solely on a crime or infraction that is not disqualifying under federal law, or does not relate directly to child safety, permanence, or wellbeing.

STATUS – This legislation was signed into law by Governor Inslee.[96]

PRUDENT PARENT STANDARD [97]

For many years, foster youth have reported that they miss out on everyday activities and experiences because, as dependents of the state, they must go through a lengthy approval process through their social workers and that approval process creates barriers to participation. Inspired and advocated by youth at The Mockingbird Society, the Prudent Parent Standard legislation proposed providing caregivers authority to allow children placed in their care to participate in normal childhood activities based on a reasonable and "prudent parent" standard. The legislation specified that the "standard is characterized by careful and thoughtful parental decision making that is intended to maintain a child's health, safety, and best interest while encouraging the child's emotional and developmental growth."

Ultimately, the legislation would permit caregivers to allow a child in their care to participate in extracurricular, enrichment, and social activities such as school field trips, overnight stays with friends, and summer or other camp participation without prior approval of the caseworker, the Department, or the court. Under the reasonable and Prudent Parent standard, background checks would not be required for persons who will have unsupervised contact with a foster youth based on caregiver

[92] SB 6095
[93] This issue was highlighted in OFCO's 2012 Annual Report, available at: www.ofco.wa.gov
[94] Revise August 2014, available at: http://www.dshs.wa.gov/pdf/ca/secretaryslist.pdf
[95] The Adoption and Safe Families Act of 1997
[96] Chapter 88, Laws of 2014
[97] ESSB 6479

authorizations. Foster youth advocated that the Prudent Parent Standard would help bring normalcy to their lives.

STATUS – This legislation was signed into law by Governor Inslee.[98]

EXTENDED FOSTER CARE FOR YOUTH 18 YEARS OF AGE AND OLDER [99]

In 2011, legislation was enacted to establish the Extended Foster Care program, allowing youth to receive foster care services after age 18 and up to age 21 if the youth was participating in a secondary education program or a secondary education equivalency program. In 2012, the Legislature expanded the program's eligibility to include youth who were enrolled, or had applied for and demonstrated intent to enroll, in a postsecondary academic or postsecondary vocational program. In 2013, eligibility for extended foster care services[100] was further expanded to include youth who are participating in a program or activity designed to promote or remove barriers to employment.[101] During the last legislative session, the Extended Foster Care program eligibility was expanded once more to include youth who are engaged in employment for 80 hours or more per month. At least six months before the dependent youth turns 18, the department must provide the youth with written documentation explaining the availability of extended foster care services and instructions about how to access those services.[102]

OFCO's testimony on the Senate companion bill to the House Bill that ultimately passed—which originally also included youth who could not engage in academic, vocational, or employment pursuits because of a documented medical condition—expressed that the legislation would provide basic care and stability necessary for foster youth transitioning into adulthood. OFCO testified that as a community, we support and encourage our own children's career ambitions and provide basic assistance while they gain education and or work experience, and the legislation would provide equal support to our foster youth in pursuing their ambitions.

By providing the basic services to assist foster youth successfully transition into adulthood, we can help prevent negative outcomes for youth exiting foster care. For example, studies of youth who leave foster care without a safe, permanent family reveal over half of the youth experienced one or more episodes of homelessness, and nearly 30 percent were incarcerated at some point.[103] Extended foster care services will also help break the cycle of generational child abuse or neglect—where foster youth who aged out re-enter the child welfare system, this time as young parents. There remains only one population of foster youth who could become eligible for Extended Foster Care through additional legislative efforts: foster youth with documented medical conditions.

STATUS –This legislation was signed into law by Governor Inslee.[104]

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[98] Chapter 104, Laws of 2014, *available at* http://apps.leg.wa.gov/billinfo/summary.aspx?bill=6479&year=2013.
[99] EHB 2335
[100] Extended foster care services may include the following: (1) placement in licensed, relative, or otherwise approved care; (2) supervised independent living settings; (3) assistance in meeting basic needs; (4) independent living services; (5) medical assistance; and (6) counseling or treatment. RCW 13.34.030(8).
[101] RCW 74.13.031(11)
[102] RCW 13.34.145(3)
[103] Fostering Connections, Analysis No. 1, McCoy-Roth, Freundlich and Ross, Jan. 31, 2010. Available at: http://www.fosteringconnections.org/tools/assets/files/Connections_Agingout.pdf
[104] Chapter 122, Laws of 2014, *available at* http://apps.leg.wa.gov/billinfo/summary.aspx?bill=2335&year=2013.

IMPROVING THE ADOPTION PROCESS [105]

Legislation was introduced but not passed in 2014 addressing recommendations to improve the adoption system. As discussed earlier in this report, proposed rules currently under review implement many of these recommendations. Key provisions of this legislation would:

- Strengthen professional qualifications for individuals conducting pre and post placement reports and establish continuing education requirements.
- Require pre-placement reports to discuss the applicant's family and community connections and the family's support network. The report must also review any prior pre-placement reports.
- Ensure that pre-placement reports, whether approved, denied or incomplete, are filed with the court.
- Make information readily available to individuals considering adoption and require OFCO to convene a work group to review and compile material that must be provided to prospective adoptive parents. Information reviewed and updated every two years.
- Monitor implementation of recommendations to improve the adoption process by requiring OFCO to include in its annual report information on the departments progress in implementing recommendations made in the Severe Abuse of Adopted Children Report.
- Improve the ability to track adoption outcomes through the use of Data Cards maintained by the Department of Health.

OFCO's testimony emphasized that this legislation would address many of the issues identified in the Severe Abuse Report, and findings in the State Auditors survey of adoptive parents.[106] OFCO's duty to monitor implementation of recommendations to improve the adoption process would assure that issues and concerns identified in these reports continue to be reviewed and assessed. By establishing professional qualifications for individuals conducting pre-placement reports, and identifying topics addressed in these reports, this legislation would enhance the assessment process of prospective adoptive parents. This bill would also aid adoptive families by providing information about adoption and available support services.

STATUS – This legislation was not passed by the Legislature.

PROPOSED LEGISLATION CONCERNING THE DEPARTMENT OF EARLY LEARNING (DEL)

The Department of Early Learning oversees the licensing of child care centers and family home providers in Washington State.[107] Two bills were introduced, but did not become law this past session addressing issues in licensed child care facilities. One bill concerned "safe sleep" practices by child care providers, the other would require DEL to conduct a Child Fatality Review if a child fatality occurs in a licensed child

[105] ESHB 1675
[106] *The Experiences and Perspectives of Washington Families who Adopted Children from Foster Care.* Available at: www.sao.wa.gov.
[107] RCW 43.215.200

care facility. Previous OFCO reports[108] highlighted both issues, and the Ombuds provided testimony on each bill.

Fatality Reviews When a Child Dies in a Licensed Day Care Facility[109]

Children's Administration (CA) is required to complete child fatality reviews[110] when a fatality is suspected to be caused by child abuse or neglect of any minor in the care of DSHS or a supervising agency, or if the child or family had received child welfare services within the past year. These reviews are an opportunity to increase the understanding of the circumstances around the child's death, examine the events and circumstances surrounding the child's death and identify gaps in practice and improve the child welfare system. Based on these reviews, both CA and OFCO issue reports and recommendations to the Legislature. However, neither DEL nor CA is required to conduct a child fatality review when a child dies in a licensed day care facility.

Legislation proposed in 2013 would have required that DEL complete a child fatality review if a child fatality occurs in a licensed child care center, licensed child care home, or an Early Childhood Education and Assistance Program. The purpose of the fatality review is to develop recommendations for DEL and the Legislature to strengthen health and safety protection for children. This bill also required DEL to: complete the review within 180 days following the fatality; issue a report to the Legislature; and publish the reports to a public website.

OFCO supported the intent of this legislation that child deaths should be reviewed when they occur under a state agency's watch—whether that be CA or DEL. Under present laws, child fatalities that occur in DEL programs, licensed centers, or licensed child care homes are not investigated or reviewed by an external committee, even if there is an allegation of abuse or neglect related to the fatality, and the proposed legislation would close that gap. We should endeavor to learn lessons and strengthen child safety when a child death occurs in a child care facility licensed by the State of Washington. OFCO testified that the number of child deaths and near deaths that occur annually in licensed DEL facilities are very few- two fatalities in 2012, and three in 2013. While fatalities in licensed child care facilities are rare, when these tragedies do occur, OFCO believes it is important to share critical information with the community given what is at stake for the thousands of children and families who utilize DEL licensed facilities.

STATUS – This legislation was not passed by the Legislature.

"Safe Sleep" Practices in Licensed Child Care Facilities

Previous OFCO reports have focused on unsafe sleep environments contributing to preventable, infant fatalities. OFCO found that in 2012, two-thirds of the infant fatalities reviewed involved unsafe sleep practices. Unsafe sleeping practices include: adults, older children, or pets sleeping with an infant; putting an infant to sleep on an adult bed, couch, sofa or other soft surface not designed for an infant; and the presence of soft items such as pillows, blankets, or stuffed animals in the infant's crib.[111]

[108] [Citation]
[109] SHB 2165
[110] RCW 74.13.640
[111] 2013 OFCO Annual Report, available at: www.ofco.wa.gov

Legislation proposed in 2013 required DEL to provide licensed child care providers with safe sleep information and to assess safe sleep practices during monitoring visits. The bill also outlines the consequences if a provider fails to meet safe sleep practices—upon a provider's first violation of safe sleep practices, the licensor must develop a compliance plan agreement with the provider. The provider is also put on notice that a subsequent violation concerning safe sleep would result in license revocation.

OFCO testified that current WAC's governing sleep equipment in licensed child care facilities include: guidance on what type of cribs or bassinets a provider must use; how tight fitting mattress pads and sheets must be; how often bedding must be laundered; and, of course, that infants must be put to sleep on their backs unless a parent provides written notice—from the parent and a health care provider—that the child may be placed in an another sleeping position. OFCO noted that in order to ensure that children sleep safely, providers must implement and routinely follow these practices. OFCO offered that one violation of these standards is too many, as one incident of a provider failing to meet safe sleep practices can result in the death of a child. When parents drop off their child at a licensed day care provider, they expect the provider to understand the importance of safe sleep practices and to implement those practices.

STATUS – This legislation was not passed by the Legislature.

V. APPENDICES

APPENDIX A:
Complaints Received by Region and Office

APPENDIX B:
Child Demographics in Complaints to OFCO

APPENDIX C:
Child Fatalities and Near Fatalities Reviewed by OFCO – Additional Data

APPENDIX D:
Child Fatality Review Recommendations 2012 - 2013

APPENDIX A: COMPLAINTS BY REGION AND OFFICE

The following table provides a detailed breakdown of CA regions and offices identified in received OFCO complaints

REGION	OFFICE	
1 North	Clarkston DCFS	2
	Colfax DCFS	1
	Colville DCFS	14
	Spokane DCFS	70
	Moses lake DCFS	14
	Newport DCFS	1
	Omak DCFS	2
	Wenatchee DCFS	9
	DCFS Adoptions (Region 1 North)	*0*
	DLR (Region 1 North)	*3*
1 South	Ellensburg DCFS	1
	Goldendale DCFS	2
	Richland DCFS	22
	Sunnyside DCFS	2
	Toppenish DCFS	4
	Walla Walla DCFS	10
	Yakima DCFS	28
	DCFS Adoptions (Region 1 South)	*0*
	DLR (Region 1 South)	*4*
2 North	Alderwood / Lynnwood DCFS	23
	Arlington / Smokey Point DCFS	16
	Bellingham DCFS	21
	Everett DCFS	24
	FVS/Lynnwood DCFS	2
	Monroe/Sky Valley DCFS	16
	Mount Vernon DCFS	13
	Oak Harbor DCFS	5
	DCFS Adoptions (Region 2 North)	*1*
	DLR (Region 2 North)	*1*

REGION	OFFICE	
2 South	King East DCFS	22
	King South DCFS	27
	King West DCFS	29
	Martin Luther King, Jr. DCFS	21
	White Center DCFS	6
	DCFS Adoptions (Region 2 South)	*3*
	DLR (Region 2 South)	*5*
3 North	Bremerton DCFS	12
	Pierce East DCFS	23
	Pierce West DCFS	32
	Pierce South DCFS	26
	DCFS Adoptions (Region 3 North)	*10*
	DLR (Region 3 North)	*5*
3 South	Aberdeen DCFS	30
	Centralia DCFS	12
	Forks DCFS	3
	Kelso DCFS	7
	Long Beach DCFS	2
	Port Angeles DCFS	3
	Port Townsend DCFS	5
	Shelton DCFS	7
	South Bend DCFS	1
	Stevenson DCFS	4
	Tumwater DCFS	19
	Vancouver DCFS	41
	DCFS Adoptions (Region 3 South)	*0*
	DLR (Region 3 South)	*1*
Other	Central Intake Unit	6
	Children's Administration HQ	1
	Non-OFCO Complaints	39

APPENDIX B: CHILD DEMOGRAPHICS IN COMPLAINTS TO OFCO

The following table provides a detailed breakdown of the race / ethnicity of children identified in completed OFCO investigations.

NON-LATINO / NON-HISPANIC	
African American	8.85%
African American & American Indian or Alaska Native	0.86%
African American & Asian	0.19%
African American & American Indian or Alaska Native & Caucasian	0.29%
African American & Some Other Race	0.10%
American Indian or Alaska Native	5.61%
American Indian or Alaska Native & Native Hawaiian Pacific Islander	0.10%
Asian	1.14%
Asian & Native Hawaiian Pacific Islander	0.29%
Asian & Some Other Race	0.10%
Caucasian	56.52%
Caucasian & African American	5.61%
Caucasian & American Indian or Alaska Native	2.76%
Caucasian & Asian	0.19%
Caucasian & Native Hawaiian Pacific Islander	0.48%
Caucasian & Some Other Race	0.10%
Native Hawaiian Pacific Islander	0.29%
Native Hawaiian Pacific Islander & Some Other Race	0.10%
Some Other Race	2.00%
Declined to Answer	1.90%

LATINO / HISPANIC	
African American	0.57%
African American & Asian	0.19%
American Indian or Alaska Native	0.38%
Asian	0.10%
Caucasian	10.09%
Caucasian & African American	0.67%
Caucasian & American Indian or Alaska Native	0.29%
Caucasian & Some Other Race	0.10%
Some Other Race	0.10%
Declined to Answer	0.10%

APPENDIX C: OFCO-REVIEWED CHILD FATALITIES AND NEAR FATALITIES – ADDITIONAL DATA

There are three DSHS CA geographic regions, each divided into north and south sub-regions. The Regional Office and number of children served are provided for context.

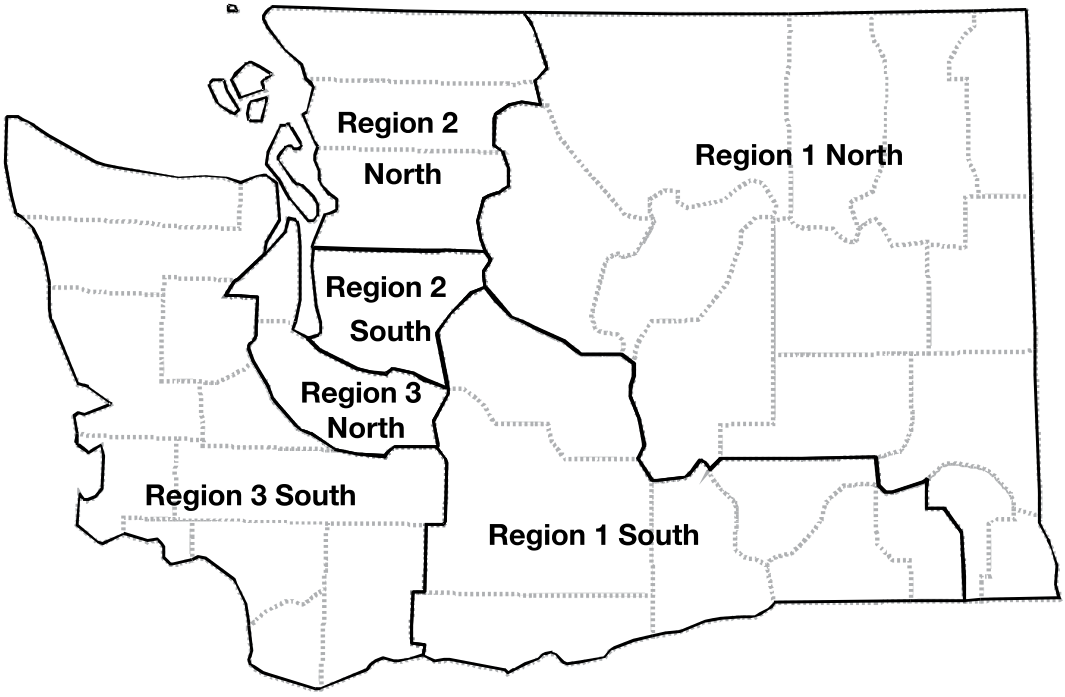

Table 10: **Child Fatalities by DSHS Region**
By Calendar Year (January 1st - December 31st)

	2010	2011	2012	2013
Region 1 North	10	10	6	8
Region 1 South	11	15	3	5
Region 2 North	11	7	7	9
Region 2 South	14	10	7	13
Region 3 North	13	11	8	16
Region 3 South	17	7	11	10
Statewide	76	60	42	61

Table 11: **Child Fatalities with Open Cases**

By Calendar Year (January 1st - December 31st)

	2010	2011	2012	2013
CPS	20	22	14	16
CWS	11	6	5	3
DLR	0	1	1	0
FVS	4	1	2	3
FRS	3	1	0	0
ARS	0	0	0	0
Statewide	38	33	22	22

Table 12: **Near-Fatalities by Age Group**

By Calendar Year for 2011-2013; 2014 data includes only Jan. 1 through Oct. 31.

	2011	2012	2013	2014
0-2 year	6	13	20	8
3-7 years	1	1	5	3
8-12 years	1	0	0	0
13-17 years	4	2	5	6
Statewide	*12*	*16*	*30*	*17*

Table 13: **Near-Fatalities by Most Recent CA Program** [112]

By Calendar Year for 2011-2013; 2014 data includes only Jan. 1 through Oct. 31.

	2011	2012	2013	2014
CPS	9	10	24	8
CWS	1	3	5	7
DLR	1	2	0	0
FVS	1	1	1	0
FRS	0	0	0	1
ARS	0	0	0	0
Statewide	12	16	30	17

[112] Some near-fatalities involved families who only had "screened out" referrals in the past 12 months, or near-fatalities that occurred in daycare settings (DEL) with no referral history on the family

APPENDIX D: CHILD FATALITY AND NEAR FATALITY REVIEW RECOMMENDATIONS 2012-2014

The recommendations made by representatives from the community, OFCO, and Children's Administration participating in child fatality and near-fatality reviews are forwarded to a Children's Administration's administrator or Children's Administration's Continuous Quality Improvement Committee for review and prioritization. At regular intervals, administrators are required to report on the progress of implementing a recommendation or provide a written response when a specific recommendation was not implemented.

Listed below, by topic are the 120 recommendations made in Child Fatality Reviews and Near Fatality Reviews conducted from January 1, 2012 through April 31, 2014, and the implementation status for each recommendation.[113] Recommendations that were considered and not implemented are also listed separately, with the department's explanation why no further action was taken on the recommendation.

PARTNERSHIPS WITH COMMUNITY PROFESSIONALS	
Inter-Agency- Improve communication between the Division of Developmental Disabilities and Children's Administration so that CA receives information about eligibility, services, and resources for developmentally delayed children in foster care.	Completed/office
Law Enforcement- The Committee recommends CA facilitate a joint meeting between the Yakima CA office and law enforcement to review how investigative efforts are coordinated as specified in the Yakima County Child Abuse Protocol.	In Process/office
Law Enforcement- The Committee recommends that Aberdeen DCFS attempt to work toward improving the referral process with the specific law enforcement agency identified during the review. The goal would be to develop a more reliable system for forwarding and tracking the intakes sent to the law enforcement agency thereby improving timely assignments to detectives.	Completed/office

[113] OFCO has summarized these recommendations. The full text of each Child Fatality Review recommendation and the *Executive Child Fatality Reviews* are available at: http://www1.dshs.wa.gov/ca/pubs/fatalityreports.asp

PARTNERSHIPS WITH COMMUNITY PROFESSIONALS	
Law Enforcement- In dependency proceedings when there is an active criminal investigation Children's Administration should make concerted efforts to include and consult with the assigned detective prior to making changes in parent/child contact, e.g. visitation in accordance with the respective county protocols required by RCW 26.44.185.	Completed/ *RCW 13.34.136*
Law Enforcement- When CA's local office administrators renew or establish interagency agreements with local law enforcement agencies, consider addressing utilization of technology for information sharing between agencies and when to notify local law enforcement if CA receives an intake alleging a child's whereabouts is unknown and there are concerns or risk of abuse or neglect.	In Process/Region
Department of Corrections- CA should explore establishing a formal and systematic information exchange with Washington State Department of Corrections.	Completed/Statewide
Department of Corrections- CA should convene a workgroup to develop an updated working agreement with the DOC WCCW similar to the one initiated in 2000 between the then Region 5 CA Regional Administrator and the Superintendent of WCCW. It is recommended that: 1) be a broader inter-department agreement. 2) The work group should also include participation by representatives from the Office of Attorney General and attorneys working with clients involved in dependency matters. 3) The agreement should cover collaborative protocols for screening of participants eligible for the Residential Parenting Program (RPR) at the Purdy facility as well as procedures for screening pregnant inmates who are not eligible for the program and for which post-delivery caretaking arrangements may or may not need to involve Children's Administration. This might include guidelines regarding use of CA staff to be available to consult with WCCW staff on RPR screening committee meetings and inmate Infant Care Plan development even if not involving a client having an active case with CA to the extent such involvement is authorized by law. 4) The workgroup should consider identifying interagency liaisons within CA and DOC that have dedicated responsibilities outlined in the agreement. 5) The agreement should provide a clear understanding of roles and responsibilities for both WCCW and CA staff regarding information inquiries, the specific types of information that can be shared within current legal authority, and case staffing protocols. Once a formalized interagency working agreement is completed, it should be made available to all CA staff as an online reference document.	Completed/Statewide
Private Organization- CA office should include a plan to increase communication with the local hospital following an intake regarding abuse and/or neglect originating at a hospital.	Completed/office

PARTNERSHIPS WITH COMMUNITY PROFESSIONALS	
Private Organization -The DCFS Area Administrator should initiate contact with the local medical facility identified during the review where staff experience difficulty getting direct contact with medical providers. The goal should be to engage in dialog to explore ways to improve information sharing as permitted by RCW 26.44 and to explore opportunities for agency cross training.	Completed/office
Private Organization- CA and private agencies need to have the ability to freely exchange information about foster care applicants' previous licenses, denials, findings, and background checks. The committee recommends changing statutes that limit this exchange of information to all this to occur. See RCW 74.15 and 26.44.031 (4) and 13.50.100 (11).	Completed/Statewide
Native American Tribe- The current "Memorandum of Understanding Between the Tulalip Tribes of Washington and DSHS Children's Administration for Sharing Responsibility in Delivering Child Welfare Services to Children of the Tulalip Tribes" should be revised to increase the specificity of the roles and responsibilities of tribal and Children's Administration social workers.	In Process/Region
Native American Tribe- CA continue to work on establishing an updated formal Memorandum of Agreement (MOA) between The Puyallup Tribe of Indians and CA for sharing responsibility in delivering child welfare services to children of the Puyallup Tribe. A local agreement should clearly establish the roles and responsibilities of tribal social services and CA social workers working together to provide services, include procedures for staffing and transferring cases, and expectations for documenting case planning decisions.	In Process/Region
Native American Tribe- CA should continue with the current efforts in Region 2 North[1] to complete agreements designed to clarify the roles and responsibilities of the Tribes and CA to enhance coordination and cooperation between the Tribes and CA in providing appropriate child welfare services to Indian children to meet their safety and well-being needs.	In Process/Region
INTER-STATE AGENCIES- Explore opportunities for developing working relationships with the child welfare agencies in the near-by neighboring state	Completed/office
INTER-STATE AGENCIES- When Child Near-Fatality or Fatality reviews involve families with a history of receiving child welfare services from states in addition to Washington, Children's Administration should establish information-sharing agreements with the other states. The agreements should allow for the exchange of Child Near-Fatality and Fatality reports between the involved states and possible reciprocal participation in reviews.	Not Implemented

PARTNERSHIPS WITH COMMUNITY PROFESSIONALS	
Community- The Committee recommends CA establish a lower Klickitat County CPT/LICWAC that meets a minimum of one time per month. The purpose of this CPT/LICWAC would be to provide a local staffing resource with knowledge of the local community and people.	Completed/office

PROVIDE TRAINING	
Domestic Violence- Invite a local DV advocacy center to join CPS at a unit meeting and discuss the different forms and patterns of DV.	Completed/office
Domestic Violence- Due to the high co-occurrence of domestic violence and child maltreatment and the importance of accurate assessment for child safety purposes, DV training for CA staff is recommended on an ongoing basis as an adjunct to the CA SW Practice Guide to DV.	In Process/Statewide
*Domestic Violence- C*omplete comprehensive in-person training for all CA staff about domestic violence. Training should include information about the impact of domestic violence on children; and assessing for violence perpetrated by extended family members.	In Process/Statewide
Domestic Violence- Because the identification of domestic violence is critical when making case decisions intended to increase safety for children, on-going training and regular consultation on domestic violence for CA staff is recommended. Training should address how to use the CA's Social Worker's Practice Guide to Domestic Violence and assessing safety threats to children.	In Process/Statewide
Domestic Violence- Provide all CA social workers and supervisors with training about domestic violence. The Committee further recommends: • Invite a team of professionals from a variety of disciplines such as law enforcement, medicine, mental health and domestic violence to participate in the development of the training curriculum and to participate at the training events. • The training should promote the benefit of partnerships between CA and domestic violence agencies and encourage social workers to consult with domestic violence advocates when working with families impacted by domestic violence.	In Process/Statewide
Domestic Violence- The Committee recommends all social workers read and discuss the Social Worker's Practice Guide to Domestic Violence prior to the completion of the Regional Core Training (RCT).	Completed
Decision Making- the CPS supervisors working in the Children's Administration office where this case was assigned receive additional training on how to guide CPS social workers in gathering information about the subjects of CPS investigations and how to fully utilize the Structured Decision Making® tool in case planning.	Completed/office
Solution based Casework-The Committee recommends the unit assigned at the time of the fatality receive additional training related to the creation and monitoring of Solution Based Casework (SBC) case plans.	Completed/office

PROVIDE TRAINING	
Safety- CA is planning to provide additional staff training on safety assessment and planning. The Committee recommends the training include an emphasis on the importance of information gathering when assessing for safety and suggests this case as a good training example.	Completed/Statewide
Safety- all DLR licensors receive training on the safety concerns associated with DE rooms (e.g., potential hanging hazards, facility policies regarding the use of the DE room, and the ability to maintain line of sight supervision for children placed in the DE room). The committee noted the current checklist did not require DLR to inspect the DE room for safety and visibility concerns.	Not Implemented
Safety- The Committee recommended CA provide all CA social workers with a concise guide of what to look for when completing an initial home visit and subsequent health and safety checks.	In Process/Statewide
Safety- Develop and provide social workers with training on the risk and prevention of childhood injuries. The Committee recommends CA consider using existing training materials readily available from organizations promoting injury prevention.	In Process/Statewide
Safety- The Committee recommends social workers receive and demonstrate a strong understanding of the safety planning process prior to the carrying of cases and the completion of Regional Core Training (RCT).	Completed/Statewide
Safety- The Committee recommends all social workers receive and demonstrate a strong understanding of the safety assessment and safety planning process prior to the carrying of cases and the completion of Regional Core Training (RCT).	Completed/Statewide
Safety- The Committee recommends social workers receive and demonstrate a strong understanding of the safety planning process prior to the carrying of cases and the completion of RCT.	In Process/Statewide
Safety- The Committee recommends all social workers receive and demonstrate a strong understanding of the safety assessment and safety planning process prior to carrying cases and at the completion of Regional Core Training (RCT).	Completed/Statewide
Safety- The Committee recommends social workers receive an annual refresher training regarding safety planning.	In Process/Statewide

PROVIDE TRAINING	
Safety- The Committee recommends all CA social workers receive an annual refresher training regarding the completion of safety assessments and safety plans.	In Process/Statewide
Safety- The Committee recommends all CA social workers receive an annual refresher training regarding safety planning.	In Process/Statewide
Safety- The Committee recommends all CA social workers receive an annual refresher training regarding the completion of safety assessments and safety plans.	In Process/Statewide
Safety- The Committee noted CA's Safety Framework is based on information gathering, assessing, and analyzing and planning for safety throughout the life of a case and focuses on a comprehensive family assessment. It is recommended that a review of Child Safety Framework be provided to all staff.	In Process/Statewide
Safe Sleep- Infant safe sleeping training should be available to CA staff. The training curriculum should be standardized and include information on how to evaluate an infant's sleep environment, how to engage caregivers in a discussion about safe sleep, and risk factors known to increase the risk of Sudden Unexpected Infant Death (SUID) and Sudden Infant Death Syndrome (SIDS). Curriculum should also address the distinction between SUID and SIDS and the implications for CPS investigations.	Completed/Statewide
Safe Sleep- Provide training on infant safe sleeping practices and infant growth and development to all CA social workers.	Completed/Statewide
Mental Health/Chemical Dependency- Mental health and chemical dependency trainings should include a focus on the need to include detailed collateral information with the referral to a provider.	In Process/Statewide
Mental Health/Chemical Dependency- CA should consider exploring a "continuing education" requirement system whereby social work staff would be required to receive training on mental health, DV and chemical dependency every few years rather than only offering optional training.	In Process/Statewide
Chemical Dependency- CA will review the existing substance abuse training curriculum to ensure staff is receiving current and sufficient information about methadone. CA will consider offering additional substance abuse training.	Completed/Statewide

PROVIDE TRAINING	
Chemical Dependency- CA will review the existing substance abuse training curriculum to ensure staff is receiving current and sufficient information about methadone. CA will consider offering additional substance abuse training.	Completed/Statewide
Substance Abuse/Methadone- The Committee recommends that CA review the curricula of both basic and advanced substance abuse trainings offered to CA staff for consideration of adding specific information as to assessing safety of young children in the care of methadone using (prescription or illicit use) caretakers.	In Process/Statewide
Placement Decisions- CA should continue to reinforce with SW's and FTDM facilitators the importance of evaluating the possible impacts to a child being placed, as well as the impact the placement might have on children already in the home (e.g., the biological children of relative caregivers). Promotion of this concept should continue to occur annually in statewide CA training available to social work and program staff, such as the "Lessons Learned" presentation held around the state.	Completed/Statewide
"Lessons Learned"- CA should incorporate the following practice issues into any future "Lessons Learned from Child Fatalities" presentations for CA staff: (1) making purposeful effort to find out why a parent does not have care and/or custody of other biological children, including making contact with the custodial parent or relative caregivers; (2) giving deliberate consideration to referring a marijuana using parent for substance abuse assessment when that parent has any past diagnosis for substance abuse/chemical dependency issues, especially if they co-occur with mental health and DV issues.	Not Implemented
"Lessons Learned"- Children's Administration should provide training to staff about lessons learned from Child Near-Fatality and Fatality reviews. The training should include an emphasis on collateral contacts, accurate documentation, verifying information, and collaboration with contracted providers.	Completed/Statewide

PROVIDE TRAINING	
"Lessons Learned"- CA might consider incorporating for discussion two aspects of this case for future state-wide presentations on Lessons Learned from Child Fatalities. (1) discuss working with chronically referred, frequently encountered, non-isolated families evidencing a pattern of pervasive chronic neglect and substance abuse in which abuse and neglect appears to be accepted or tolerated by the adults and the children likely stemming from intergenerational transmission of family values. (2) clarify for staff the expectations for contacting tribes following an intake, notifying tribes when a case has been opened by CA, determining and documenting current Native American status, and engaging tribes in case planning especially when multiple tribes are involved.	Completed/Statewide
Foster Parents- Foster parent training specific to the special needs and supervision of developmentally delayed child. The Committee specifically recommended that this recommendation not prevent placement into foster homes.	Completed/Statewide
Foster Parents- At the time of initial licensing and licensing renewal, require foster parents to complete training on the risk and prevention of childhood injuries. The Committee recommends the training include information on the proper use of safety equipment such as bicycle helmets, car seats and personal flotation devices.	Not Implemented
Case Transfers- Children's Administration should provide a written reminder to all case-carrying social workers about case transfer protocols. The reminder should address both transfers between social workers working in the same office and transfers between offices.	Not Implemented
Case Transfers- The statewide Child Protective Services program manager should present this case to the regional Child Protective Services program managers as an example of the importance of communication and follow-up at the time of a case transfer.	Completed/Statewide
Locating Families- Social workers and the CSO should be provided training on how to work together to locate CA involved families.	Completed
Identifying Fathers-The Committee noted that the father's name and/or information was frequently missing from the Native American Questionnaire. The Committee recommends social workers explain why a father is not listed on the Native American Questionnaire. Additional training should be provided to social workers to ensure this recommendation is completed.	Not Implemented

PROVIDE TRAINING	
Law Enforcement Reports- Provide Children's Administration staff with a reminder about policy and statute relevant to reporting serious injury to law enforcement.	Completed/Statewide
Photographic Evidence- The Committee noted pictures of the home environment would have provided an accurate and unbiased reflection of the home environment. The written description of the home environment varied significantly and it was difficult to assess the home without photographic evidence. The Committee recommends all CA social workers receive a reminder about the benefits of photographing the home environment.	Not Implemented
Mandated Reporters- CA should provide guidance and training on mandated reporter expectations to staff and providers, including reporting of unexplained injuries on dependent children and recognizing when there is a pattern of explained injuries.	In Process/Statewide
Critical Thinking- CA should consider developing and administering training on bias and critical thinking. This training should include the importance and value of a 'devil's advocate' or dissenting opinions and how to work with challenges to existing beliefs.	In Process/Statewide
Critical Thinking- The Committee recommends CA discuss the concern of groupthink and the possible pitfalls of such, with drug court teams across the state.	Implemented/Statewide

CHILD FATALITY INVESTIGATIONS & REVIEWS	
Fatality Investigations- CPS investigation involving a child fatality resulting from suspected child abuse or neglect, should be conducted by CPS staff from an office with no prior involvement with the child or the child's family.	Completed/Statewide
Case Documentation- The Committee noted a significant amount of documentation was entered into FamLink following the fatality. The Committee believed the documentation accurately reflected case activity and met all policy requirements; however, the Committee questioned CAs practice of destroying hand written case notes after the information is entered into FamLink. The Committee believes CA policy should require the retention of all hand written case notes that exist at the time of the fatality. This recommendation should not change the requirement that hand written case notes be entered into FamLink.	Not Implemented

SAFETY PLANNING AND RISK ASSESSMENT	
Safety Plans- CA is encouraged to re-assess and consider modifying the Child Safety Framework safety plan policy that does not currently allow a child to remain in relative care with a safety plan if a safety threat meets the criteria of an "unsafe child." There may be situations in which a Safety Plan could be initiated within the relative home so that placement disruption (whether temporary or longer term) does not need to immediately occur.	Not Implemented
Structured Decision Making- While recognizing that a complete SDM manual is accessible to all CA staff via the agency intranet, the Committee suggests CA consider developing a desk version "cheat sheet" that could prompt workers to improve accuracy of risk level assessment by quick reference to definitions for each item on the SDM.	Not Implemented
Safety & Visits- Given the intrusive nature of a psycho-sexual evaluation, Children's Administration should reassess parent/child contact (e.g. visitation duration, supervision, location) prior to the next parent-child visit when a judge orders a parent undergo such psycho-sexual evaluation in the course of a dependency proceeding.	Completed/Statewide
Database Systems- CA to consider adding resources such as Lynx Northwest, Lexus Nexis or Spillman. CA should evaluate these databases and determine if these systems are able to provide social workers with information needed to increase child safety.	Not Implemented

SAFETY PLANNING AND RISK ASSESSMENT	
Licensed Facilities- Group home should: maintain all observation windows to ensure an unhindered view of the entire DE room; and eliminate all blind spots in the DE room by completing structural changes as needed. WAC should be changed as it allows DE rooms to contain blind spots that are not visible by staff.	Completed/Region
Licensed Facilities- WAC 0388-148-0487 does not require line of sight supervision for children placed in a DE room. The WAC for DE rooms should be modified to require line of sight supervision while a child is placed in a DE room. In addition, the committee recommends the Group Home Checklist (Form 16-187) used by DLR licensors be modified to ensure group home staff have the capability of maintaining line of sight supervision while a child is in DE rooms. The committee noted that this recommendation may require some group homes to redesign the configuration of their DE rooms to allow for line of sight supervision. The use of bubble windows may limit the need for significant structural redesigns.	Completed/Statewide
Licensed Facilities- The committee recommends WAC 0388-148-0487 be modified to require all belts, shoes, and hoodie strings of youth to be removed when a youth is placed into a DE room.	Not Implemented
Licensed Facilities- WAC 388-148-0205 requires licensed foster homes keep all medication in locked storage. WAC does not specify what constitutes locked storage. The Committee believes WAC 388-148-0205 should be modified to specify all medications be kept in a locked container or another storage area made of strong, unbreakable material when not in use similar to the WAC for firearm and ammunition storage.	Not Implemented

SAFETY PLANNING AND RISK ASSESSMENT	
Licensed Facilities- WAC 388-148-0120(2) and (3) specifically references any child's suicide attempt that results in injury requiring medical treatment or hospitalization and suicidal/homicidal ideations, gestures, or attempts that do not require professional medical treatment. WAC 388-148-0120 requires foster parents to report incidents contained in WAC 388-148-0120(2) and (3) as soon as possible and in no instance later than forty-eight hours to the local Children's Administration intake staff and the child's social worker or case manager. Although, the Committee found no action taken outside the requirements of WAC 388-148-0120, the Committee believed the WAC should be modified to match WAC 388-148-0123. WAC 388-148-0123 requires foster parents to report, "As soon as you have reason to know a child in your care is missing as defined in WAC 388-148-0010, or has refused to return to or remain in your care, or whose whereabouts are otherwise unknown, you or your staff are required to notify the following: (a) The child's assigned social worker, if the child is in the department's custody; (b) CA intake, if the social worker is not available or it is after normal business hours; or (c) The case manager if the child is placed by a child placing agency program. The Committee recommends WAC 388-148-0120 require foster parents, private agency licensors, and case managers to report incidents as soon as they have reason to believe a child is experiencing suicidal ideation or attempted/completed suicide. All reports should be made to the child's assigned social worker, CA intake, and the private agency case manager if a child placing agency program places the child.	Not implemented

EFFECTIVE CPS INVESTIGATIONS	
Health & Safety Checks- The Committee believes CPS social workers should be required to complete a monthly health and safety check of the children similar to the policy requirement for cases in a FVS or CFWS program.	Completed/Statewide
Health & Safety Checks- When a CPS case has remained open beyond the timeframes established by policy and there has been no recent in-person contact between the assigned social worker and the identified child victims, the social worker should conduct an additional in-person visit with identified victims under the age of six or any child victim with special needs prior to closing the case.	Completed/Statewide
Assessing Parents & Caregivers- CPS social workers should complete the GAIN-SS at the time of initial investigative contact with the parent(s) identified as a subject on the intake or person(s) acting in the role of parent and living in the child's home.	Completed/Statewide
Access to Criminal History- Currently, CA policy provides CPS social workers with discretion in deciding when to access the National Crime Information Center (NCIC) database. The Committee recommends, if permissible by law, a change in policy to require social workers to access the National Crime Information Center (NCIC) database during the course of a CPS investigation.	Not Implemented
Contacting Referrers- CA should review policy and practice guidelines regarding contacting of referrers by the assigned CPS investigator. The Committee is suggesting that CA find a way to reinforce with field staff the practice of routinely contacting referrers as a significant opportunity to gather additional information important to the accurate determination of child safety, risk for future child maltreatment, and investigative findings.	In Process/Statewide

CASEWORK PRACTICE	
Law & Policy Updates- CA to ensure it has an effective way to communicate changes to policies, laws and procedures to staff on an ongoing basis. CA should have a method to aid social workers in quickly and easily accessing laws, policies and procedures.	In Process/office
Case Documentation- at the next Central Case Review for the Vancouver DCFS office, evaluate case documentation standards (including timeframes for entry of information into FamLink) as a quality assurance review measure.	In Process/Region
Assessing out-of-state Parents- More guidance is needed for workers with cases involving non-offending out-of-state parents not under an ICPC but who are placement options for their non-dependent child involved with DCFS. It is recommended that CA, in collaboration with legal consultation with the AGO, develop guidelines to provide clarity as to (1) what system search activities are authorized, (2) what other strategies for information gathering may be used (e.g., internet searches, social media sources), and (3) what other criminal and CPS history should be sought.	In Process/Statewide
Assessing Parents and Caregivers- Review the current statutory and policy requirements for vetting parents and their partners prior to placement of dependent child (e.g., Sirita's Law) and consider how these standards might be applied when children who are not yet dependent are placed with an out-of-state parent, as occurred in this case. The key aspect of this recommendation is to strengthen practice such that the department identifies the risks associated with placement with an out-of-state parent when the department lacks information about that parent, their partner and/or their living environment, rather than presenting this situation as neutral, with no evidence of unfitness.	Not Implemented
Photographic Evidence- SW's should take photographs for documentation purposes whenever possible. All SW's should have quick access to a camera or a phone camera. All cameras should have the ability to upload data into FamLink.	Completed/Statewide
Investigative Tools- CA should conduct a review of the FamLink investigative tools in an effort to decrease the impact on workload due to possible duplication of documentation related to the investigative tools.	Completed/Statewide
Infants- Establish statewide policy to require CA social workers conducting home visits to complete a visual examination of all infants under the age of one year. The infants should be fully unclothed to allow the social worker to monitor for possible injury or signs of malnourishment.	In Process/Statewide

CASEWORK PRACTICE	
Critical Incidents & Staff Reassignment- CA should consider implementing policy mandating reassignment of staff following a critical event on an assigned case. The Committee recommends the establishment of a policy rather than allowing for individual choice of reassignment following a critical incident.	Not Implemented
CAPTA Appeals- Pre-CAPTA appeals should be reviewed and approved at a level higher than an Area Administrator when the subject of the finding is appealing so they may provide care for children or vulnerable adults. If a pre-CAPTA founded finding is reversed the electronic record should include the reason for the reversal.	Not Implemented
FamLink Notifications- FamLink is designed to notify social workers of any new intake associated with an open case; however, FamLink will not notify social workers when a subject is connected with a different family. For this reason the CPS social worker did not receive notice of the new screened out allegation. The Committee recommends the supervisor and social worker automatically receive notification via email any time a subject is connected to an open case.	Not Implemented
Case Supervision- When a change in supervisory coverage for a work unit of Indian Child Welfare social workers occurs, the cases assigned to that unit should be jointly staffed by the previous and new supervisors. This approach would highlight for the new supervisor which cases are particularly complex or involve children at greater risk of maltreatment.	Not Implemented
Case Transfers- The committee believes transfers should be routed through intake so the time/date of transfer can be tracked and the case assigned a timeframe for the initial contact following transfer (based upon risk) as determined by the new office or intake.	Not Implemented
Access to Criminal History- The committee believes it would be beneficial for social workers to have instant access to a subject's criminal history and prior contacts with law enforcement.	Not Implemented
Medical Emergencies- The Committee noted that neither the foster mother nor case manager called 911 prior to arriving at the hospital with the two foster girls. The Committee reviewed DSHS Form 10-290 (Rev. 03/2012) and noted the Medical Policy Statement section of the form requires the foster parent to report any serious injury or illness to a child's social worker. The Committee believes this form should be modified to include a statement requiring the foster parent to call 911 for any medical related emergency. The committee believed contracted providers (including case managers)	Implemented/Statewide

CASEWORK PRACTICE	
should also sign the medical policy statement as they may be in a position of responding to a medical emergency.	
Case Planning- CA should review with OAG how the department proceeds with recommendations to the court in cases where one or both parents are believed to have caused a serious non-accidental injury to a young child and for which no accountability is established. While the Committee concludes that the department should not generally recommend reunification in such cases, it is open to the development by CA of more precise guidelines for such decisions.	In Process/Statewide
Home Studies- The Committee recommends the Administrative Review process and the home study process be completed concurrently. The initiation of the home study process should not be delayed until the completion of the Administrative Review. The Committee was aware that the social worker completed the appropriate background checks and initial walk through at the time of J.B.'s placement; however, the Committee believed the home study process provides important additional information and recommends the home study process be initiated immediately following the initial placement of a foster child into an unlicensed caregiver's home.	In Process/Statewide
Medication Storage- The near-fatal incident occurred because J.B. accidentally ingested Methadone while in unlicensed care. The Committee recommends unlicensed placements keep their medications in a locked container. The storage container should meet the same standards set for licensed foster homes. Unlicensed placements are only required to keep medication in an inaccessible area.	In Process/Statewide
Caseloads- The Committee recommends LEP cases be weighed in a manner that sufficiently reflects the additional workload involved. The Committee also recommends CA focus on recruiting and retaining qualified Spanish speaking staff in offices with a high Spanish speaking population.	Not Implemented
Water Safety- By March 2014, CA should convene a workgroup consisting of professionals representing water safety, foster parenting, public health, law enforcement, the Division of Licensed Resources, and CA's contracted training provider to consider the following: • Update WAC 388-148-0170 (relating to the water safety of foster children) with specific instruction about when to require foster children to use United States Coast Guard-approved personal flotation devices. • Expand WAC 388-148-0170 to require safety and supervision plans when a foster home is in close proximity to an open body of water such as a pond or stream.	Completed/ Statewide

CASEWORK PRACTICE	
• Develop written guidelines on water safety for use by DLR staff responsible for creating safety and supervision plans for licensed home and facilities. • Revise CA's Guidelines for Foster Child Activities (DSHS form 22-533) to include specific guidance about participation in swimming, boating and water recreation by children in foster care.	
Water Safety- Revise the Foster Home Inspection Checklist (DSHS form 10-183) to include a specific section about water safety in foster homes.	Not Implemented
Out-of-Home Placement- Update CA's Placement Agreement form (DSHS form 15-281) to indicate the out-of-home placement provider has read and agreed to comply with the Guidelines for Foster Child Activities.	In Process/Statewide
Private Agencies-The Committee recommends CA conducts annual on-site reviews of CPAs as a strategy to CPA compliance with the myriad of laws, administrative codes, and policies relevant to foster care licensing and contracting.	Not implemented
Private Agencies- The Committee recognized that CA and the CPA collaborated consistently when conducting health and safety visits in the caregiver's home. It is recommended CA consider conducting occasional independent monthly health and safety visits when other agencies are involved.	Not Implemented
Non-compliance with Court Ordered UAs- The Committee recommends the Spokane CA office work with system partners (such as the courts and chemical dependency providers) to discuss the systems response when a parent fails to comply with court ordered UA testing. The Committee believes the mother's no-shows during the prior dependency should have been given greater weight by CA and the courts.	In Process/office
CA Staff Support- Management in the CA office where A.F.'s case was assigned should provide a reminder to staff about the support available following a critical event.	Completed/office
CA Staffing- CA should consider re-establishing the funding for Chemical Dependency Professionals contracted to work directly in CA offices. The increased accessibility to specialized consultation would be beneficial to CA social workers working with families impacted by substance abuse.	Not Implemented
CA Staffing- The Committee recommends that CA explore the possibility of re-initiating the Chemical Dependency Professional (CDP) liaison program which provided the CA field offices with "in house CDPs" that were available	Not Implemented

CASEWORK PRACTICE	
for substance abuse related consultation, informational resources, guidance for client engagement, and community resources. The Committee is aware that current state budget constraints may pose a barrier to this recommendation.	
CA Staffing- In recognition of the complexity of requesting child welfare records from other states, the committee recommends Children's Administration consider expanding the existing Child Abuse and Neglect history check unit to create a centralized approach to all requests for out-of-state child welfare records. A centralized unit would relieve CA social workers of the time consuming task of determining the record requesting requirements set by individual states and the follow-up often needed to ensure records are received in a timely fashion.	Not Implemented
CA Staffing- The Committee recommended re-instating the placement of chemical dependency professionals within the DSHS offices.	Not Implemented
CA Staffing- The hiring and retention of Child Protective Services social workers and supervisors should be a top priority of Children's Administration.	Completed/Statewide
CA Staffing- CA should ensure adequate back-up supervisory coverage for social workers when a supervisor is unavailable for reasons such as extended leave or special assignments. The experience and expertise of the individual selected to provide back-up coverage should be relevant to the supervisory need.	Completed/Statewide
CA Staffing- When a case-carrying social worker is assigned a special project, the social worker's supervisor and manager should implement a plan to ensure adequate coverage of the social worker's existing caseload.	Completed/office
CA Staffing- CA should consider strategies to support CPS social workers when caseloads exceed a reasonable number or when cases assigned to one social worker are exceptionally complex.	Not Implemented
Information Technology- The Committee believes findings need to be easily located by investigative social workers. The Committee noted it is challenging for social workers to locate findings in MODIS. For this reason, the Committee believes any founded finding discovered in MODIS through the course of an investigation should be manually added to FamLink so it can be considered during future investigations.	Not Implemented
FamLink- During the course of the review, the Committee noted that several	Completed/Statewide

CASEWORK PRACTICE	
of the reports provided to the Committee reflected the review facilitator as the author of those reports. The Committee learned that CA's computer system, FamLink, automatically places the name of the person printing the document as the author of the document. The Committee recommended that a change request be submitted to Children's Administration Technology Services to ensure all documents printed from FamLink accurately reflects the actual author.	

INTAKE SCREENING DECISIONS	
CA Intake- Remind CA's intake supervisors of the importance of a comprehensive review of a parent's history of involvement with CA when making intake screening decisions. The Committee recommends the statewide intake program manager for Children's Administration provides this reminder in a "lessons learned" format to all intake supervisors.	Completed/Statewide

COMMUNITY AND FAMILY EDUCATION	
CA Outreach- The Committee recommends CA continue community outreach about child abuse. The Committee recommends that community education includes tools such as You Tube, social media, and regular contact with community organizations.	Completed/Statewide

EFFECTIVE INTERVENTION WITH FAMILIES	
The Committee recommends social workers talk to parents about Safe Sleep as a routine part of the investigation when working with expectant mothers.	Completed/Statewide

SERVICES & OTHER	
Supervised Visits- Visits between the mother and her children involved significant conflict and turmoil. The Committee recommends CA add a therapeutic visitation contract.	Completed/office
Service Providers- Service Providers who are contracted with CA to provide services to CA clients should be contractually obligated to participate with reviews and turn over any relevant documents when requested.	Completed/Statewide
Service Providers- Children's Administration should consider revising the contract requirements for in-home service providers to include weekly observation of any child living in the home of the family receiving the contracted service.	In Process/Statewide
Court- In cases where the judge orders a child's placement with a specific caregiver over the objection of a parent, the Committee recommended the reasons be articulated in the court record.	Completed/Legis *RCW 13.34.130*
Foster Parent Resources- The Wenatchee area has a shortage of foster placements for teenage females. CA should recruit and retain foster homes for teenage females with specific behavioral needs that don't rise to the level of requiring a BRS placement.	Completed/Region
Foster Parent Resources- Efforts should be made to focus recruitment and retention on foster homes that can meet the needs of high needs children.	Completed/Statewide

STATEWIDE RECOMMENDATIONS CONSIDERED / NOT IMPLEMENTED	
Recommendation	**Explanation for No Implementation**
Safety Planning and Risk Assessment- CA is encouraged to re-assess and consider modifying the Child Safety Framework safety plan policy that does not currently allow a child to remain in relative care with a safety plan if a safety threat meets the criteria of an "unsafe child." There may be situations in which a Safety Plan could be initiated within the relative home so that placement disruption does not need to immediately occur.	Safety plans are not created in out of home care situations.
Provide Training- CA should incorporate the following practice issues into any future "Lessons Learned from Child Fatalities" presentations for CA staff: (1) making purposeful effort to find out why a parent does not have care and/or custody of other biological children, including making contact with the custodial parent or relative caregivers; (2) giving deliberate consideration to referring a marijuana using parent for substance abuse assessment when that parent has any past diagnosis for substance abuse/chemical dependency issues, especially if they co-occur with mental health and DV issues.	Lessons Learned does emphasize comprehensive investigations that would address these issues.

STATEWIDE RECOMMENDATIONS CONSIDERED / NOT IMPLEMENTED	
Recommendation	**Explanation for No Implementation**
Safety Planning and Risk Assessment- CA should review the current statutory and policy requirements for vetting parents and their partners prior to placement of dependent child (e.g., Sirita's Law) and consider how these standards might be applied when children who are not yet dependent are placed with an out-of-state parent. The key aspect of this recommendation is to strengthen practice such that the department identifies the risks associated with placement with an out-of-state parent, their partner and/or their living environment, rather than presenting this situation as neutral, with no evidence of unfitness.	Parents have an intrinsic right to parent their children. We have to look through the pieces of information we have and work with the other state to obtain and help determine fitness of the parent.
Casework Practice- CA should consider implementing policy mandating reassignment of staff following a critical event on an assigned case. The Committee recommends the establishment of a policy rather than allowing for individual choice of reassignment following a critical incident.	
Casework Practice- CA should consider re-establishing the funding for Chemical Dependency Professionals contracted to work directly in CA offices. The increased accessibility to specialized consultation would be beneficial to CA social workers working with families impacted by substance abuse.	Specialized case consultation is done on a case by case basis. CA staff are trained to consult with community based chemical dependency professionals when working with chemically dependent clients.
The Committee recommended re-instating the placement of chemical dependency professionals within the DSHS offices.	Cannot be implemented due to budget constraints

STATEWIDE RECOMMENDATIONS CONSIDERED / NOT IMPLEMENTED	
Recommendation	**Explanation for No Implementation**
Effective CPS Investigations- Pre-CAPTA appeals should be reviewed and approved at a level higher than an Area Administrator when the subject of the finding is appealing so they may provide care for children of vulnerable adults. If a pre-CAPTA founded finding is reversed the electronic record should include the reason for the reversal.	Not rated priority by CQI Advisory Committee
Casework Practice- FamLink is designed to notify social workers of any new intake associated with an open case; however, FamLink will not notify social workers when a subject is connected with a different family. For this reason the CPS social worker did not receive notice of the new screened out allegation. The Committee recommends the supervisor and social worker automatically receive notification via email any time a subject is connected to an open case.	
Provide Training- Children's Administration should provide a written reminder to all case-carrying social workers about case transfer protocols. The reminder should address both transfers between social workers working in the same office and transfers between offices.	Not ranked as priority by CQI Advisory Committee
Casework Practice- the committee recommends Children's Administration consider expanding the existing Child Abuse and Neglect history check unit to create a centralized approach to all requests for out-of-state child welfare records.	The CA/N History Unit needs additional resources to implement this recommendation. At this time, they are providing extensive back-up to the NCIC Unit. Within existing resources, the Child Abuse and Neglect history check unit is available to assist social workers with the process for obtaining out of state child abuse records.

STATEWIDE RECOMMENDATIONS CONSIDERED / NOT IMPLEMENTED	
Recommendation	**Explanation for No Implementation**
Casework Practice- When a change in supervisory coverage for a work unit of Indian Child Welfare social workers occurs, the cases assigned to that unit should be jointly staffed by the previous and new supervisors. This approach would highlight for the new supervisor which cases are particularly complex or involve children at greater risk of maltreatment.	Not ranked as priority by CQI Advisory Committee
Casework Practice- The committee believes transfers should be routed through intake so the time/date of transfer can be tracked and the case assigned a timeframe for the initial contact following transfer (based upon risk) as determined by the new office or intake.	The current procedure for transferring cases emphasizes direct sharing of case information between involved staff. Facilitating the transfer of cases is outside the role of intake.
Casework Practice- The committee believes it would be beneficial for social workers to have instant access to a subject's criminal history and prior contacts with law enforcement.	CA staff is trained to use local and tribal law enforcement resources when there are urgent concerns regarding a subject's criminal history.
Provide Training- all DLR licensors receive training on the safety concerns associated with DE rooms (e.g., potential hanging hazards, facility policies regarding the use of the DE room, and the ability to maintain line of sight supervision for children placed in the DE room). The committee noted the current checklist did not require DLR to inspect the DE room for safety and visibility concerns.	There are only three facilities statewide using secure time-out rooms. There is an administrative review process at the statewide administrator level that is required to approve licensing a facility with these secured rooms. DLR will ensure.

STATEWIDE RECOMMENDATIONS CONSIDERED / NOT IMPLEMENTED	
Recommendation	**Explanation for No Implementation**
Safety Planning and Risk Assessment- The committee recommends WAC 0388-148-0487 be modified to require all belts, shoes, and hoodie strings of youth to be removed when a youth is placed into a DE room.	Referred to Children's Administration's Legislative liaison for further consideration.
Casework Practice-The Committee believes findings need to be easily located by investigative social workers. The Committee noted it is challenging for social workers to locate findings in MODIS. For this reason, the Committee believes any founded finding discovered in MODIS through the course of an investigation should be manually added to FamLink so it can be considered during future investigations.	Recommendation was reviewed and determined to be outside of the scope of Children's Administration Technology Services. Findings in MODIS include Pre-1998 and there is currently no way to manually enter findings into FamLink. Modis is being redesigned to make finding findings easier. FamLink change would be incredibly difficult and would include a large dedication of resources to make the changes in FamLink.
Casework Practice -CA to consider adding resources such as Lynx Northwest, Lexus Nexis or Spillman. CA should evaluate these databases and determine if these systems are able to provide social workers with information needed to increase child safety.	Many of these systems come at cost per user and can be costly to the department. Staff receives ongoing training on existing resources for obtaining client information relevant for investigations and assessing child safety.
Provide Training -The Committee noted that the father's name and/or information were frequently missing from the Native American Questionnaire. The Committee recommends social workers explain why a father is not listed on the Native American Questionnaire. Additional training should be provided to social workers to ensure this recommendation is completed.	Not ranked as priority by CQI Advisory Committee

STATEWIDE RECOMMENDATIONS CONSIDERED / NOT IMPLEMENTED	
Recommendation	**Explanation for No Implementation**
Partnerships with Community Professionals- When Child Near-Fatality or Fatality reviews involve families with a history of receiving child welfare services from states in addition to Washington, Children's Administration should establish information-sharing agreements with the other states. The agreements should allow for the exchange of Child Near-Fatality and Fatality reports between the involved states and possible reciprocal participation in reviews.	Other states have been invited to critical incident reviews when they have significant history on the family.
Provide Training- The Committee noted pictures of the home environment would have provided an accurate and unbiased reflection of the home environment. The written description of the home environment varied significantly and it was difficult to assess the home without photographic evidence. The Committee recommends all CA social workers receive a reminder about the benefits of photographing the home environment.	CA social workers have access to cameras and are trained to take photographs when appropriate during the course of a CPS investigation.
Casework Practice- Currently, CA policy provides CPS social workers with discretion in deciding when to access the National Crime Information Center (NCIC) database. The Committee recommends, if permissible by law, a change in policy to require social workers to access the National Crime Information Center (NCIC) database during the course of a CPS investigation.	Staff receives ongoing training on determining when to request criminal background information during the course of a CPS investigation. Staffing of CA's centralized unit for accessing criminal background information now offers expanded 24 hour coverage.

STATEWIDE RECOMMENDATIONS CONSIDERED / NOT IMPLEMENTED	
Recommendation	**Explanation for No Implementation**
Safety Planning and Risk Assessment - WAC 388-148-0205 requires licensed foster homes keep all medication in locked storage. WAC does not specify what constitutes locked storage. The Committee believes WAC 388-148-0205 should be modified to specify all medications be kept in a locked container or another storage area made of strong, unbreakable material when not in use similar to the WAC for firearm and ammunition storage.	The WAC requires locked storage for medication; this naturally would be made of a strong material. The medication in this case was in a locked file cabinet, which would qualify both as a locked container, as well as a container of strong unbreakable material. DLR would not allow a locked medication box that could be easily broken.
Intake Screening Decisions- WAC 388-148-0120(2) and (3) specifically references any child's suicide attempt that results in injury requiring medical treatment or hospitalization and suicidal/homicidal ideations, gestures, or attempts that do not require professional medical treatment. WAC 388-148-0120 requires foster parents to report such incidents as soon as possible and in no instance later than forty-eight hours to the local Children's Administration intake staff and the child's social worker or case manager. The Committee recommends WAC 388-148-0120 require foster parents, private agency licensors, and case managers to report incidents as soon as they have reason to believe a child is experiencing suicidal ideation or attempted/completed suicide. All reports should be made to the child's assigned social worker, CA intake, and the private agency case manager if a child placing agency program places the child.	The purpose of a report to intake is to refer for an investigation. An appropriate plan regarding a youth with suicidal ideation should be made directly to the social worker, who can develop the appropriate response plan. The licensor would defer to the child's social worker who is aware of the dynamics of the case and the specific needs of the child.

STATEWIDE RECOMMENDATIONS CONSIDERED / NOT IMPLEMENTED	
Recommendation	**Explanation for No Implementation**
Casework Practice - While recognizing that a complete SDM manual is accessible to all CA staff via the agency intranet, the Committee suggests CA consider developing a desk version "cheat sheet" that could prompt workers to improve accuracy of risk level assessment by quick reference to definitions for each item on the SDM.	Not ranked as priority by CQI Advisory Committee
Casework Practice - The Committee recommends LEP cases be weighed in a manner that sufficiently reflects the additional workload involved. The Committee also recommends CA focus on recruiting and retaining qualified Spanish speaking staff in offices with a high Spanish speaking population.	Not ranked as priority by CQI Advisory Committee
Safety Planning and Risk Assessment - Revise the Foster Home Inspection Checklist (DSHS form 10-183) to include a specific section about water safety in foster homes.	There are already three lines related to water safety on this inspection checklist. The current checklist should not be modified, given that new WACs are being developed and will be implemented in October. The inspection checklist will be redrafted at that time.
Provide Training- At the time of initial licensing and licensing renewal, require foster parents to complete training on the risk and prevention of childhood injuries. The Committee recommends the training include information on the proper use of safety equipment such as bicycle helmets, car seats and personal flotation devices.	The department does not have the capacity to require this of all providers. Recommendation is being forwarded to the Alliance as a suggested in-service training or on-line training available to satisfy in-service training requirements. We have also identified some reputable websites with good childhood injury information and those hyperlinks have been uploaded to the DSHS Foster Parent website.

STATEWIDE RECOMMENDATIONS CONSIDERED / NOT IMPLEMENTED	
Recommendation	**Explanation for No Implementation**
Casework Practice -The Committee recommends CA conducts annual on-site reviews of CPAs as a strategy to CPA compliance with the myriad of laws, administrative codes, and policies relevant to foster care licensing and contracting.	DLR is currently completing a minimum of 2 health and safety reviews per year for BRS providers, as well as comprehensive reviews halfway through the three-year licensing period. Not all CPAs provide direct care, certify homes or are necessarily contracted with the department. Licensors also complete health and safety reviews on non-BRS programs routinely, though it is not required. If a CPA is out of compliance with administrative rule, a licensing investigation would be conducted. We are completing health and safety reviews more frequently than the recommendations in the programs that are at highest risk.
Casework Practice -The Committee noted a significant amount of documentation was entered into FamLink following the fatality. The Committee questioned CAs practice of destroying hand written case notes after the information is entered into FamLink. The Committee believes CA policy should require the retention of all hand written case notes that exist at the time of the fatality.	Every employee of the department who conducts an interview of any person involved in an allegation of abuse or neglect shall retain his or her original written records or notes setting forth the content of the interview unless the notes were entered into the electronic system operated by the department which is designed for storage, retrieval, and preservation of such records.
Safety Planning and Risk Assessment - The Committee recognized that CA and the CPA collaborated consistently when conducting health and safety visits in the caregiver's home. It is recommended CA consider conducting occasional independent monthly health and safety visits when other agencies are involved.	We considered this and are not going to implement this recommendation at this time. This would be a workload increase on staff at this time.

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HEIKE LAKE
Lutheran Community Services
Spokane

ROSEY THURMAN
Team Child
Spokane

STAFF

Director Ombuds – Retired, November 30, 2014

Mary Meinig is a licensed independent clinical social worker who has served the citizens of Washington as the Director-Ombuds since 2002, and served as an Ombuds with the office from 1997 through 2001. Prior to joining OFCO, Ms. Meinig maintained a successful clinical and consulting practice that focused on issues of victimization, family reunification and family resolution. She also worked as an associate for Northwest Treatment Associates for five years, providing treatment for children and families affected by abuse and trauma. Her earlier social work experience included residential treatment, child protective services and school social work. She received a Master of Social Work degree from the University of Washington in 1974.

Acting Director Ombuds

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

Ombuds

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

Ombuds

Cristina Limpens is a social worker with extensive experience in public child welfare in Washington State. Prior to joining OFCO, Ms. Limpens served as a quality assurance program manager for Children's Administration, working to improve social work practice and promote accountability and outcomes for children and families. Prior to that, Ms. Limpens worked with children and families involved in the child protection and child welfare system. Ms. Limpens earned a Master of Social Work degree from the University of Washington. She joined OFCO in June 2012.

Ombuds

Erin Shea McCann is a licensed attorney with experience representing children and youth in Washington's foster care system, as well as children and youth experiencing homelessness. Prior to joining OFCO, Ms. McCann was a Staff Attorney with the Children & Youth Project at Columbia Legal Services where she served as co-counsel for the state's 10,000 foster children in the reform process that resulted from a settlement in the case of Braam v. Washington. Additionally, Ms. McCann worked to ensure that the more than 25,000 homeless students in Washington were properly identified and served by their school districts under federal homeless education law. She started with CLS in 2007 as an Equal Justice Works Fellow. Ms. McCann graduated from the University of Washington and received her J.D. from Seattle University School of Law.

Special Projects / Database Administrator

Bryan Davis is a public policy professional with experience in urban healthcare, community outreach, and public relations. For several years, he helped young adults living on the streets connect with supportive housing and sustainable recovery options. Prior to joining OFCO, he worked for the City of Seattle, engaging local constituents and other stakeholders on the environmental and social benefits of capital improvement projects and programs occurring in their communities. Mr. Davis is a graduate of the Evans School of Public Affairs at the University of Washington, where he focused on health policy, social economics, and public sector finance.

Intake and Referral Specialist / Office Administrator

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