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

2011 Annual Report

Mary Meinig, Director Ombudsman
Patrick Dowd, Ombudsman
Colleen Hinton, Ombudsman

www.governor.wa.gov/ofco

STATE OF WASHINGTON
OFFICE OF THE FAMILY AND CHILDREN'S OMBUDSMAN
6720 FORT DENT WAY, SUITE 240
TUKWILA, WA 98188
(206) 439-3870 • (800) 571-7321 • FAX (206) 439-3877

January 2012

To the Residents of Washington State:

I am pleased to submit the 2011 Annual Report of the Office of the Family and Children's Ombudsman. This report provides an account of OFCO's activities from September 1, 2010 to August 31, 2011 and our recommendations to improve the child welfare system.

In this time of economic uncertainty and cuts to both public and private services that assist families, there is an even heightened need for independent and objective oversight of our child welfare system. During this reporting period, OFCO completed 614 complaint investigations concerning 924 children and over 600 families. One out of every seven complaints was handled as an "emergent investigation" as the allegations involved either a child's immediate safety or an urgent situation requiring timely intervention. The majority of complaints in which the Ombudsman intervened or provided assistance were successfully resolved. I am proud of OFCO's vigilance and dedication to promoting the safety and welfare of the children and families of Washington State.

In addition to complaint investigations, OFCO monitors practices and procedures within the child welfare system and makes recommendations to better serve children and families. Over the past year, OFCO became alarmed at an emerging trend of severe child abuse and neglect occurring in adoptive, pre-adoptive or guardianship placements. The Ombudsman brought these concerns to Governor Gregoire's attention and the Governor requested that the Assistant Secretary of Children's Administration, Denise Revels Robinson, and OFCO further collaborate to address these issues.

I want to express my appreciation to the Governor, the Legislature, the Department of Social and Health Services, private agencies and advocates who are committed to excellence in child welfare outcomes. I also wish to acknowledge departing Department of Social and Health Services (DSHS) Secretary Susan Dreyfus' significant contribution to improving the safety and welfare of children and families.

Most importantly, I thank the parents, youth, relatives, foster parents, professionals and others who brought their concerns to our attention. We take their trust in our office most seriously and it is an honor to serve the citizens of Washington State.

Sincerely,

Mary Meinig
Director Ombudsman

ADVISORY COMMITTEE

WESTERN WASHINGTON COMMITTEE

TERESA BERG
Pierce County Sheriff's Office, Tacoma

LYNNETTE JORDAN
United Indians of All Tribes Foundation, Seattle

CARLA GRAU-EGERTON
Island County CASA

GARY PREBLE
Private Attorney, Olympia

NANCY ROBERTS-BROWN
Catalyst for Kids, Seattle

LOIS SCHIPPER
Seattle & King County Public Health, Seattle

JIM THEOFELIS
The Mockingbird Society, Seattle

SUE HOTT, M.D.
Swedish Physicians Children's Clinic, Seattle

BRYNA DESPER
Northwest Adoption Exchange, Seattle

BRENDA LOPEZ
Parent Representation, Seattle

CENTRAL WASHINGTON COMMITTEE

SUE BAKER
Chelan/Douglas County Court Appointed Special Advocate, Wenatchee

DANN FLESHER
Relatives as Parents, Benton City

SHERRY MASHBURN
Parents Are Vital in Education, Sunnyside

DEAN MITCHELL
Moses Lake Police Department, Moses Lake

FRANK MURRAY
Yakima County Court Appointed Special Advocate, Yakima

PATTY ORONA
Yakima County School District, Yakima

MARY-JEANNE SMITH
Foster Parent Association of Washington

EASTERN WASHINGTON COMMITTEE

KELLY BUSSE
Spokane Police Department, Spokane

ELLEN CADY *
Northwood Middle School, Spokane

PATRICK DONAHUE
Spokane County Court Appointed Special Advocate, Spokane

TARA DOWD
The N.A.T.I.V.E. Project, Spokane

ART HARPER
Foster Parent Liaison, Spokane

KIM KOPF
Whitman County CASA, Colfax

ROSEY THURMAN
Team Child, Spokane

HEIKE LAKE
Lutheran Community Services, Spokane

AMBROSIA EBERHARDT,
Veteran Parent, Spokane

**No longer Advisory Committee Member*

LEGISLATIVE CHILDREN'S OVERSIGHT COMMITTEE

SENATOR JIM HARGROVE, CHAIR
8th District

REPRESENTATIVE MARY HELEN ROBERTS
27th District

REPRESENTATIVE LARRY HALER
24th District

SENATOR VAL STEVENS
21st District

REPRESENTATIVE RUTH KAGI
32nd District

SENATOR DEBBIE REGALA
39th District

STAFF

Director-Ombudsman
Mary Meinig is the Director of the Office of the Family and Children's Ombudsman, which investigates complaints about the actions of state child welfare agencies involving children at risk of abuse or neglect, or families involved with child protection services. In addition to addressing complaints, as the Director Ombudsman, Ms. Meinig identifies system-wide issues and recommendations to the Governor, the Legislature and agency officials. Prior to joining the Office of the Family and Children's Ombudsman in 1997, 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 where she worked with children and families affected by abuse and trauma. Prior to her work at Northwest Treatment Associates, Ms. Meinig's social work experience included residential treatment, child protective services and school social work. She received her Master of Social Work degree from the University of Washington in 1974.

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

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

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

Ombudsman
Corey Fitzpatrick Wood is a licensed attorney with experience representing parents in dependency proceedings as well as youth in truancy and at-risk youth proceedings. She received her law degree from the University of Washington, where she participated in the school's Children and Youth Advocacy Clinic. Ms. Wood has worked extensively with at-risk youth and currently serves on the board of Street Youth Legal Advocates of Washington. Prior to law school, Ms. Wood worked for OFCO as an Information and Referral Specialist.

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

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

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EXECUTIVE SUMMARY

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

This report provides an account of OFCO's complaint investigation activities from September 1, 2010, through August 31, 2011. OFCO's administrative reviews of critical incidents such as child fatalities and near fatalities include cases through December 2011. 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 Ombudsman are set forth in state laws:[1]

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

Complaint Investigation and Intervention:
Investigate, upon the Ombudsman's 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; however, the ombudsman may decline to investigate any complaint as provided by rules adopted under this chapter;

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 with a view toward appropriate preservation of families and ensuring 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 the procedures for addressing the needs of families and children;
- 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. (Duty created in 2008)

Annual Reports:

- Submit annually to the committee and to the governor a report analyzing the work of the office including recommendations; and
- Issue an annual report to the legislature on the status of the implementation of child fatality review recommendations. (Duty created in 2008)

[1] RCW 43.06A and RCW 26.44.030.

INQUIRIES AND COMPLAINT INVESTIGATIONS CORE DUTIES

OFCO received 1,418 inquiries from families and citizens seeking assistance or information about the child welfare system in 2011. Approximately 43 percent of these contacts were formal complaints requesting an Ombudsman investigation. Between September 1, 2010 and August 31, 2011, OFCO completed 614 complaint investigations regarding 924 children and resulting in 65 adverse findings against the department. As in previous years, issues involving the separation and reunification of families and the safety of children living at home or in substitute care were by far the most frequently identified issues in complaints. One out of every seven complaints met OFCO's criteria for an emergent investigation as they involved issues of imminent child safety or well being.

OMBUDSMAN IN ACTION

The annual report describes four main categories of Ombudsman action known as "interventions:"

- Inducing corrective action;
- Facilitating resolution;
- Assisting the agency in avoiding errors and conducting better practice, and
- Preventing future mistakes.

Thirty-one complaints required intervention by the Ombudsman. The vast majority of complaints in which the Ombudsman intervened or assisted resulted in the complaint issue being resolved.

Effective November 2009, OFCO and DSHS entered into an inter-agency agreement, creating a protocol for communicating adverse findings and recommendations to the department. This has resulted in greater transparency of OFCO's work as well as heightened accountability for DSHS. The agreement stipulates that OFCO will provide Children's Administration (CA) with written notice of adverse findings made on a complaint investigation. CA is invited to formally respond to the finding, and may present additional information and request a revision of the finding.

REVIEW OF CRITICAL INCIDENTS

The Ombudsman conducts administrative reviews of cases of recurrent child maltreatment as well as all fatalities and near fatalities of children whose family had an open case with DSHS at the time of death or near fatality, or within a year prior. During this reporting period OFCO conducted 177 administrative reviews of critical incident cases – 76 child fatalities, 12 near fatalities and 89 cases of recurrent maltreatment. Through these reviews, the Ombudsman identifies common factors and systemic issues regarding these critical incidents. Issues and recommendations discussed in this section of the annual report include:

- Unsafe sleep environment continues to be a significant risk factor in many infant deaths;
- Child fatalities are disproportionally high for American Indian, Alaskan Native; and African American children;
- Child Protective Services routinely fails to complete investigations in a timely manner in cases of recurrent maltreatment; and
- Mental health, substance abuse and domestic violence are common factors in cases of recurrent maltreatment.

On occasion, recognizing OFCO's unique role, CA leadership specifically requests that OFCO review and report on certain high-profile or complex cases. Examples of these in-depth reviews in 2011 appear on pages 77 and 114 of this Report.

WORKING TO MAKE A DIFFERENCE

Child Abuse and Neglect in Permanent Placements

The Ombudsman also identifies reoccurring issues and concerns that could be symptomatic of a larger problem. Over the past two years, the Ombudsman has noted a pattern of severe child abuse and neglect occurring in adoptive, pre-adoptive or guardianship placements. What is of particular concern is that in these cases, the child abuse or neglect occurred in homes that had been screened, assessed and approved as a permanent placement for the child. This section details common factors identified in these cases, and discusses further steps necessary to address this issue in greater detail and assure the safe and permanent placements for children in state care.

Child Welfare Legislation

As part of the Ombudsman's duty to recommend systemic change, the Ombudsman reviews and analyzes proposed legislation and testifies before the Legislature on pending bills. This section provides a highlight of those bills on which OFCO provided testimony or those which impact the child welfare system. Legislation discussed in this section addressed topics including:

- Creating a state Indian Child Welfare Act;
- Improving child fatality reviews in child welfare cases;
- Extended foster care for children 18 years of age and older; and
- Unannounced home visits for dependent children.

SYSTEM IMPROVEMENT EFFORTS

Because of the Ombudsman's independent perspective and knowledge of the child welfare system, the Ombudsman is often invited to participate in efforts to improve outcomes for children and families. During the past year, these efforts included: serving as a member of the *Child Welfare Transformation Design Committee* in phase I, implement performance based contracts for child welfare services and in phase II, establish pilot projects contracting with private agencies for child welfare case management services; participating in Executive Child Fatality Reviews and served on a national workgroup on child fatalities; and participating in collaborative efforts with both public and private agencies to engage fathers in child welfare proceedings.

KEY FINDINGS AND RECOMMENDATIONS

- In 2011, OFCO complaint investigations resulted in 65 adverse findings against the department, the most common findings concerned: Parents' Rights and Child Safety. The vast majority of complaints in which OFCO intervened were successfully resolved.

- Alarmed by incidents of severe child abuse and neglect in adoptive, pre-adoptive and other permanent placements, OFCO brought this issue to the attention of the Governor's Office and Children's Administration and recommended that Washington State in partnership with private child welfare agencies convene a work group of experts and leaders within the child welfare community to examine these issues in greater detail. At the request of Governor Gregoire and the Secretary of DSHS, the Children's Administration is taking the lead in working with OFCO to develop and implement a plan to address these concerning cases.

- Complaint investigations and case reviews revealed that Child Protective Services routinely fail to complete Investigative Assessments within the 45-day deadline required by policy. The timely completion of investigations is crucial to child safety and effective case planning. This issue has been identified in previous reports and OFCO renews its prior recommendation that CA Identify the common causes of delays in completing CPS investigations and take steps to ensure that Investigative Assessments are completed in a timely fashion.

- Unsafe sleep environment continues to be a significant risk factor in many infant deaths and child fatalities are disproportionally high for American Indian, Alaskan Native; and African American children.

TERMS AND ACRONYMS

Dependent Child	A child for whom the state is acting as the legal parent.
AAG	Assistant Attorney General
AIRS	Administrative Incident Reporting System
ARS	Alternative Response System
ARY	At Risk Youth
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
CPS	Child Protective Services
CPT	Child Protection Team
CFWS or CWS	Child and Family Welfare Services or Child Welfare Services
DCFS	Division of Children and Family Services
DDD	Division of Developmental Disabilities
DEL	Department of Early Learning
DOH	Department of Health
DLR	Division of Licensed Resources
DMH	Division of Mental Health
DSHS	Department of Social and Health Services
ECFR	Executive Child Fatality Review
EFSS	Early Family Support Services
FamLink	CA's computerized database introduced in late January 2009
FRS	Family Reconciliation Services
FVS	Family Voluntary Services
ICPC	Interstate Compact for the Placement of Children
OFCO	Office of the Family and Children's Ombudsman
SDM	Structured Decision Making
VSA	Voluntary Service Agreement

I. ROLE OF THE OMBUDSMAN

"After speaking with your office the way CPS handled my case was more professional. Thank you"

-Parent

ROLE OF THE OMBUDSMAN

The Washington State Legislature created the Office of the Family and Children's Ombudsman in 1996, in response to two high profile incidents that illuminated the need for oversight of the child welfare system.[2] The Ombudsman provides families and citizens an avenue to obtain an independent and impartial review of DSHS decisions. The Ombudsman is also empowered to intervene to induce DSHS to reconsider or change problematic decisions that are in violation of the law or that have placed a child or family at risk of harm, and to recommend system-wide improvements to the Legislature and the Governor.

INDEPENDENCE

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

IMPARTIALITY

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

CONFIDENTIALITY

OFCO maintains the **confidentiality** of citizens who contact the Ombudsman to initiate a complaint investigation unless such confidentiality is waived by the citizen. This protection makes citizens, including professionals within DSHS, more likely to contact OFCO and to speak candidly with the Ombudsman about their concerns.

CREDIBLE REVIEW PROCESS

OFCO has **a credible review process** that promotes respect and confidence in OFCO's oversight of DSHS. Ombudsmen are qualified to analyze issues and conduct investigations into matters of law, administration, and policy. We have collective experience and expertise in child welfare law, social work, mediation, and clinical practice and are trained in the United States Ombudsman Association Governmental Ombudsman Standards. In November 2009, OFCO and DSHS entered into an inter-agency agreement to improve communication, accountability and bring greater clarity to the working relationship between the two agencies.[3]

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

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

AUTHORITY

Under chapter RCW 43.06A, the Legislature enhanced the Ombudsman's investigative powers by providing it with broad access to confidential DSHS records and the agency's computerized case-management system. It also authorized OFCO to receive confidential information from other agencies and service providers, including mental health professionals, guardians ad litem, and assistant attorneys general.[4] The Ombudsman operates under a shield law which allows OFCO to protect the confidentiality of the Ombudsman's investigative records and the identities of individuals who contact the office. This encourages individuals to come forward with information and concerns without fear of possible retaliation.

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

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

WORK ACTIVITIES

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

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

- **Responding to Complaints.** The Ombudsman impartially investigates and analyzes complaints against DSHS and other agencies. We spend more time on this activity than any other. Thorough complaint investigations and analyses enable the Ombudsman to respond effectively when action must be taken to change an agency's decision and to accurately identify problematic policy and practice issues that warrant further examination. They also enable the Ombudsman to support actions of the agency when it is unfairly criticized for properly carrying out its duties.

- **Taking Action on Behalf of Children and Families.** The Ombudsman intervenes when necessary to avert or correct a harmful oversight or mistake by DSHS or another agency. The Ombudsman's actions include: prompting the agency to take a "closer look" at a concern; facilitating information sharing; mediating professional disagreements; and sharing the

[4] See also RCW 13.50.100(6).

Ombudsman's investigative findings and analyses with the agency to correct a problematic decision. Through these actions, the Ombudsman is often successful in resolving legitimate concerns.

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

The Ombudsman utilizes virtually all of its resources – 6.8 full-time employees (FTEs) to perform these activities. The Ombudsman's work activities are described in more detail in the sections that follow.

II. LISTENING TO FAMILIES AND CITIZENS

- Inquiry Profiles
- Complainant Profiles

"I owe a HUGE debt of gratitude to the Ombudsman. I believe OFCO was instrumental in bringing my grandbaby home. Thank you!"
-Relative

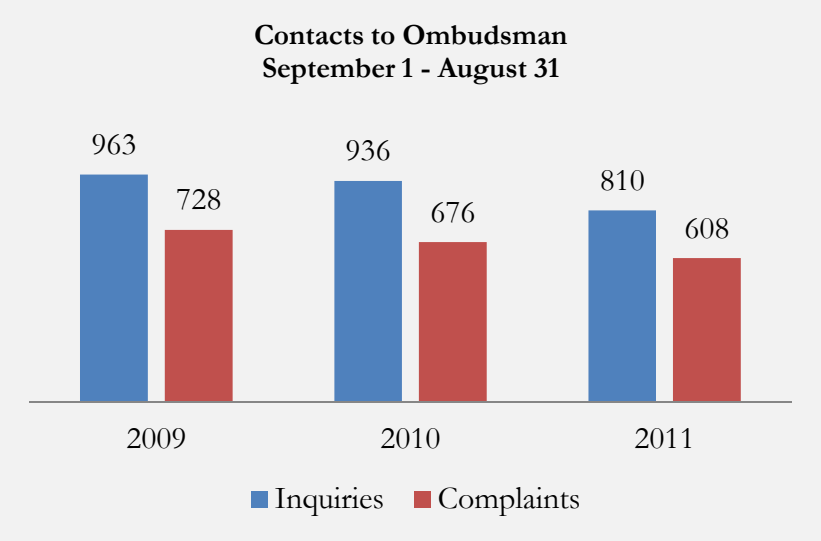
INQUIRY PROFILES

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

This section describes contacts made by families and citizens during the Ombudsman's 2011 reporting year.[5] Data from previous reporting years is included for comparison.

CONTACTS TO THE OMBUDSMAN

Families and citizens contacted the Ombudsman **1,418** times in 2011, 810 of these contacts were **inquiries** made by people seeking information. Approximately 43 percent of these contacts were formal complaints seeking an investigation by an Ombudsman.



Source: Office of the Family and Children's Ombudsman, September 2011

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

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

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

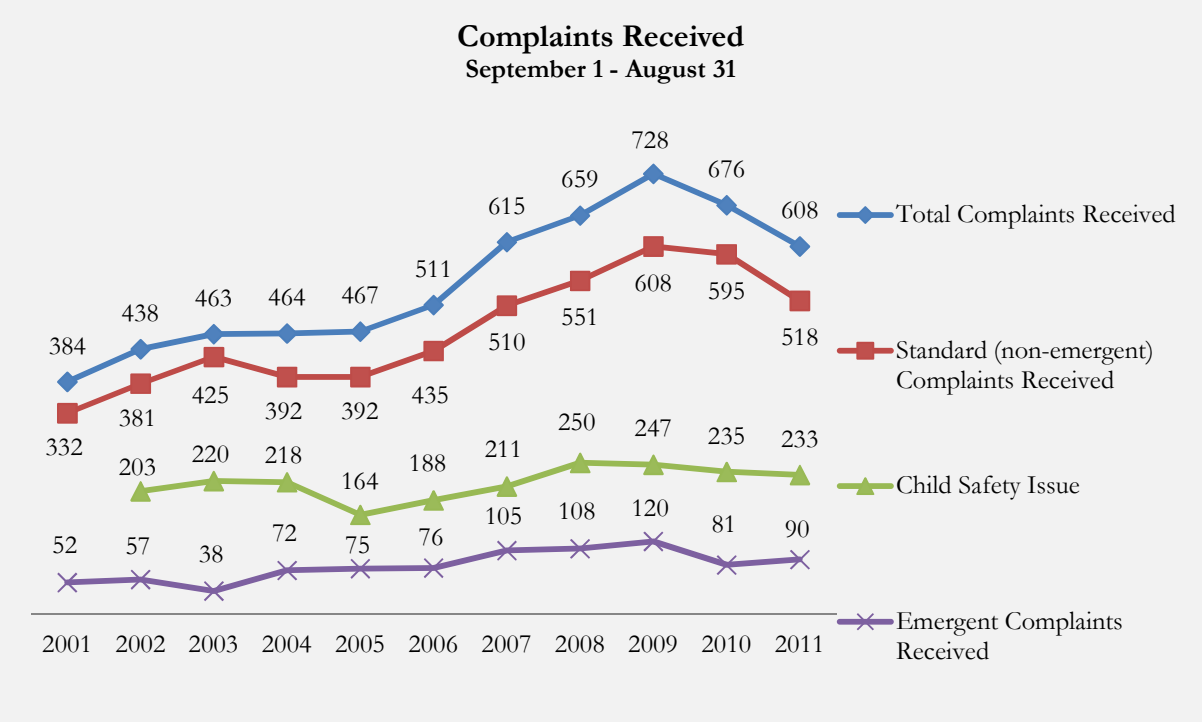
[5] The Ombudsman's annual reporting period is September 1 to August 31.

COMPLAINTS RECEIVED

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

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

The Ombudsman received 608 complaints in 2011. Of these, **fifteen percent were emergent (90 complaints)**. Emergent complaints most often involved child safety or situations in which timely intervention by the Ombudsman could make a significant difference to a child or family's immediate well-being. **Over one-third** of all complaints involved a **child safety** issue **(230 complaints, or 38 percent)**.



Source: Office of the Family and Children's Ombudsman, September 2011

MANDATED NOTIFICATION OF CRITICAL INCIDENTS

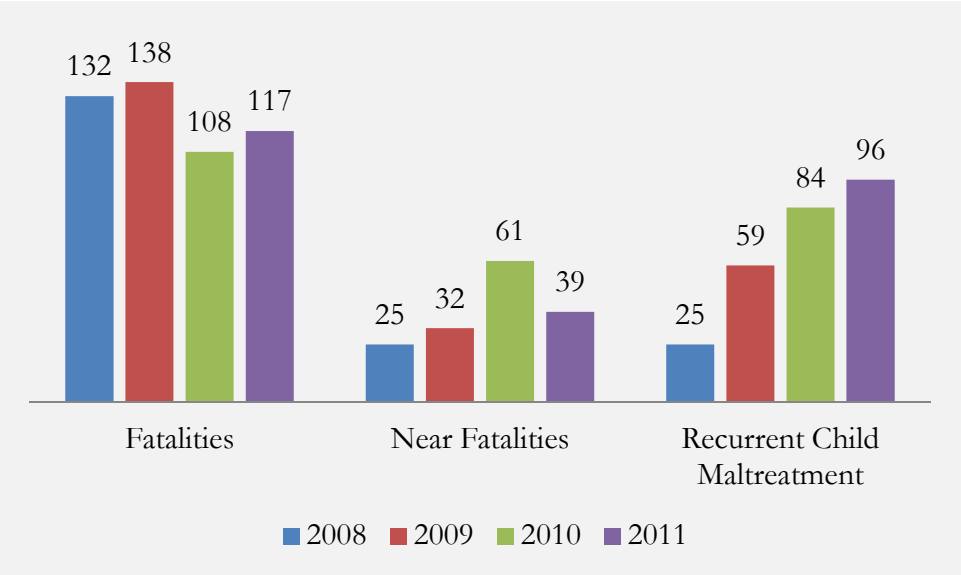
Effective June 2008, the Department of Social and Health Services, Children's Administration (DSHS CA) is required to notify OFCO regarding:

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

The graph below describes the number of DSHS CA notifiers received and reviewed by OFCO during the three most recent reporting periods. The section on child fatalities and near fatalities appearing later in this report does not include all notifications of these incidents received from DSHS, but rather those incidents that meet OFCO's criteria for review during the calendar year.[6] The increase in near fatality and third founded case notifications is associated with more reliable notification to OFCO and does not necessarily indicate there has been an increase in these incidents.

DSHS/CA NOTIFICATIONS RECEIVED DURING OFCO REPORTING YEAR, 2008-2011

September 1 – August 31



Source: Office of the Family and Children's Ombudsman, October 2011

[6] For further discussion of these criteria and fatality reviews, see OFCO Critical Incident Case Reviews, page 69.

DSHS REGIONS AND DIVISIONS IDENTIFIED IN COMPLAINTS

DSHS Children's Administration (CA) is the state's only provider of child protection services and largest provider of child welfare services. It is therefore not surprising that CA was the subject of 96 percent of complaints in 2011.[7]

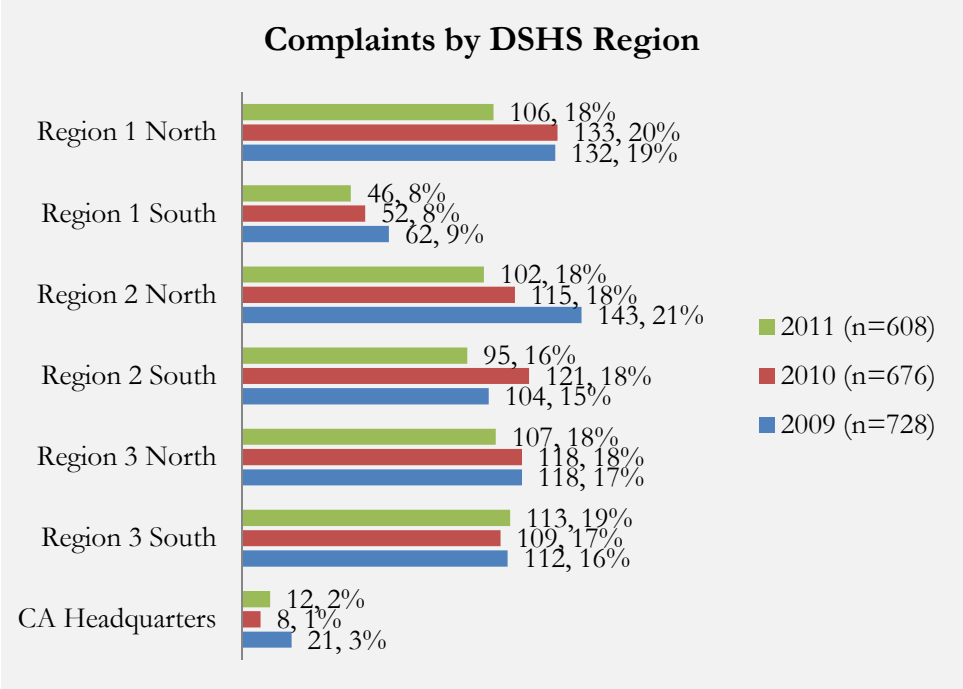
Of the complaints against CA, 96 percent were directed at DCFS, which includes Child Protective Services (CPS), Child and Family Welfare and Adoption Services (CFWS or CWS), Family Reconciliation Services (FRS), and Family Voluntary Services (FVS). A small percentage of complaints (three percent) involved the Division of Licensed Resources (DLR), which licenses and investigates alleged child maltreatment in foster homes, group homes and other residential facilities for children.

Four complaints were directed at the Department of Early Learning (DEL). OFCO investigates only complaints involving child safety and child maltreatment in child care facilities. Complaints about licensing or other actions by DEL are redirected to DEL Service Area Managers.

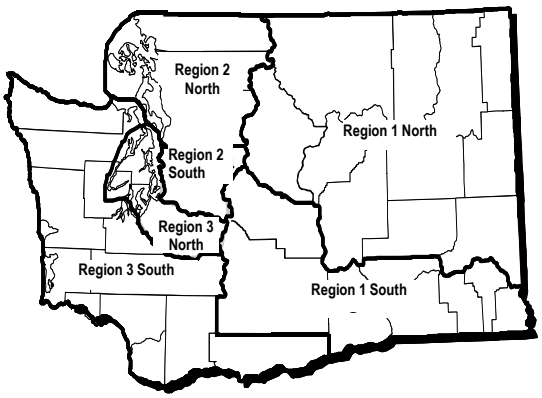
[7] The remaining complaints were directed against other DSHS divisions, such as the Division of Developmental Disabilities (DDD) and Division of Behavioral Health & Rehabilitation (DBHR), Washington Courts, local Court Appointed Special Advocate (CASA)/Guardian Ad Litem (GAL) programs, DSHS contract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

COMPLAINTS BY DSHS REGION

During the 2011 reporting year, DSHS consolidated its existing six geographic regions of the State into three regions, each with two sub-regions.[8] Complaints decreased in all regions except Region 3 South. Complaints in each region for the period from 2000-2011 are shown in Appendix A.



Source: Office of the Family and Children's Ombudsman, September 2011



Regional Offices	*Population*[9]	*Clients served By CA*
Region 1 North – Spokane	838,400	29,174
Region 1 South – Yakima	565,200	22,799
Region 2 North – Everett	1,084,200	34,037
Region 2 South – Seattle	1,861,300	39,281
Region 3 North – Tacoma	1,035,300	31,930
Region 3 South – Vancouver	1,103,600	37,238

[8] The former Regions 1 and 2 are now Region 1 North and Region 1 South, respectively; former Regions 3 and 4 are now Region 2 North and Region 2 South, respectively; and former Regions 5 and 6 are Region 3 North and Region 3 South, respectively. For a detailed map, see http://ca.dshs.wa.gov/intranet/pdf/offices/dshsregionalmap.pdf

[9] http://clientdata.rda.dshs.wa.gov/

COMPLAINTS RECEIVED BY DCFS OFFICE AND REGION 2010-2011

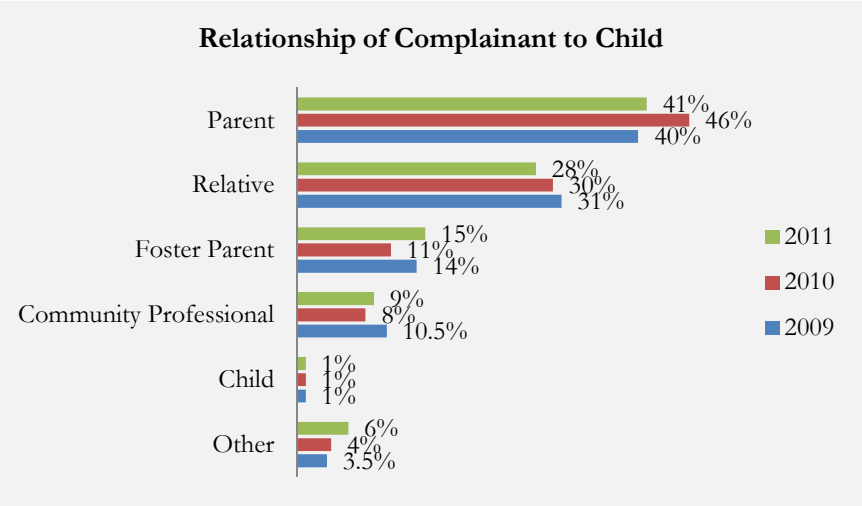
	2010		2011	
	DCFS	DLR	DCFS	DLR
Region 1 North Total	**130**	**3**	**103**	**3**
Spokane	72	2	60	1
Colville	13		17	
Moses Lake	13		9	
Wenatchee	14	1	4	1
Colfax	4		0	
Newport	6		5	
Omak	7		6	1
Republic	1		2	
Clarkston	0		0	
Region 1 South Total	**50**	**2**	**43**	**3**
Yakima	18		16	2
Richland/Tri-Cities	16	1	13	
Walla Walla	8	1	5	
Toppenish	3		0	
Ellensburg	3		3	
Sunnyside			4	
White Salmon	1		1	
Goldendale	1		1	1
Region 2 North Total	**114**	**1**	**95**	**7**
Everett	26		35	5
Bellingham	13	1	18	
Alderwood/ Lynnwood	23		9	1
Arlington/Smokey Point	26		7	
Mount Vernon	9		13	1
Monroe/Sky Valley	11		8	
Oak Harbor	5		5	
Friday Harbor	1		0	
Statewide	**8**		**10**	**2**
CA Headquarters	6		5	2
Central Intake	2		5	

	2010		2011	
	DCFS	DLR	DCFS	DLR
Region 2 South Total	**117**	**4**	**90**	**5**
King South/Kent	28	1	25	
Martin Luther King Jr.	19		13	
King West	22		17	
King East/Bellevue	24		19	
Office of Indian Child Welfare	7		3	
Seattle Centralized Services	9		4	
White Center	7		2	
Seattle Central	1	3	7	5
Region 3 North Total	**114**	**4**	**103**	**4**
Centralized Services	4	4	1	4
Pierce East	38		33	
Pierce West	46		46	
Bremerton/Kitsap	26		23	
Region 3 South Total	**106**	**3**	**100**	**13**
Vancouver	27		33	3
Aberdeen	18	1	18	1
Port Angeles	6		7	
Centralia	9		5	1
Tumwater	8		14	
Kelso	8		12	1
Shelton	7		3	
Stevenson	2		0	
Lacey/Olympia	7	2	5	7
South Bend	3		1	
Long Beach	7			
Port Townsend	3		2	
Forks	1		0	

COMPLAINANT PROFILES

PERSONS WHO COMPLAINED

As in previous years, parents, grandparents and other relatives of the child whose family is involved with DSHS filed the majority of the complaints to the Ombudsman. We continue to have few children contacting the Ombudsman on their own behalf.



Source: Office of the Family and Children's Ombudsman, September 2011

RACE/ETHNICITY OF THE PERSON WHO COMPLAINED

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

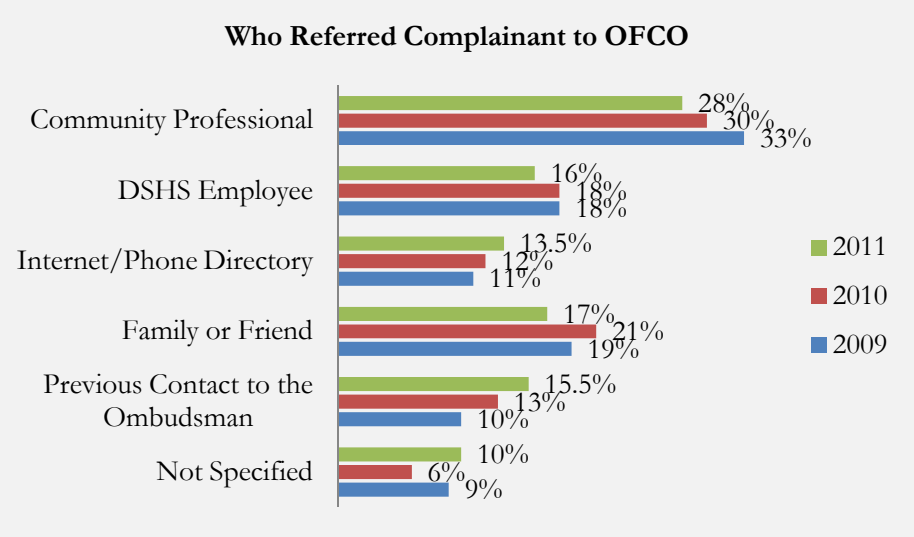
Race/Ethnicity	OFCO 2011	Total WA Population[10]
Caucasian	68.6%	77.3%
African American	8.2%	3.6%
American Indian/Alaska Native	3.1%	1.5%
Asian	1.3%	7.2%
Native Hawaiian and Other Pacific Islander	0.2%	0.6%
Other	0.3%	0%
Multi-Racial	3.8%	4.7%
Declined to Answer	14.5%	--
Hispanic	4.3%	11.2%
Caucasian, not Hispanic	65.5%	72.5%

[10] Taken from 2010 US Census http://quickfacts.census.gov/qfd/states/53000.html

As the table above shows, African Americans and American Indians are over-represented in individuals complaining to OFCO as compared with their representation in state population data, while Hispanics and Asians are under-represented. However, when racial data of children who were the subject of our complaints is compared with the population of children in placement by the CA (see page 24), OFCO appears to be evenly representing children in the child welfare system.

HOW THEY HEARD ABOUT THE OMBUDSMAN

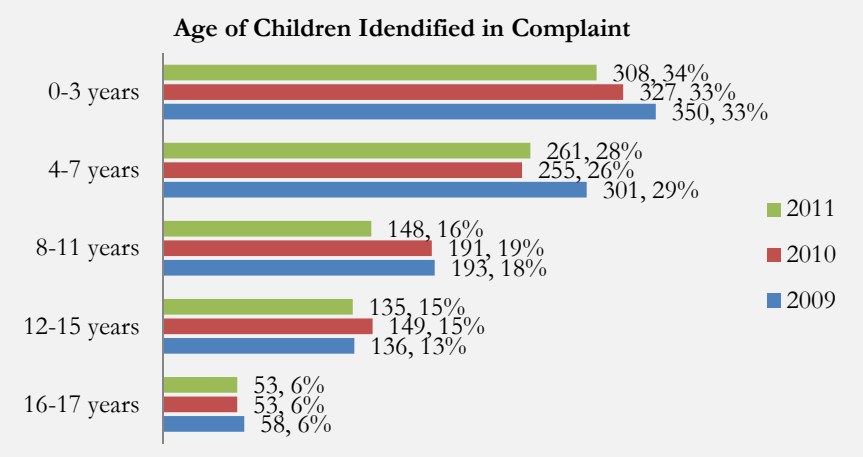
The majority of individuals filing complaints with the Ombudsman indicated that they were referred to the office by someone else. Over one-quarter (28 percent) of complainants reported that they were referred by a **community professional/service provider** (e.g., teacher, counselor, child care provider, doctor, private agency social worker, mental health professional, attorney, CASA/GAL, legislator's office). A growing number of individuals (13 ½ percent) found OFCO through an **internet search** or a phone directory, or from **previous contact** with OFCO (15 ½ percent). Slightly fewer individuals were referred by a **DSHS employee** (16 percent) compared with previous years, as was the case with referrals from **family or friends** (17 percent). The remaining complainants did not specify how they heard about the Ombudsman.



Source: Office of the Family and Children's Ombudsman, September 2011

AGE OF CHILDREN IDENTIFIED IN COMPLAINTS

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



Source: Office of the Family and Children's Ombudsman, September 2011

Note: Children identified in more than one complaint are counted more than once. One percent of children were 18 years or older in 2009 and 2010 and 2011.

RACE/ETHNICITY OF CHILDREN IDENTIFIED IN COMPLAINTS

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

Race/Ethnicity	OFCO 2011	Children's Administration[11]	WA Child Population[12]
Caucasian	66.7%	59.7%	80.6%
African American	9.4%	9.8%	4.5%
American Indian or Alaska Native	5.3%	12.1%	2.0%
Asian or Pacific Islander	2.1%	1.4%	6.8%
Other	0.3%	3.4%	0%
Multi-Racial[13]	14.2%	11.8%	6.0%
Declined to Answer	0.8%	1.7%	--
Hispanic	12.9%	15.5%	15.5%
Caucasian, Not Hispanic	57.3%		

[11] Race of children in placement taken from Children's Administration Performance Report 2008 http://www.dshs.wa.gov/pdf/ca/08Report1.pdf
[12] Population of children in Washington taken from Children's Administration Performance Report 2008 http://www.dshs.wa.gov/pdf/ca/08Report1.pdf
[13] See Appendix B for detailed breakdown of multi-racial categories.

COMPLAINT ISSUES

The following table shows the number of times various issues within these categories were identified in complaints.[14]

As in previous years, issues involving the **separation and reunification of families** (raised **295** times in complaints) and the **safety of children living at home or in substitute care** (raised **230** times in complaints), were by far the most frequently identified issues in complaints to the Ombudsman. **Both of these complaint categories decreased slightly** in 2010 and again in 2011; however, some of the subcategories within each of them shifted noticeably.

Concerns about the *safety of children in out-of-home care* have **decreased steadily** since 2008, and decreased again slightly in 2011. This year OFCO tracked complaints about safety concerns during the child's visit with their parent as a distinct category, since we appear to be getting more complaints about this issue. Regarding 30-day health and safety visits to children in out-of-home care, it should be noted that OFCO found many more than two instances of this (see section on adverse findings later in this report); the table below reflects only the number of times this was specifically complained about by the complainant. Complainants may frequently be unaware that health and safety visits are not occurring as they should, depending on their relationship to the child.

Complaints about **family separation and reunification** saw some changes in numbers since the previous year.

- Complaints about *children being unnecessarily removed from parents* **went back to 2009 levels**.
- Complaints about *lack of contact between children and their parents or other family members* **decreased 28 percent,** to a similar level complained about in 2009.
- Complaints about *failure to place children with relatives* **increased 24 percent** *over the two previous years*.
- Complaints about *inappropriate placements of children* have **decreased steadily** since 2009.
- Complaints about the agency's *failure to reunite families* **increased 17 percent** from 2010, approaching the number for 2009.

As in previous years, the **well-being and permanency of dependent children** remained our third-highest category of complaint issues (raised **117** times in complaints); however, this represented a **27 percent decrease since 2010**, when the numbers were similar to 2009. All sub-categories within this broad issue category decreased slightly in frequency, except for two issues:

- Complaints about *unnecessary moves of children or inadequate transition between moves* **increased by 34 percent** in 2011, though were still not as many as in 2009.
- Complaints about *adoption support services and other adoption issues* **decreased** to match 2009 levels.
- There were no complaints about *inadequate services to children in facilities*, a significant drop from the fourteen complaints received in 2010 and seven complaints in 2009.

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

It is difficult to draw conclusions about patterns or trends in other complaint issues given their relatively small numbers, and the fact that OFCO captures only the major complaint issues in complaints that identify multiple issues. Nevertheless, some changes regarding complaint issues may be worth noting. Complaints about **foster parent retaliation dropped again slightly**, but complaints about **licensing issues almost tripled**. Licensing issues include investigations of licensing complaints, the licensing process, and corrective action taken by DLR regarding foster care licenses. Licensing issues complained about in 2011 covered a broad spectrum, with no distinct pattern to the complaints. Of note was the fact that the vast majority of these complaints were **not substantiated** by OFCO. Complaints regarding *lack of support of foster parents* also **increased**. Complaints about *communication failures by agency staff* remained steady, although complaints about *heavy-handedness and unprofessional conduct or harassment* **decreased**. Complaints about FamLink issues went down to zero.

FREQUENTLY IDENTIFIED COMPLAINT ISSUES	**NUMBER OF COMPLAINTS**		
	2009 (n=728)	**2010 (n=676)**	**2011 (n=608)**
CHILD SAFETY	**247**	**235**	**233**
Failure to protect children from parental abuse or neglect	**144**	**150**	**139**
Physical abuse	45	50	43
Sexual abuse	27	29	30
Emotional abuse	15	13	12
Neglect/lack of supervision	52	51	47
Other	5	7	7
Developmentally disabled child in need of protection	2	0	2
Children with no parent willing/capable of providing care	14	9	11
Failure to address safety concerns involving children in foster care or other non-institutional care	60	48	42
Child safety during visits with parent	---[15]	---	5
Failure to address safety concerns involving child being returned to parental care	26	25	28
Safety of children in institutions/facilities (non child care)	1	3	1
Safety of children in child care facilities (Department of Early Learning)	--[16]	3	2
Failure by agency to conduct 30-day health and safety visits to child in out-of-home care	--[17]	--	2
Inadequate services to maintain safety of children in home			1

[15] Not separately tracked in 2009 and 2010.
[16] Not separately tracked in 2009.
[17] Not separately tracked in 2009 and 2010.

DEPENDENT CHILD HEALTH, WELL-BEING AND PERMANENCY	167	161	117
Unnecessary/inappropriate change of child's placement, inadequate transition to new placement	59	35	47
Placement instability/multiple moves in foster care	--[18]	7	2
Failure to provide child with medical, mental health, educational or other services, or inadequate service plan	41	41	31
Unreasonable delay in achieving permanency	3	9	5
Inappropriate permanency plan /other permanency issues	40	26	12
ICPC[19] issues	1	4	3
Foster Care to 21, independent living service issues	3	3	2
Failure to provide appropriate adoption support services/other adoption issues	16	33	15
Inadequate services to dependent/non-dependent children in institutions and facilities	7	14	0

FAMILY SEPARATION AND REUNIFICATION	329	313	295
Unnecessary removal of child from parental care	57	66	58
Unnecessary removal of child from relative placement	28	18	14
Failure to place child with relative (including siblings)	62	62	77
Failure to place child with other parent	3	0	1
Other inappropriate placement of child	34	25	18
Failure to provide appropriate contact between child and parent/other family members (excluding siblings)	44	57	41
Failure to provide contact with siblings	2	8	2
Failure to reunite family	81	65	76
Inappropriate termination of parental rights	5	2	5
Concerns regarding voluntary placement and/or service agreements for non-dependent children	6	8	2
Other family separation concerns	7	2	1

[18] Not tracked separately in 2009, captured as inappropriate change of child's placement (preceding category).
[19] Interstate Compact on the Placement of Children: the process by which CA obtains out-of-state home studies and supervision of out-of-state placements.

COMPLAINTS ABOUT AGENCY SERVICES	51	49	64
Inadequate CPS investigation	1	1	3
Unwarranted/unreasonable CPS investigation	--[20]	--	4
Delay in completing CPS investigation	4	3	4
Unreasonable CPS findings	31	29	30
Poor case management, high caseworker turnover, other poor service issues	7	1	3
Lack of coordination between DSHS Divisions	--[21]	4	7
Inaccurate agency records	8	9	13

OTHER COMPLAINT ISSUES	110	143	158
Foster parent retaliation	12	7	5
Foster care licensing issues	5	9	28
Lack of support/services to foster parent/other foster parent issues	15	13	19
Retaliation against relative caregiver	2	1	0
Lack of support/services to relative caregiver/other relative caregiver issues	7	6	8
Breach of confidentiality by agency	10	14	18
Unprofessional conduct, harassment, retaliation or bias/discrimination by agency staff	10	10	7
Heavy-handedness, unreasonable demands on family by agency staff	8	11	2
Children's legal issues	1	12	8
Violation of parent's rights	10	9	10
Failure to provide parent with services/other parent issues	11	9	8
Communication failures	7	38	39
FamLink[22]-related issues (mostly delay in payment to foster parents/providers)	12	3	0
Child care licensing issues (DEL)	---	---[23]	3
Inadequate child fatality review	0	0	1
Violations of the Indian Child Welfare Act	--	--[24]	2

[20] Not tracked separately in 2009 and 2010.
[21] Not separately tracked in 2009.
[22] FamLink is CA's database (SACWIS system) which replaced the CAMIS system in late January 2009.
[23] Not tracked separately in 2009 and 2010.
[24] In previous years this issue was tracked under children's legal issues.

III. TAKING ACTION ON BEHALF OF VULNERABLE CHILDREN AND FAMILIES

PART ONE: INVESTIGATING COMPLAINTS

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

PART TWO: CASE-SPECIFIC COMPLAINTS RAISING SYSTEMIC ISSUES

- Systemic Issue: Delay in Permanency Resulting from Systemic Problems
- Systemic Issue: Failure to Fully Protect Siblings in Severe Sexual Abuse Case

"Thank you! As a foster parent it is good to know that you are there to help."

-Foster parent

PART ONE: INVESTIGATING COMPLAINTS

The Ombudsman reviews every complaint received to determine whether it falls within OFCO's jurisdiction.[25] Through impartial investigation and analysis, the Ombudsman determines an appropriate response such as:

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

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

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

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

[25] The Ombudsman may also initiate an investigation without a complaint. During the 2011 reporting period, OFCO initiated eleven investigations. Six of the OFCO initiated investigations were closed and five of the investigations remained open (often for monitoring only) at the end of the reporting period.

COMPLETED INVESTIGATIONS AND RESULTS

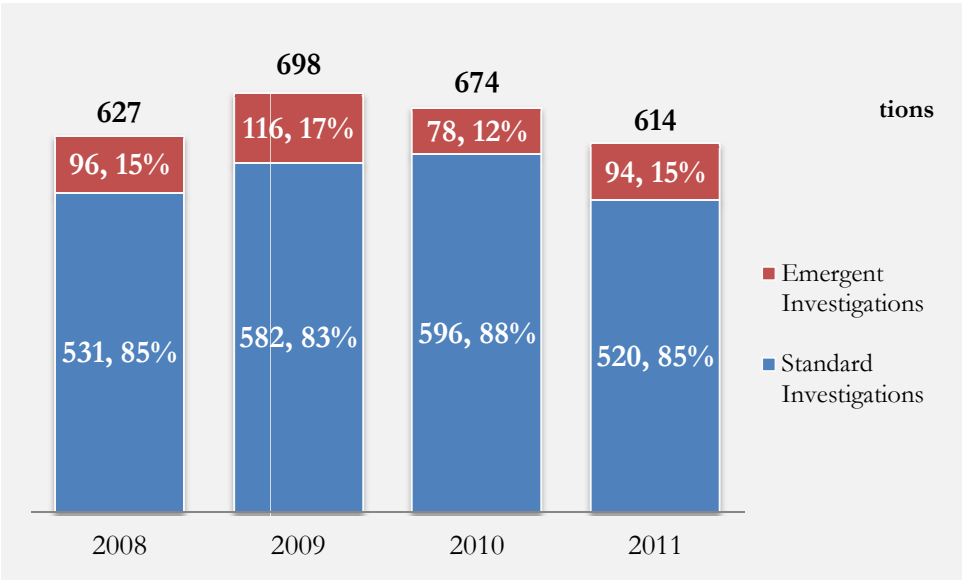
COMPLETED INVESTIGATIONS

The Ombudsman completed **614 complaint investigations** in 2011.[26] These investigations involved **924 children and more than 608 families**. As in previous years, the majority of these investigations were **standard non-emergent investigations** (85 percent).

In 2011, about one out of every seven investigations (fifteen percent) met the Ombudsman's criteria for initiating an **emergent investigation,** i.e. when the allegations in the complaint involve either a child's immediate safety or an urgent situation where timely intervention by the Ombudsman could significantly alleviate a child or family's distress. When taking an emergent complaint, the Ombudsman begins the investigation immediately after receiving a call from a complainant, or after screening a complaint received by mail as emergent. Over the years, the Ombudsman has substantiated or intervened in emergent complaints at a higher rate than non-emergent complaints. In 2011, the Ombudsman intervened or provided assistance to resolve concerns in twenty-one percent of emergent complaints, compared with nine percent of non-emergent complaints. Of the emergent complaints, eighteen percent were resolved without Ombudsman intervention or assistance.

Type of Investigations Completed

September 1 to August 31



Source: Office of the Family and Children's Ombudsman, September 2011

[26] Of the completed investigations in 2011, 88 percent were investigations of complaints received during that reporting year, while twelve percent were of complaints received in a previous reporting year. At the end of 2011, six percent of complaints received remained open. For the purposes of this section, investigations of complaints raising identical issues involving the same child/family are counted only once. The actual number of complaints closed in 2011, including these identical complaints from more than one complainant, was 649.

INVESTIGATION RESULTS

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

- **Ombudsman Intervention:** The Ombudsman substantiated the complaint issue and intervened to correct a violation of law or policy, or to achieve a positive outcome for a child or family.

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

- **Otherwise Resolved:** The complaint issue may or may not have been substantiated, but was resolved by the complainant, the agency, or some other factor. In the process, the Ombudsman may have offered suggestions, referred complainants to community resources, made informal recommendations to agency staff, or provided other helpful information to the complainant.

- **No Basis for Intervention:** The complaint issue was unsubstantiated, and the Ombudsman found no agency errors in reviewing the case. The Ombudsman explained why the alleged action is not a violation of law or policy or unreasonable under the circumstances and helped the complainant better understand the role and responsibilities of the child welfare agency.

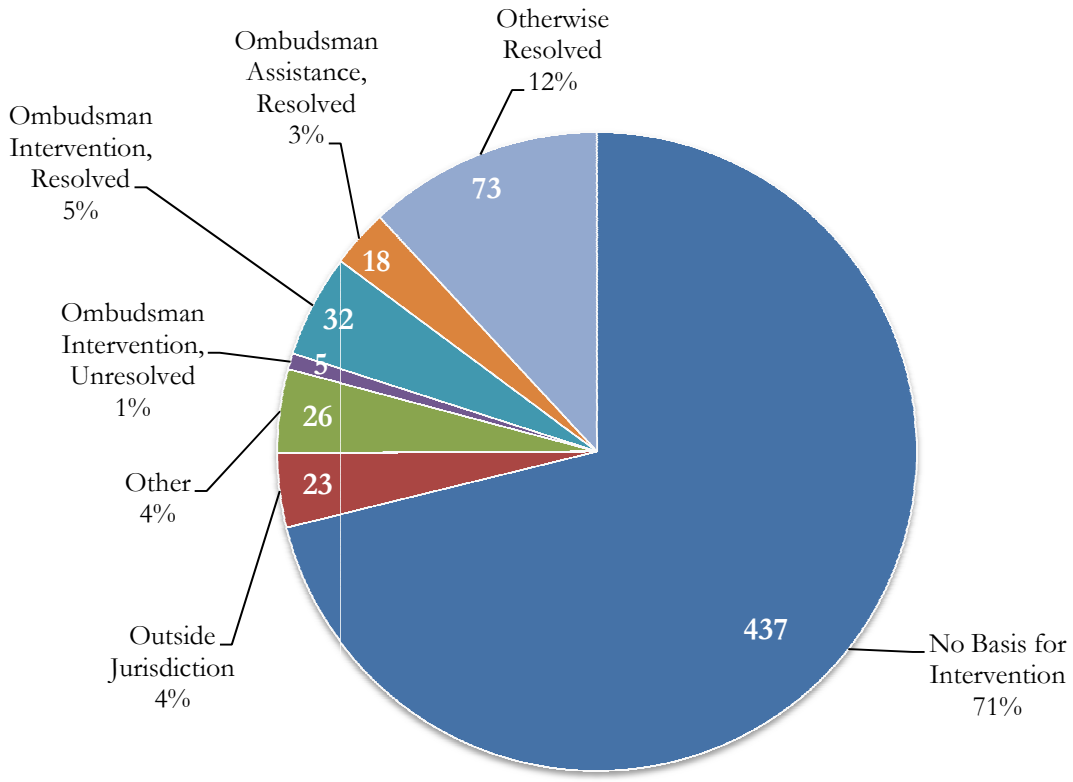
- **Outside Jurisdiction:** The complaint was found to involve agencies or actions that were outside of OFCO's jurisdiction. When possible, the Ombudsman refers complainants to an appropriate office or agency that may be able to assist them with their concern.

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

Investigation results have remained fairly consistent over the last three years. The Ombudsman **assisted or intervened** to resolve the situation in **nine percent of complaints** in 2011. This represents **fifty complaints**, involving at least fifty families, and many more children. OFCO found a larger percentage of complaints to be **unsubstantiated (71 percent)** in 2011 than in 2010 **(64 percent).**

INVESTIGATIONS RESULTS

TOTAL COMPLAINTS=614



Source: Office of the Family and Children's Ombudsman, September 2011

THE OMBUDSMAN IN ACTION

The Ombudsman takes action when necessary to avert or correct a harmful oversight or avoidable mistake by the DSHS or another agency. **Thirty-one complaints required intervention by the Ombudsman.**[27] Many of these investigations required a substantial investment of time by the Ombudsman. As stated earlier in this section, the rate of intervention was more than two times higher in emergent complaints than non-emergent complaints.

INTERVENTIONS BY THE OMBUDSMAN RESULT IN RESOLUTION

The vast majority of complaints in which the Ombudsman intervened or assisted resulted in the complaint issue being **resolved (90 percent)**.[28] Here are two examples:

EXAMPLE 1: MISHANDLING OF CHILD PROTECTIVE SERVICES (CPS) CASE

CPS conducted an inadequate investigation of allegations of physical abuse of a non-dependent fifteen year old youth by a parent, and then delayed in resolving the case. The Ombudsman found that CPS failed to notify the parents of the allegations in a timely manner, failed to interview collateral sources of information, and demonstrated a bias against the parents. The youth was promptly interviewed by CPS and law enforcement the day after the referral was received; the youth described family conflict but denied being abused, and stated that the allegations had been made in an attempt to get attention. CPS did not inform the parents of the allegations until two and a half months later, and informed the parents that the case would be closed as unfounded. A few days later, a new referral was received again alleging physical abuse by the parent. After interviewing the youth, who had bruises on both arms reported to be caused by a parent, law enforcement took the youth into protective custody and CPS filed for dependency, placing the youth in foster care. The youth's conflicting statements between the two interviews were not assessed in greater detail, and CPS did not interview school personnel, community professionals involved with the family, or other collateral sources, who later described the allegations as highly unbelievable and probably attributable to a high level of family conflict. Nevertheless, the inadequate CPS investigation resulted in a founded finding of physical abuse. Furthermore, CPS failed to provide appropriate visitation between the youth and the parents. No visits occurred for an entire year, and very little progress was made in the dependency case, as the parents were still denying the allegations.

At this point the Ombudsman received a complaint and conducted a full investigation and review of the case. The Ombudsman immediately intervened by bringing the above findings to the attention of the regional administrator. A new social worker was assigned to the case, and family counseling was established with a mutually agreed-upon therapist. The Ombudsman also requested that the CPS finding of physical abuse be reviewed by the area administrator. Ultimately, the youth admitted that the allegations of physical abuse were untrue, and the bruises attributed to being caused by the parent were actually caused by the youth's boyfriend. The founded CPS finding was overturned. Regular visitation began, and the youth returned home the following month. The dependency was dismissed.

[27] This percentage represents a one percent decrease since 2010, and a three percent decrease since 2009.
[28] Emergent complaints were also resolved by CA without Ombudsman intervention or assistance at a considerably higher rate (18 percent) than standard complaints (11 percent).

Example 2: FAILURE TO FOLLOW CPS CHILD INTERVIEW PROTOCOL

CPS violated law, policy and procedure in conducting an investigative interview of a six year old non-dependent child regarding sexual abuse allegations. Law enforcement was present for a portion of this interview and participated in questioning the child. After reviewing both the transcript and the audio recording of the interview, the Ombudsman contacted the Deputy Regional Administrator with the following concerns:

- **CPS failed to ask the required questions to establish that the child's participation in the interview was voluntary and not a seizure under the 4th Amendment.**[29]
- **CPS failed to terminate the interview upon the child's request.**[30] The child first said he wanted to get back to class less than a quarter of the way through the interview. He repeated this request at least fifteen times over the course of the interview.[31]
- **CPS failed to establish this young child's ability to understand the difference between truth and lie.**[32]
- **Lack of coordination between CPS and law enforcement.**[33] A detective entered the room after CPS had already begun questioning the child. At one point both adults were questioning the child simultaneously.

This interview did not result in a clear statement from the child. The child was later interviewed two additional times: once the following day where he reportedly told the nurse examining him that "his dad touched his pee pee", and then a few weeks later where he would not participate or answer any questions.

Based on these adverse findings regarding this interview, the Ombudsman contacted the Deputy Regional Administrator requesting a review of the interview and consideration of re-training the CPS investigator through the Harborview Center for Sexual Assault and Traumatic Stress regarding investigative interview standards. In response, the Area Administrator (AA) contacted the Ombudsman to report that the AA had already met with the investigative social worker and supervisor at some length and debriefed this interview. The Ombudsman reiterated that OFCO's recommendation remained that the social worker complete outside training through Harborview. OFCO was later informed that the training had been completed.

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[29] See U.S. Const. amend. IV; Practice and Procedures Guide § 2331(D)(2)(c); Children's Administration Memo dated January 7, 2010, Re: URGENT POLICY AND PROCEDURE UPDATE REGARDING INTERVIEWS OF CHILDREN BY CHILD PROTECTIVE SERVICES SOCIAL WORKERS; see also Greene v. Camreta, 588 F.3d 1011 (9th Cir. 2009), *vacated in part*, Camreta v. Greene, 563 U.S. __ (2011).

[30] Id.

[31] Page numbers of the interview transcript were referenced in the letter sent by OFCO to CA for specific findings about the interview.

[32] Washington State Child Interview Guide, pgs.13-14 ("For children pre-school through age 7, use the Lyon-Saywitz picture tasks included in the Appendix to assess Truth/Lie understanding & to show that the child understands that it is wrong to lie.").

[33] See RCW 26.44.180.

FEW INTERVENTIONS BY THE OMBUDSMAN REMAIN UNRESOLVED

In **eight complaints in which the Ombudsman assisted or intervened**, the agency did not change its position. In four of these cases, the Ombudsman determined that the agency's decision not to change its position was ultimately acceptable. For example, in a case in which the Ombudsman was monitoring an in-home dependency on three children, ages four, two and seven months, a domestic violence incident occurred in the home resulting in law enforcement involvement. Because the domestic violence was not perpetrated by an adult living in the home, the CPS referral regarding this incident did not screen in for investigation. Child and Family Welfare Services (CFWS) established that the parent had relapsed and was not following through with services that were a condition of the in-home dependency. The Ombudsman asked the agency to consider removing the children based on the level of risk to the children's safety. CFWS planned to remove the children, but by the time a court hearing was scheduled, the parent had re-engaged with services, signed a new safety plan, and the risk level had lowered considerably. According to CFWS, the Assistant Attorney General (AAG) advised the agency against recommending to the court that the children be removed. The child's Court Appointed Special Advocate (CASA) was in agreement with leaving the children in the home. The Ombudsman found the agency's position to be not clearly unreasonable.

In the other four complaints in which the agency did not change its position despite Ombudsman intervention or assistance, the complaint or other problematic issue identified by the Ombudsman **remained unresolved**. These cases are often complex cases in which there are multiple stakeholders other than CA who can impact the outcome of the case. In one such complaint, for example, the issue became moot:

FAILURE TO PLACE CHILD WITH RELATIVE

CFWS declined to place a three and a half year old legally free child with out-of-state paternal relatives who had passed an adoption home study, instead choosing to proceed with the child's adoption by the foster parents. The agency opposed the move as the child was bonded to the foster family and was visiting with older siblings in the area regularly. CFWS also had concerns about the paternal relatives' ability to protect the subject child from the father. The guardian ad litem was in favor of the child remaining in the foster-adopt placement. Prior to termination of parental rights, the father wanted the child adopted by the paternal relatives. The mother wanted the child to remain in the foster-adopt home. Three court motions were filed to place the child with the relatives, all of which the department opposed, and the court denied. The Ombudsman found the agency's lack of support for relative placement to be problematic, for the following reasons:

1. State law and policy states a clear preference for placement with relatives.
2. The relatives demonstrated an ongoing commitment to the child by pursuing every legal avenue available to them.
3. The relatives received two approved home studies and complied with CFWS's request that they undergo counseling to help them understand the father's abuse history and how to protect the child in the future. The counselor had provided a favorable report.
4. The relatives came from a neighboring state to visit the child in Washington

monthly, over a period of almost a year and a half.
5. The relatives stated their intention to continue these monthly visits for the child to visit with siblings in Washington, should they be allowed to adopt the child.

The Ombudsman had concerns about possible bias on the part of the department against the relatives and failure to follow the preference for relative placement as required by state law. The Ombudsman therefore requested that the Regional Administrator review the case. Following this review, the case was transferred to the adoption unit, which appeared more neutral about the child's placement; however, the agency did not change its recommendation to the court that the child remain in foster care, and court decisions continued to favor adoption by the foster parents. By the time the relatives contested the child's adoption, the child had been in the foster home for two and a half years, and was four and a half years old. At the contested adoption hearing, the judge ordered that the child be adopted by the foster parents.

OMBUDSMAN OFFERS ASSISTANCE TO RESOLVE COMPLAINTS WITHOUT "INTERVENING"

Complaints receiving "Ombudsman Assistance" are different from complaints in which the Ombudsman intervened, in that the findings of the Ombudsman's investigation did not rise to the level of a clear violation of law or policy or a clearly unreasonable action or decision on the part of the agency, but the complaint had validity justifying the Ombudsman's assistance in resolving the concerns. In 2011, nineteen complaints[34] were resolved by the Ombudsman in this manner by ensuring that *critical information was obtained and considered* by the agency, by *facilitating timely communication* among the people involved in order to resolve the problem, or by *mediating a compromise*. For example:[35]

RE-PLACEMENT IN FOSTER CARE AVOIDED

CA Division of Licensed Resources (DLR) delayed in completing an ICPC[36] home study on the relative of a child who was dependent in another state, but currently placed with the relative in Washington. The Ombudsman found no violation of law or policy, nor any clearly unreasonable action by the agency: DLR was within ICPC timeframes for completing the home study, and the social worker had in fact completed it some time ago, but was awaiting administrative approval for a waiver regarding a background check on the relative's spouse for a non-permanent disqualifying criminal conviction from fourteen years ago. As a result of the delay in the administrative approval, the child needed to be returned to foster care in the other state, due to the imminent expiration of the temporary 30-day placement approval in Washington. The Ombudsman provided assistance in getting the background check reviewed up the chain of command, and although the child was returned to a former foster home in the neighboring state for 24 hours, the child

[34] This represents three percent of complaints, a decrease since 2010 and 2009 when the Ombudsman provided direct assistance to resolve a complaint in five percent of complaints.
[35] For other examples, see Examples A and B in the Ombudsman in Action: Facilitating Resolution table, page 42.
[36] The Interstate Compact on the Placement of Children, commonly abbreviated to ICPC, is a contract among member states and U.S. territories authorizing them to work together to ensure that children who are placed across state lines for foster care or adoption receive adequate protection and support services.

was allowed to return to Washington with the relative for another thirty days, pending approval of the home study. The review of the background check was expedited, resulting in the ICPC home study being approved within the deadline.

COMPLAINTS RESOLVED WITHOUT SIGNIFICANT ASSISTANCE BY THE OMBUDSMAN

In 2011, **twelve percent of complaints were resolved between the agency and the complainant without significant assistance or intervention by the Ombudsman**. This represents a small decrease since 2008-2010 when the percentage of otherwise resolved complaints remained fairly consistent, around fifteen percent of complaints. In most cases, the Ombudsman contacts the agency to confirm that steps are being taken to resolve the issue. **Some complainants report that the mere fact of the Ombudsman contacting the agency and asking questions appears to assist in ensuring that any problems are resolved.** For example:

PLACEMENT WITH NON-CUSTODIAL PARENT

The Ombudsman received a complaint that CFWS was failing to place a six year old dependent child with the non-custodial parent, after the child was removed from the custodial parent. The non-custodial parent was complying with court-ordered services and making good progress. The Ombudsman found that the child had not lived with this parent for over a year, the parent had prior CPS history, and the agency was still assessing the parent's ability to care for the child safely, through court-ordered services and evaluations. The Ombudsman monitored the case for three months, while the parent continued to participate in services and evaluations, and verified that the agency held regular shared planning meetings with family members and providers. The custodial parent (who received a CPS finding of neglect) meanwhile made little progress in remediating parental deficiencies identified in the dependency. At that point, the shared planning team and the agency were satisfied that the child could safely be placed with the non-custodial parent, and at the next court review hearing, CFWS recommended that the child be placed with that parent in an in-home dependency, with ongoing monitoring and services.

OMBUDSMAN FINDS NO BASIS FOR INTERVENTION

In 2011, seventy-one percent of complaint investigations were closed after the Ombudsman either found no basis for the complaint, or found no unauthorized or *clearly* unreasonable actions by the agency warranting intervention.[37] The Ombudsman 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. For example:

COMPLAINT ABOUT BREACH OF CONFIDENTIALITY UNSUBSTANTIATED

A relative, who had made a referral to CPS alleging neglect of a two year old non-dependent child by the parents, complained to the Ombudsman that CPS disclosed the identity of the referent to the parent, causing conflict among the extended family. The Ombudsman established that the CPS supervisor and Area Administrator had already investigated this concern, and that the CPS investigator had denied disclosing the identity of the referent. The investigator explained that when the parents were confronted with the allegations contained in the referral (per CPS investigation protocol) the parents stated that they guessed who made the referral based on the nature of the reported concerns. The investigator reported neither confirming nor denying the parents' suspicions. The Ombudsman therefore found no evidence to support a breach of confidentiality by CPS.

PROFESSIONAL CONCERNED ABOUT CHILD'S SAFETY FROM SEXUAL ABUSE

In another example, the Ombudsman found no unauthorized or clearly unreasonable actions by the agency in a case involving founded allegations of sexual abuse of a ten year old non-dependent child by the father. A concerned professional contacted the Ombudsman when the family court authorized unsupervised visits between the child and the father. The Ombudsman found that CPS had investigated and founded an allegation of sexual abuse of the child by the father, and filed a dependency and placed the child in out-of-home care. This was a highly complex case in which prior to CPS involvement, the father had obtained temporary custody of the child through family court, after the mother began experiencing mental health problems. When the child disclosed sexual abuse by the father during a visit with the mother, the police took the child into protective custody. CPS filed a dependency and placed the child in out-of-home care. The CPS investigation resulted in a founded finding of sexual abuse, but the prosecutor declined to file charges against the father, and the father successfully appealed the CPS finding, which was later overturned. Meanwhile, the mother successfully obtained custody of the child in family court, with CPS testifying in favor of this action; however, the father was granted unsupervised visits. The Ombudsman established that CPS had assessed the mother as being protective, recommended dismissal of the dependency because the mother was an appropriate caregiver, and ensured that the mother and child were receiving appropriate services. The Ombudsman found that CPS could take no further protective action, and the complaint was closed.

[37] This number was higher than in 2010, when 64 percent of investigations were closed as unsubstantiated or with no basis for intervention by the Ombudsman.

TYPES OF INTERVENTION BY THE OMBUDSMAN

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

1. Interventions to induce corrective action.
2. Interventions to facilitate resolution of an agency error and/or a CA client's concerns.
3. Interventions to help the agency avoid errors and conduct better practice.
4. Interventions to help the agency prevent future mistakes. These are cases in which an agency error is brought to the Ombudsman's attention after-the-fact, and corrective action is no longer possible. The Ombudsman brings the problem to the attention of agency officials, so steps can be taken to prevent such errors from recurring in the future.

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

OMBUDSMAN IN ACTION: INDUCING CORRECTIVE ACTION

Key Issue	Investigative Finding	Ombudsman Action	Outcome
Failure to provide reasonable accommodations to disabled clients	CPS failed to provide letters regarding the findings of a CPS investigation to two visually impaired parents in an alternate format such as Braille.	The Ombudsman asked that the letters be resent in Braille.	CPS sent Braille transcriptions of the letters to the parents.
Failure to follow Child Protection Team (CPT) recommendations	CFWS authorized a transition home with an increasing schedule of overnight visits between two dependent children, ages six and three, and a parent despite a recent recommendation by the CPT that the children remain in out-of-home care with continuing day visits until further progress was demonstrated. The Ombudsman found that the CPT recommendations were reasonably based upon concerns for the children's safety and well-being.	The Ombudsman contacted the Area Administrator to question this plan in light of the CPT's concern about the children's safety and well-being in the overnight care of the parent.	The visitation schedule was scaled back to one overnight visit a week until further court order.
Unreasonable screening decisions by CPS intake	CPS intake screened out three referrals alleging physical abuse and neglect of a fourteen year old non-dependent youth. The Ombudsman found that the referrals were made by mental health professionals reporting ongoing safety concerns, and warranted review of the initial screening decisions.	The Ombudsman contacted the intake program manager and requested a review of the screening decisions.	The third referral was screened in for investigation following a review by the program manager. The investigation resulted in a dependency petition, and the youth was placed in out-of-home care.
Unreasonable CPS finding	CPS made a finding of neglect against a parent that was not supported by the evidence gathered during the investigation. Furthermore, the parent alleged that no notification of this finding had been received. The parent lost employment as a result of the finding.	The Ombudsman contacted the Area Administrator and requested a review of the finding.	The Area Administrator agreed that there was a lack of evidence to support a finding of neglect, and the finding was overturned.

OMBUDSMAN IN ACTION: FACILITATING RESOLUTION

Key Issue	Investigative Finding	Ombudsman Action	Outcome
Inappropriate placement of dependent child **EXAMPLE A**	CFWS placed a ten year old child in a foster home from which the child had been removed three years prior, during a CPS investigation of the foster home. Although the results of that investigation were inconclusive and the home was still licensed, the Ombudsman found that the foster parents had spoken negatively to and about the child in the past, and did not have a positive relationship with the child.	The Ombudsman contacted the CFWS supervisor to discuss these concerns.	The supervisor was unaware of the past issues with this foster home and welcomed the information. The agency moved the child to a different foster home within ten days.
Inadequate customer service by CPS intake **EXAMPLE B**	CPS intake placed a mandated reporter on hold for almost an hour when the caller was attempting to report child abuse. This occurred prior to the end of the school day and the start to a long holiday weekend.	The Ombudsman contacted an intake supervisor to report the problem.	The intake supervisor agreed to have the supervisor's direct line provided to the mandated reporter so the report could be immediately taken.
Lengthy delay in providing public disclosure	CA failed to provide agency records to former foster youth who had submitted a records request more than a year prior.	The Ombudsman contacted the regional Forms and Records Analyst to identify the reason for the lengthy delay.	The analyst reported that there was a large backlog of records requests due to budget and staff cuts. These particular requests were still in process, but the analyst offered to have the youths contact her directly in a month if the records had not yet been received.

Failure to support visits with relatives	CFWS refused to allow visits between three dependent children, ages two, seven and eight, and their grandparents with whom they were previously placed long-term. The Ombudsman found that although the children's counselor had recommended against visits due to their and the grandparents' distress over the removal, the children were strongly bonded to their relatives and were requesting visits. Visits were also supported by the children's CASA.	The Ombudsman contacted CFWS to request that a trial telephone call be considered followed by a reconsideration of visits if the call went smoothly.	CFWS facilitated a telephone call followed by periodic visits while the children were in foster care, until a more formal visitation plan could be established with the children's new relative adoptive placement.
Failure to serve youth with dependency petition	CPS failed to serve the subject youth in a dependency petition (age sixteen) with the petition and notice of the court hearing. The youth was a victim of physical abuse and wanted to inform the court of her fear of the parent. Due to the lack of notice, the youth missed the opportunity to attend the shelter care hearing, and was unaware of her right to be represented by an attorney.	The Ombudsman contacted CPS and requested that this information be provided as soon as possible.	CPS informed the youth about the petition and her rights the following day.
Delay in obtaining prescribed medication for dependent youth	DSHS delayed in authorizing urgently needed psychotropic medication for a seventeen year old youth in foster care, despite a private agency case manager intensively working to resolve the issue for several hours. The youth had missed one dose of medication already due to a placement disruption and presented a danger to self and others.	The Ombudsman contacted CFWS, who did not have a plan for resolving the situation. The Ombudsman contacted DSHS Health and Rehabilitation Services Administration (HRSA) to urge speedy authorization to the pharmacy to ensure the youth's prescription could be filled by the end of the day.	DSHS/HRSA provided authorization for the medication later that day.

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

Key Issue	Investigative Finding	Ombudsman Action	Outcome
Failure to support visits with relatives	CFWS was supporting a CASA's court motion to suspend visitation between a three year old dependent child and the grandparents. The grandparents had petitioned the court to adopt the child, and an adoption trial was pending. The Ombudsman found no evidence that the visits were harming the child.	The Ombudsman contacted CFWS and requested that the agency reconsider its support of the motion to suspend visitation.	The agency agreed to support reduced visitation rather than suspended visitation.
Unintended consequence of policy change regarding voluntary placement agreements (VPAs)	CFWS gave two weeks' notice that a VPA for a nineteen year old youth would be terminated. This was due to a change in policy disallowing VPAs except under special circumstances, as well as stricter enforcement of an existing policy disallowing youths in dependency guardianships to enter VPAs after age eighteen. The Ombudsman found the abrupt termination of the VPA would result in harm to the youth.	The Ombudsman contacted the Independent Living Program Manager to request that more notice be provided to allow for an adequate transition of the youth to adult services and SSI funding.	The program manager agreed to extend the VPA for an additional month to allow for shared planning to occur. A suitable transition plan was developed and implemented to allow for the youth to continue receiving needed services and schooling.
Inadequate transition plan in move of foster children	CFWS failed to create a meaningful transition plan for two legally free children, ages three and four, who were being moved from their foster home to a relative placement. The children had never met the relatives, and the plan allowed for only one overnight visit prior to the move. A Foster Care Assessment Program evaluation had recommended that any planned move for the four year old be slow and planned. No shared planning meeting was held to discuss the plan.	The Ombudsman contacted the CFWS supervisor and area administrator to request that a more appropriate transition plan be considered, with input from the foster parents and professionals involved with the children.	A shared planning meeting was held and professionals, the foster parents, and relatives provided input. The transition plan was extended several weeks from the original plan.

OMBUDSMAN IN ACTION: PREVENTING FUTURE MISTAKES

Key Issue	Investigative Finding	Ombudsman Action	Outcome
Failure to place with relative	CFWS failed to place five dependent siblings with a suitable out-of-state relative who had passed a home study. While this case was complex in that the five children had a wide age range and differing placement needs, the Ombudsman found the failure to place with the relative especially troubling in the case of the youngest child.	The Ombudsman contacted the CFWS supervisor and learned that a new ICPC home study request was to be submitted shortly. The Ombudsman noted concerns about the management of this case in a notification letter to the agency.	In response, the Regional Administrator directed all CFWS supervisors to review all cases to ensure completion of a relative search and assessment of all suitable relatives.
Delay in conducting CPS investigation	CPS did not investigate allegations of physical abuse and neglect of three non-dependent children ages nine, six and four, until seven days after law enforcement (LE) arrested the heavily intoxicated parent. The Ombudsman found that CPS had received the LE report only five days after the arrest, and the referral was screened in for an investigation within 72 hours. Meanwhile, the subject parent had been released from jail and resumed care of the children.	The Ombudsman contacted the CPS supervisor to identify the cause of the delay in receiving the report from LE. The Ombudsman also contacted the Central Intake Program Manager to request a review of the response time assigned to this referral under the circumstances.	The CPS supervisor reported that CPS was planning to meet with the sheriff's deputy to strengthen referral procedures between the agencies to avoid such delays in the future. The manager indicated that best practice in such a case would be for CPS intake to establish the whereabouts of the subject parent before assigning a response time, to accurately determine the level of risk to the children. However, the assigned worker has the discretion upon receiving the referral, to decrease the response time based upon the worker's assessment of the reported information.

OMBUDSMAN'S ADVERSE FINDINGS

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

Adverse findings fall into three broad categories:

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

If these criteria are met and the Ombudsman believes that the agency's action or inaction could cause foreseeable harm to a child or parent, the Ombudsman intervenes to persuade the agency to correct the problem. The Ombudsman shares the adverse finding with supervisors or higher level agency officials, and may recommend a different course of action, or request a review of the case by higher level decision makers. If the Ombudsman's finding involved poor practice by the agency rather than a violation or clearly unreasonable action, if the complaint involves a current action, the Ombudsman intervenes where possible to assure better practice. When it involves a past action, the Ombudsman documents the issue and brings it to the attention of agency officials. When a complaint or several complaints raise a systemic issue, the Ombudsman may open a "systemic investigation," and/or make a "systemic finding." An example of a systemic finding is presented on page 60.

COMMUNICATION OF ADVERSE FINDINGS TO DSHS

As set forth in the November 2009 interagency agreement entered into between OFCO and DSHS[38], OFCO provides written notice to CA of any adverse finding(s) made on a complaint investigation. CA is invited to formally respond to the finding, and may present additional information and request a revision of the finding. In many cases, CA provided a detailed response, sometimes with a request for a modification of OFCO's finding.

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

[38] The inter-agency agreement is available on OFCO's website at http://www.governor.wa.gov/ofco/interagency_ofco_dshs.pdf OFCO continues to work with CA on refining the most effective process for communicating adverse findings of different types, in a timely and helpful manner.

ADVERSE FINDINGS BY ISSUE FOR OFCO REPORTING YEAR 2010-2011[39]

Issue	Number of Adverse Findings	
	2010	2011
Child Safety	**15**	**12**
Failure by CFWS to ensure/monitor dependent child's safety	7	
• findings regarding health and safety visits		3
• failure to inform guardian ad litem of CPS referral on dependent child		1
• unsafe placement of dependent child with special needs		1
Failure by CPS/FVS[40] to ensure/monitor non-dependent child's safety	3	1
Inadequate CPS investigation/case management	2	3
Failure to screen in CPS referral for investigation/other screening errors	1	2
Failure to staff case with Child Protection Team prior to return home	1	
Failure by DLR to ensure safety of foster home/facility	1	
Inappropriate DLR/CPS finding (unfounded)		1
Family Separation and Reunification	**5**	**6**
Failure to reunify family		1
Failure to provide appropriate contact between parent and child	1	1
Failure to provide sibling visits		1
Failure to provide contact with relative/fictive kin	1	
Unreasonable removal of non-dependent child from home	1	1
Unreasonable removal of dependent child from relative caregiver	2	
Failure to place child with relative		1
Failure to place child with non-custodial parent		1

[39] Findings in some of the major categories are broken down more specifically in 2011 than in 2010.
[40] Family Voluntary Services.

Dependent Child Health and Well-Being	8	5
Failure to provide adequate medical care	1	
Failure to provide appropriate services to meet special needs	3	
Placement issues (incl. placement delays, inadequacies, unavailability)	4	
• unnecessary/multiple moves		2
• inadequate transition plan		1
• unreasonable plan to move child based on non-safety related licensing issues		1
Failure to provide CHET screen in a timely manner		1

Dependent Child Permanency	8	6
Delay in permanency	8	5
Failure to obtain Regional Administrator approval to move child from long-term foster home		1

Parents' Rights	14	14
Failures of notification, public disclosure or breach of confidentiality	6	4
Delay in completing/closing CPS investigation	6	6
Unreasonable finding of CPS investigation	1	1
Unreasonable pursuit of termination of parental rights	1	
Failures of due process, dependency proceedings		
• failure to serve non-custodial parent with dependency petition		1
• failure to hold shelter care hearing within 72 hours of child being taken into protective custody		1
Inaccurate information provided in dependency petition		1

Foster Parent Issues	9	7
Poor communication by agency, unreasonable treatment	1	
Violation of foster parent rights	1	5
• failures of notification		
Overly lengthy DLR/CPS investigation, inappropriate findings	1	
Failure to provide foster parent with support services	1	
Failure to follow licensing investigation protocol	1	
Unreasonable licensing delays/other licensing errors	3	2
Unreasonable DLR licensing investigation finding against foster parent	1	

Children's Legal Issues	**3**	**2**
Lack of attorney or guardian ad litem for dependent child	1	
Violations of Indian Child Welfare Act	2	
Failure to notify youth of right to request counsel		1
Failure to serve youth with dependency petition and notice of hearing		1

Poor Casework Practice Resulting in Harm to Child or Family	**11**	**8**
Inadequate adoption home study		1
Failure to follow CPS child interview protocol		1
Failure to conduct supervisory reviews	1	
Communication failures	2	
High caseworker/supervisor turnover affecting continuity of case	2	
Inaccurate, incomplete or delayed documentation	4	1
Other poor practice	2	5

Relative Caregiver Issues	**5**	**2**
Poor communication, poor treatment, lack of support	2	
Failure to notify • of CPS finding • of court hearing	2	2
Unreasonable CPS finding against relative caregiver	1	

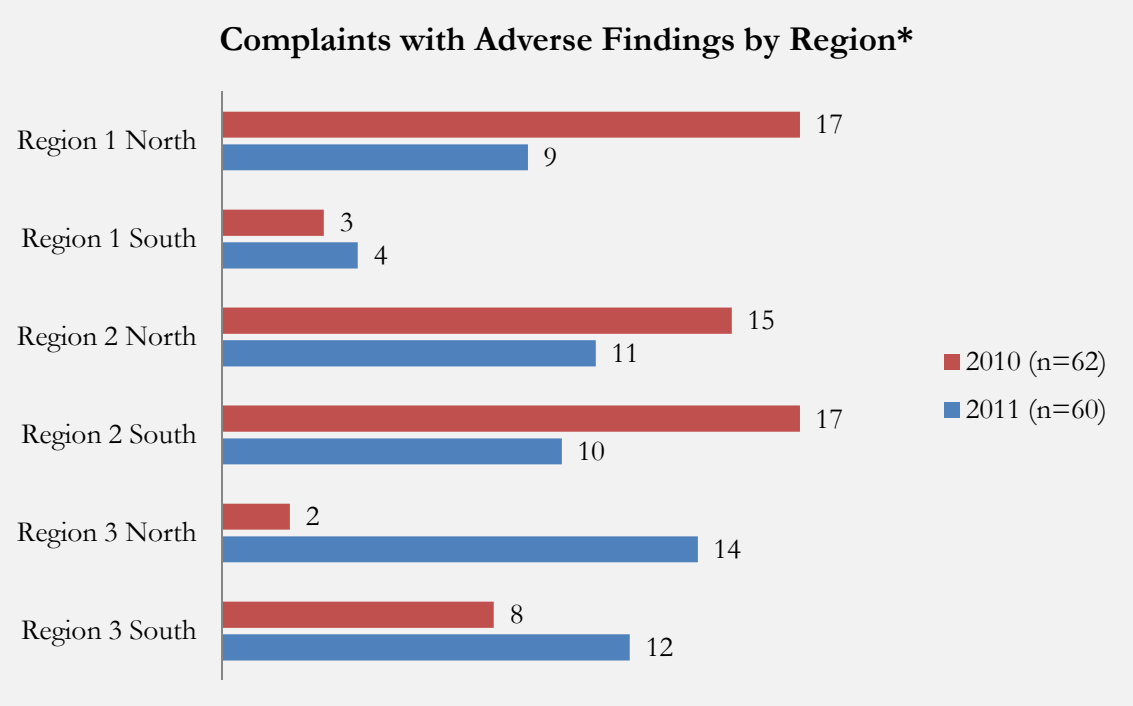
FamLink Issues	**1**	**1**
Failure to expunge old CPS referrals per RCW 26.44.031	1	1

Other Findings	**3**	**2**
Lack of coordination between DSHS divisions resulting in harm to child/family	3	1
Inadequate child fatality review		1
TOTAL NUMBER OF FINDINGS	**82**	**65**
TOTAL NUMBER OF CLOSED COMPLAINTS WITH ONE OR MORE FINDING	**62**	**60**

The number of adverse findings against the agency **decreased in 2011** (a total of **65 findings**) from 2010 (**82 findings**). The **total number of complaints with one or more adverse finding**, however, actually **increased slightly: 9.7 percent** of complaints had an adverse finding in 2011 compared with **9.2 percent** in 2010. Given the relatively small number of adverse findings, as well as OFCO's practice of limiting adverse findings in investigations to only the most egregious actions or inaction by the agency, it is not possible to draw meaningful conclusions from this data. With that caution in mind, some general observations may be made to assist DSHS in identifying potentially problematic areas. The above table shows that the two most common categories of adverse findings related to **child safety concerns** (accounting for **nineteen percent** of the adverse findings) and **violations of parents' rights** (accounting for **21.5 percent** of the total findings). These categories of findings both represented an **increase over last year** – child safety accounted for eighteen percent of findings last year, and parents' rights for seventeen percent. The next largest categories of adverse findings involved **poor casework practice resulting in harm to a child or family (thirteen percent, remaining steady with 2010 findings)** and **foster parent issues (eleven percent, also consistent with 2010)**. Adverse findings related to **delays in permanency decreased** since 2010 (**five findings** as compared to **eight findings in 2010**), as did findings involving **relative caregivers** (**two findings** compared to **five findings in 2010)**, and lack of coordination between DSHS Divisions (one finding compared to three findings in 2010).

ADVERSE FINDINGS BY DSHS REGION

Region 3 North and South (formerly Regions 5 and 6) **accounted for almost 44 percent** of the complaints with adverse findings, while **Region 1 North and South** (formerly Region 1 and 2) had **comparatively few (almost 22 percent)**. See Appendix C for details on the adverse findings by issue and DSHS region.



Source: Office of the Family and Children's Ombudsman, October 2011

***Note**: The total number of adverse findings for all complaints with findings was 65 in 2011 and 82 in 2010.

AGENCY RESPONSES TO ADVERSE FINDINGS

Pursuant to the Inter-Agency Agreement between OFCO and the Department of Social and Health Services,[41] OFCO provided written notice of any complaint adverse findings to DSHS, to allow the agency to review the findings and respond. OFCO received several responses to these notifications, many of which were quite detailed; six of CA's responses included a request for OFCO to modify or reverse a finding, based on additional or clarifying information provided by CA. OFCO modified a finding in two of these six cases.

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

CA AGREEMENT WITH ADVERSE FINDING, NO REQUEST FOR MODIFICATION

OFCO FINDING

CFWS failed to pursue relative placement for five dependent children in a timely manner. An out-of-state relative contacted DCFS regarding possible placement of the children in mid-2009. The relative worked in the child welfare system and was familiar with permanency planning. At that time, four of the siblings were placed with relatives and/or long term foster parents; the youngest child, YC, was not in a potentially permanent home and was not placed with a relative or a sibling. However, the case plan was reunification, and two of the children were reunified with their parent in 2009. Reunification was ultimately unsuccessful as the children were again removed from the parent's care in November 2009

Learning that the children were back in care and that reunification may no longer be the permanent plan, the relative again contacted DCFS in December 2009 and requested to be considered for placement. The CFWS social worker documented that the relative was only requesting placement of two of the older children and initiated the ICPC process only for these two children. After a visit to Washington in April 2010, the relative communicated to DCFS her interest in being considered as a placement resource for YC. At this point, YC had been in her current foster home for five months and she was the only sibling not placed either with a sibling or a relative and not having regular contact with her other siblings.

In June 2010, the ICPC home study approved the relative to adopt all five children. After being contacted again by the relative, DCFS submitted another ICPC request for all five children. Only a few weeks later however, DCFS withdrew this ICPC request as the older children had been in their placements for approximately two years. Case documentation indicate DCFS was not in support of placement with the relative based on the length of time the children had been in their respective placements which also provided regular sibling contact. However, this reasoning did not apply to the youngest child, who had only been in her current placement for seven months and who was not having the same level of sibling contact as the older siblings. When OFCO contacted DCFS to express this concern, we learned that the case had just been staffed with an Area Administrator and Office of Constituent Relations, and an ICPC request would be submitted for YC. This ICPC request was submitted in July 2010 and was quickly approved.

[41] See http://www.governor.wa.gov/ofco/interagency_ofco_dshs.pdf

Thereafter, the relative filed a motion to intervene and for placement of YC. This news was upsetting to the pre-adoptive foster parents, who apparently had not been previously informed that there was a potential relative available for placement of this child. DCFS filed a declaration supporting relative placement for YC. However, the court denied the motions and ruled that YC would not be moved to relative placement.

OFCO acknowledges that DCFS took action to remedy the issues with the initial ICPC requests and that in the end, DCFS did support relative placement for YC in the court hearing in September 2010. Law and policy make clear that placement with a suitable relative is in a child's best interest unless "there is reasonable cause to believe that the health, safety, or welfare of the child would be jeopardized or that efforts to reunite the parent and child will be hindered." RCW 13.34.030(1)(b)(ii). Promoting a child's life-long connections to their families fosters a sense of identity and well-being. OFCO's adverse finding focuses on DCFS' actions in June and July 2010 when, even after it was clear that the relative's ICPC home study was going to be approved, DCFS took the position that YC should not be moved to a relative placement. As early as December 2009, YC's situation should have been considered separately from her older siblings, given her age, shorter length of time in her current placement, the fact that she was not already placed with a relative or a sibling, and the fact that was not having the same level of ongoing sibling contact as her older siblings.

CA RESPONSE

Excerpts from CA's written response to OFCO:

> *Thank you for your feedback regarding the lack of timely pursuit of relative placement for five dependent children in violation of RCW 13.34.030 (1)(b)(ii). We do not disagree or request modification of your finding.*
>
> *Effective immediately CFWS supervisors are reviewing all out of home cases to ensure completion of a relative search and assessment of all suitable relatives.*
>
> *The expectation is that all CFWS cases will receive a thorough relative search by the relative search specialist within the policy timeline. The CFWS social workers and/or supervisor will follow up with the suitable relatives reported by the relative search specialist within two weeks of the receipt of the report.*
>
> *CFWS social workers and/or supervisor will refer a suitable relative for a relative home study within the policy timeline. The CFWS supervisors will assess the placement of dependent children during the monthly case review with the social workers to ensure adherence to the relative placement policy.*
>
> *If it is appropriate, an assigned CFWS social worker will commence the ICPC process in timely manner. If there is a reason not to follow through with the ICPC for a suitable relative, the assigned CFWS social worker and supervisor will staff case immediately with the Area Administrator.*
>
> *CFWS supervisors will staff cases with the Area Administrator where there is a placement disagreement between the department and the court and/or VGAL.*

CA DISAGREEMENT, OFCO MODIFICATION OF AN ADVERSE FINDING

SUMMARY OF OFCO'S ORIGINAL FINDING

DCFS/CFWS failed to provide court ordered visitation to parents of a six year old dependent child during a period of transition of jurisdiction of the case between two regions. The court order provided six hours per week of parent-child visitation. Case planning was complicated by the fact that the dependency was filed by Region A DCFS while the family was in the process of moving across the State. The six year old child was placed with a relative in Region B in May 2010. The parents were also living in Region B and in August 2010 the court ordered the transfer of jurisdiction to Region B. Prior to the formal transfer of jurisdiction, Region A DCFS attempted to arrange visitation and make up visits through Region B after the contracted visitation supervisor was no longer available, but encountered difficulties in obtaining a response from Region B DCFS, including confusion as to who was assigned to the case, if anyone, in Region B. At one point when OFCO contacted Region B, we learned that the case had been assigned to a social worker who was out on extended leave.

As of August 20, 2010, the CFWS case had been assigned in Region B and OFCO contacted the assigned CFWS Supervisor to ask whether visitation and make-up visits for this family could be prioritized given that there had already been a gap in visits during the case transfer. The Supervisor explained that a new visitation referral had been made but that no provider had been identified. Also, OFCO was informed that after initial review of the case, the DCFS social worker did not believe that supervision of the visits was necessary.

Thereafter, Region B DCFS convened a shared planning meeting and the parents began having visitation through the relative placement. However, the last documented visit through the relative placement occurred the weekend of September 18-19, 2010. It appears from the case notes that the relative was no longer willing to supervise visits, that another visit supervisor had not been identified, and that the social worker was working on an agreed order to allow unsupervised visits. As a result, the parents and child were not provided court ordered visitation for a period of over one month, with the exception of one visit supervised by the social worker on September 30, 2010 and a three hour visit supervised by the CFWS Supervisor on October 16, 2010. This is a violation of RCW 13.34.165(2)(ii) ("Visitation is the right of the family…[and] may be limited or denied only if the court determines that such limitation or denial is necessary to protect the child's health, safety, or welfare."). The agreed order was signed October 28, 2010 resolving the issue, and the family has since been reunified.

OFCO's main goal in bringing these issues forward is to encourage improvement in communication and coordination when cases are transferred between Regions, and especially to ensure that parents and children are provided with the visitation they are entitled to under court orders.

CA REQUEST FOR MODIFICATION OF FINDING

CA's response letter to OFCO in full:

> ***The department is requesting the adverse finding dated February 28th, 2011 by the Office of the Ombudsman be overturned.*** *Per the Notice of Adverse finding it is*

stated that the department failed to meet the law, policy, and procedure of providing visitation to the family between September 2010 and October 2010. Policy and procedures regarding jurisdictional transfer and courtesy supervision was followed by the [three DCFS offices involved], and visitation was provided to the parents.

Courtesy supervision was provided by the [Region B2] office when the child was placed with [a relative]. Courtesy supervision was from 5/16/2010 until 08/16/10 when the case transferred to the [Region B1] office. Policy 4430 states courtesy supervision includes assessment of services and placement, casework support and facilitation of the child's service plan.

In regards to the transfer of the case from [Region A] to [Region B], there were some lapses in communication; however, the policy of transferring cases between jurisdictions was met. Per policy 4431.B, which states transfer of jurisdiction must include the following: The sending office supervisor must contact the receiving office supervisor to request transfer. The sending office must consult with the AAG in the receiving office to discuss transfer of jurisdiction; once this occurs an official request can be made. When the court in the sending office orders legal transfer of jurisdiction the case must be transferred in five working days. The court in [Region A] ordered the transfer on 8/16/2010 and the case was transferred on 8/16/2010 to [Region B]. Prior to the jurisdiction being transferred, a secondary assignment was made to [name], a CFWS social worker in the [Region B1] office, on 07/30/2010. [The assigned worker] was expected to return from medical leave on 7/30/2010; however, did not return until 8/2/10. It was this supervisor's error to assign [this worker] to the case prior to transfer and also prior to [the worker] returning from leave.

The case was officially transferred to the [Region B1] office on 08/16/10 at which time [Worker 2] was assigned. There was a lack of communication regarding the visitation due to both the [Region A] supervisor and the [Region B1] supervisor being gone on vacation. The [Region A] supervisor was on vacation from 7/30/2010 to 8/13/2010 and this supervisor was on vacation from 7/30/2010 to 8/16/2010. The case was maintained through [Region A] courts until 08/16/2010. [Worker 2] discovered on 08/17/10 that the visitation provider was no longer employed and visitation needed to be immediately addressed. The social worker provided a visit on 08/24/10 (see attachment A, Case note ID, [#]).

In regards to visitation, the department did provide court ordered visitation to the parents. Prior to [Region B] receiving this case, [Region A] provided visitation until 7/29/2010 as documented in the case record. The [Region B] office was not aware of an issue with visitation until this supervisor returned from vacation and responded to an email sent on 8/11/2010 from [Region A] supervisor, [name], who was the supervisor covering for the [sending supervisor] while she was on vacation. [The covering supervisor] reported that the [Region A] office had received a phone call from the parents stating the visitation supervisor had lost his job and visitation for 8/7/2010 was cancelled; she had placed calls to the agency with no return call. On 08/17/10, the assigned social worker [Worker 2] contacted parents and relatives and set up visitation for 08/24/10.

Once [Region B] took over supervision and case management responsibilities, supervised visitation occurred on the following dates:

- *On 8/24/10, the relative supervised a visit for the mother and father that week (see attachment A, Case Note ID, [#]).*
- *On 8/31/10, the parents cancelled the visit on 8/26/10. According to the relative the father did not call to confirm, relative contacted the father who reported the visit could not occur because, "he had a million things to do." Relatives reported the parents and child visited at the circus that week" (see attachment B, Case Note ID, [#]).*

- *On 9/3/10 a shared planning meeting was held to discuss case plan and visitation by the relatives and to address conflict between the relatives and the parents (see attachment K).*
- *On 9/9/10, the relative placement supervised a visit for parents (see attachment C Case Note ID, [#]).*
- *On 9/10/10, the parents and relative caregiver participated in the Parent/Child visitation training at the [Region B] office. The purpose of this training is for both parents and persons supervising visits to understand the process and expectations.*
- *On 9/11/10, the relative supervised a visit for parents (see attachment D).*
- *On 9/18/10, the relative supervised a visit for parents (see attachment E).*
- *On 9/19/10, the relative supervised a visit for parents (see attachment F).*
- *On 9/30/10, the social worker supervised a visit for parents (see attachment G, Case note ID, [#]).*
- *On 10/9/10, the relative supervised a visit for parents (see attachment H).*
- *On 10/16/10, the supervisor and social worker supervised a visit for parents (see attachment I, Case note ID, [#]).*
- *On 10/24/10, a paid visit provider supervised a visit for parents (see attachment J).*

The department is disappointed that there was limited contact between the [Region B] office and the Ombudsman office. There was one phone call to the [Region B] supervisor, no phone calls to the supervisor in [Region A] and no phone calls to the Area Administrator in [either region]. The information regarding visitation was available in hard copy in the file and were accessible for review.

Based on the above facts, the department ***respectfully requests OFCO to reverse their adverse finding regarding this case****.*

OFCO'S MODIFIED FINDING

OFCO's response in full to CA's request that the adverse finding be overturned:

OFCO did not find any violation of law, policy, procedure regarding the jurisdictional transfer and courtesy supervision by the [three DCFS offices]. OFCO provided the background regarding the case transfer to provide a context for the communication and visitation issues. As you note, "There was a lack of communication regarding the visitation due to both the [Region A] supervisor and the [Region B] supervisor being gone on vacation."

With respect to the finding as to the failure of DCFS to provide court-ordered visitation to the family between September 20 and October 28, 2010, **OFCO agrees to reverse the finding** based on information you have now provided indicating that four visits occurred during this period. Although one of these notes does not indicate the length of the visit, and two visits were documented to be only for three hours, OFCO makes this modification based on the fact that DCFS was making a good faith effort to provide visitation.

Finally, we note that this finding would have been avoided had OFCO's phone calls to the department been returned. OFCO attempts to resolve complaints at the lowest level possible and offers the agency the opportunity to respond to our concerns. OFCO retains the discretion to determine who we contact in the course of our complaint investigations and in general we do not disclose who we have been in contact with during the course of an investigation. In our work, we

necessarily have to rely on information provided to us by DCFS staff and through records available to us via FamLink. In this case, the Ombudsman's office contacted DCFS as follows:

- 8/11/10 phone call to [covering supervisor in Region A]. [The covering supervisor] indicated that [the assigned supervisor] had been running into difficulty getting a response from [Region B] about this case and promptly followed up by sending emails regarding the visitation issue to [Region B supervisor] and the assigned social worker.
- 8/13/10 phone call to [covering supervisor] in [Region B]. [The supervisor] expressed confusion as to how a social worker had been assigned without her knowledge, as she had been watching for the assignment request to come through. She indicated that the assigned social worker was out on extended leave. [The supervisor] stated that she would look into the matter and reply to [the Region A covering supervisor]'s email with an update.
- 8/20/10 phone call to [assigned supervisor Region B], noted in original findings letter.
- 10/20/10 left voice message for [assigned supervisor Region B], after OFCO received information that the family had only had one visit in the past month, on the child's birthday. No return call was received.
- 10/22/10 second voicemail message for [assigned supervisor Region B]. No return call was received. Attempted phone call to the assigned social worker, whose outgoing message indicated she was out of the office on Fridays.
- 10/28/10 phone call to social worker, who informed OFCO that the agreed order was signed and unsupervised visits were set to begin. OFCO considered the complaint issue resolved at this time.

OFCO's calls to the Supervisor on 10/20 and 10/22 were made in an attempt to determine whether or not visits other than the [visit] had been provided since 9/19. When the Supervisor did not return our calls, we relied on the case notes for the information, which indicated that only two visits had occurred, as noted in our findings letter.

Again, we reiterate that OFCO's main goal in bringing these issues to your attention is to encourage improvement in communication and coordination when cases are transferred between Regions, and especially to ensure that parents and children are provided with the visitation they are entitled to under court orders. We look forward to continuing to work with you in the future.

CA DISAGREEMENT, OFCO DENIAL OF REQUEST FOR MODIFICATION OF AN ADVERSE FINDING

OFCO'S FINDING

The following is a summary of OFCO's letter of notification of an adverse finding:

CPS failed to notify the out-of-state non-custodial father of a ten year old non-dependent child that the child had been taken into protective custody and a dependency filed. Furthermore, CPS denied the father's request for placement of the child. The Ombudsman found that CPS failed to take reasonable steps to locate and notify the father, who was on active military duty, of the dependency petition and court proceedings. As a result, the father was denied the opportunity to: respond to the dependency petition; be heard by the court regarding the placement of the child in shelter care, and voice concerns about placing his son with the step-father. The child had been removed from the mother, along with two younger half-siblings, after the mother overdosed on drugs at the sibling's birthday party. The mother previously had parental rights terminated with regard to two older children, and had relinquished parental rights regarding two other children. The ten year old's step-father, who was the father of the younger siblings, had a prior founded CPS finding for neglect and a conviction for domestic violence. Nevertheless, at the shelter care hearing, all three children were placed with this parent. DCFS provided extensive services, including daycare, to support this in-home dependency, but case notes indicated that the step-father was overwhelmed and had been leaving the children in the care of individuals not approved by CPS due to a history of child maltreatment.

The father of the ten year old became aware of the situation after receiving notice from Child Support Enforcement that the payment recipient had changed. The father contacted CPS and was told that the child was doing well and in the care of the step-father. The father was not informed of the dependency, the shelter care order, the alleged abuse and neglect of his child, nor of his rights as a respondent in the dependency action. The father travelled to Washington as soon as possible to try and set up a visit with the child, but even after meeting with the CFWS social worker, the father was still unaware of the basis for removal of the child nor the parent's rights regarding the legal proceedings, and was told that the child could not be placed in his care.

The Ombudsman contacted the CFWS supervisor to request that the parent be served with the dependency petition as soon as possible. The parent was served that afternoon upon arriving at the DCFS office for a visit. The parent found that the dependency petition detailed eleven prior CPS referrals and multiple CPS interventions in the prior six years. CPS had never contacted this father regarding these concerns.

After the father was served the dependency petition and secured counsel, the attorney scheduled an emergency shelter care hearing for the following week. The CFWS supervisor informed the Ombudsman that the agency would be opposing the father's request to have the child placed in his care as the child did not want to leave his younger siblings to move out-of-state. CFWS was also concerned that the father had not consistently visited the child in several years; the father maintained that the custodial parent had not cooperated with attempts to exercise visitation rights granted in the custody order. The Ombudsman found the agency's reasoning for opposing placement with this father to be clearly unreasonable and did not constitute a valid legal argument for shelter care or

dependency as to this parent. The Ombudsman contacted the Area Administrator to request that the agency reconsider its position. The Area Administrator responded that the agency would remain neutral rather than opposing the father's request for placement. At the court hearing, the court determined that there was no legal basis for dependency as to the non-custodial parent, and ordered that the child be placed in the father's care.

CA REQUEST FOR MODIFICATION OF FINDING

The following is a summary of DCFS's letter request for modification of the adverse findings:

DCFS requested that OFCO reverse its finding that the agency failed to notify the father based on the agency's extensive efforts to contact him. These efforts included mailing documents to effect service of the dependency petition to the current address obtained from the Division of Child Support (which were returned to the agency a month later with a new forwarding address) as well as several contacts with military personnel. DCFS stated that by the time the father called the assigned social worker and informed her he had just learned that his child was in the department's custody, the worker assumed (incorrectly) that he had received notice regarding the dependency.

DCFS also requested reversal of the finding that the agency denied the father's request for placement of the child. DCFS contended its position was reasonably based on the child's statement that he did not want to go and live with his father as he had not had contact with his father in several years, and did not want to be separated from his younger siblings. DCFS was also concerned that the child was exhibiting some behavior problems, had been recommended for therapy, and was on medication for Attention Deficit Hyperactivity Disorder. DCFS stated that although these issues "would not have prevented placement with [the father]", they did "warrant assessment to ensure that [the child]'s needs would be met adequately in his father's home." DCFS pointed out that at the court hearing to address the father's request for placement of the child, DCFS did not oppose placement of the child with the father.

OFCO'S RESPONSE DENYING MODIFICATION

The following is OFCO's response in full to CA's request for modification of the adverse finding:

After careful consideration of your letter dated [date] requesting modification of the adverse findings in this case, OFCO declines to modify our findings.

With regard to the notice issue under RCW 13.34.062, your letter makes clear that DCFS did make efforts to locate and contact the father. However, OFCO's intervention with DCFS was based on our investigation and finding that as of [date] (45 days after the child had been taken into custody), the father had not been served with the dependency petition, did not know the full extent of the allegations and concerns regarding his child's care, and was not fully aware of his legal rights to participate in the dependency proceedings. The fact remains that the father first learned of the child's removal from his mother through a letter sent by the Division of Child Support changing the payee for payments. As you note, the CFWS social worker "made the assumption that he had received service for the dependency action" when she spoke with the father on [date]. When OFCO contacted DCFS on [date], the Supervisor also stated that she believed the father had been served.

Because OFCO had credible information to the contrary, we asked that the Supervisor double-check. The father was served [the following day] thus resolving this issue.

As to DCFS's opposition to the father's request for placement/custody of the child, OFCO maintains that this position was clearly unreasonable. As long as there is no evidence or allegation of parental unfitness, DCFS has no authority to interfere with a parent's custodial rights, regardless of the extent of the existing relationship or the child's wishes. As OFCO acknowledged in our initial letter, due to this finding OFCO intervened with the Area Administrator, and the AA responded that CFWS would not be opposing [the father]'s request for custody of [the child], but that CFWS may remain neutral and express their concerns to the court. Thus, OFCO considers our interventions on both of these issues to have been successful.

PART TWO: CASE-SPECIFIC COMPLAINTS RAISING SYSTEMIC ISSUES

Some complaints to OFCO about the agency's actions in specific cases reflect a larger problem, such as a problematic trend in a particular office or region of the state, a pattern with a particular employee or unit, or are indicative of larger system-wide problems. In these cases, OFCO brings the systemic issue to the attention of agency officials, to offer assistance in preventing similar or ongoing problems in future cases.

Below are a couple of examples from our 2011 data, in which OFCO's findings in a particular case were communicated to the agency with the goal of improving the system.

SYSTEMIC ISSUE: DELAY IN PERMANENCY RESULTING FROM SYSTEMIC PROBLEMS

OFCO received a complaint about the delay in permanency for a then 2 ¾ year old child, who had been in out-of-home care since birth. OFCO found systemic concerns contributing to the delay in permanency for this child.

The following table shows the permanency timeline from the child's placement in out of home care until dismissal of the dependency:

DATE	AGE	PERMANENCY EVENT
August 2006	Birth	Child placed in foster care at birth
August 2007	1 year	Parental rights to older sibling terminated
September 2007	13 months	Plan to begin reunification process
October 2007	14 months	Parent moves to rural area
October-December 2007	14-16 months	Parent drops out of services, visits child only twice
January 2008	17 months	Permanency plan changed from reunification to adoption
February 2008	18 months	Child moved to adoptive home of older sibling
May 2008	21 months	DCFS sends termination petition to Attorney General
September 2008	2 years, 1 month	Attorney General files termination petition
October 2009	3 years, 2 months	Termination trial held
November 2009	3 years, 3 months	Judge denies termination
February 2010	3 years, 6 months	Child returned to parent in in-home dependency
September 2010	4 years, 1 month	Dependency dismissed

OFCO communicated these systemic concerns in a letter to CA as follows:

After careful investigation and monitoring of the case, OFCO finds that there was a significant delay in permanency for [the child], whose permanency plan was achieved after he had been in out-of-home care for 3 ½ (his entire life). This delay did not appear to be the result of a violation of a law or policy, but rather resulted from procedural delays and an overall lack of successful collaboration between the department, the Office of the Attorney General and the court system.

[The child] was placed in foster care at birth due to his mother's drug use during pregnancy and instability at the time of his birth. His mother had one older child born when the mother was 15 years old, who was in out-of-home care also. During [the younger child's] dependency in [X] County, parental rights were terminated by default regarding [the child's] older half-sibling, in [Y] County. By the time [the child] was fourteen months old, his mother had participated in services and was making sufficient progress, and the agency planned to begin reunification ([the child's] father never participated in the dependency process). However, at that point (October 2007) the mother decided to move [to Town B], a remote area with no services and limited transportation. Within three months of the mother's move, she had been terminated from all her services for non-attendance, including parenting instruction, FPS services, and substance abuse treatment. She visited the child only twice in that 90-day period.

At the next court review hearing [in January, 2008] (when [the child] was 17 months old), the court changed the permanency plan from reunification to adoption. Shortly after this hearing, the child was moved from the foster home in which he had been placed in [X County], to the adoptive home of his older sibling (in [another region of the state]). The child already had a relationship with his biological sibling as the department had begun facilitating sibling visits, and his sibling's adoptive parents were willing to adopt him if he became legally free.

DCFS forwarded a termination petition to the Attorney General's Office (AGO) [in May, 2008], four months after the January review hearing. The petition was passed back and forth between the AGO and the social worker for another four months. The AGO expressed strong reservations to the agency about the advisability of filing for termination as the parent was back in compliance with services, was clean and sober, and attending visits regularly. However, the agency was concerned about the parent's lack of attunement to the child's emotional needs, and service providers' perception that the parent was unable to place the child's needs ahead of her own. After further staffing, the AGO filed a termination petition [in September, 2008]. Due to court delays, however, the trial was delayed and by September, 2009, the AGO was again expressing concerns about whether there were sufficient grounds for termination of parental rights. [At that point] OFCO contacted the Acting Regional Administrator to request a review of the case, given the length of time the child had been in out of home care (three years, and all of his life) and the delay in achieving permanency. A decision was made to go ahead with the termination trial, which was held in October, 2009 – over a year after the termination petition was filed and nearly two years after the January 2008 review hearing ordering the permanency plan for adoption.

By that time, [the child] was 3 years and 3 months old, had been living with his older sibling's adoptive family for two years, had developed a strong attachment to his sibling and foster family and was showing signs of ongoing distress when visiting his mother. However, his mother had completed most of her court-ordered services, and had stable housing. After a lengthy trial, the judge denied the termination petition on the basis that parental unfitness had not been proven.

The child's permanency plan was achieved in February, 2010 when he was reunified with his mother, at age 3 ½. Two CPS referrals for neglect and physical abuse were investigated following the child's return home, both of which were unfounded. The dependency was dismissed six months later.

OFCO found that documentation in FamLink of casework activities was very limited between January, 2008 and the termination trial in October, 2009. This lack of documentation may have

contributed to the AGO's reticence to immediately file a petition for termination of parental rights, which contributed to case delay. For example, in the 8-month period between the review hearing and the filing of the termination petition, when case activity might be expected to be quite high, other than visitation documentation entered by the visitation supervisor, FamLink shows only the following documentation by the social worker or other agency staff: 3 health and safety visits, 1 FTDM to discuss the child's change of placement, 1 contact to the parent's service provider (to arrange anger management classes), 3 contacts with the parent (two regarding urinalyses (UAs) and one regarding setting up anger management classes), one contact from the parent's attorney about a UA, one anonymous call to CA Central Intake (not taken as a referral nor investigated) alleging that the mother (then age 20) was seen out drinking in violation of court orders, and one case review by the Area Administrator and CFWS supervisor in July, 2008 which stated that "the termination petition is in process." There were no supervisory reviews of the case documented in FamLink.

OFCO believes that there were several systemic concerns impacting this case, resulting in an unnecessary delay in permanency for the child, from inadequate documentation of casework leading up to the termination trial, to inaccessibility or lack of services necessary for reunification in rural areas, to backlogs in the court system resulting in a termination trial being held a year after a petition being filed.

OFCO continued to monitor this case for the duration of the in-home dependency, from February to September, 2010. There have been no new CPS referrals since the dependency was dismissed in September. We have therefore closed this complaint.

While OFCO did not make an adverse finding against the department in this complaint, we are troubled by the multiple factors discussed above that contributed to the significant delay in establishing permanency for this child. Additionally, the challenges presented in this case are not unique and justify formal notice of our complaint findings. OFCO welcomes any response or comments you may have regarding the case.

CA RESPONSE

OFCO received a letter of response from CA as follows:

> *Your letter brings to the table systematic concerns in achieving permanency for children served by the [specific DCFS] Office. Your letter has prompted conversation between the [DCFS] office staff, the Assistant Attorney General's office (AGO) and the Guardian at Litem (GAL) program for [X] County. Some of the concerns raised are within the arena of the Department to implement changes; however, some of the concerns involve the court calendar. In discussing this with the AGO it was noted that the Department cannot impact issues such as court continuances due to the judge's calendar. The [DCFS] Office recognizes the validity of the concerns that have been raised by the Ombudsman's Office and has taken steps to address these important issues that are within our ability to make changes.*
>
> - *Procedural Delays*
>
> 1. *Your letter referenced that the permanent plan of [the child] was changed to adoption followed by a four-month delay on the part of the Department to file a termination petition. In hindsight, we*

should have changed the permanent plan back to reunification when mother was making progress. Permanent plans are changed every other review period, approximately once a year. Concurrent planning doesn't stop the reunification efforts. I believe the [DCFS] Office has made progress in the last year around concurrent planning. As a project from the Reasonable Efforts Symposium in 2009, we developed reunification planning meetings so that the client has the opportunity to engage in services from the beginning. We have also embraced Solution Based Casework (SBC). [The child]'s case had one of the first SBC case consults as we began the planning to send [child] home after the termination trial had concluded. We have had several case consults since then; each supervisor is trained to facilitate them and do so at unit meetings monthly. We have also strengthened practice by including the adoption social worker in shared planning meetings prior to the filing of termination petitions, to discuss possible open adoption agreements and settlements.

2. *Another example of procedural delays was that the termination petition went back and forth between the AGO and the Department for several months with the AGO advising against filing. The social worker drafted the petition four times. With [this] case, the social worker did not feel that the mother had made enough progress for safe reunification and the AGO felt the Department didn't have enough grounds for termination. Ultimately, the legal opinion provided by the AGO was correct as there wasn't a legally sufficient case for termination. The Department felt pressure from the Ombudsman's Office, the caregiver, and the GAL to follow through with the termination proceeding when the AGO was advising the Department that there wasn't grounds. Had termination not been pursued, we would have avoided the year's wait for a contested trial, multiple days of trial over a two-month period, and several months waiting for the judge to issue a ruling denying termination. The office has brought questions regarding termination and reunification to the Reasonable Efforts Symposium.*
3. *The final example of procedural delays was that the contested termination trial was delayed for a year after filing, with the termination trial being held October 2009. The delay was due to court issues; not because of the action or inaction of the Department or the AGO. As an office, we have been aware there is a delay in resolution of cases. In late 2009, we began working with Partners for Our Children around the length of stay numbers. Partner's staff helped with educating the court on the issue and has done several presentations of their research data on the length of stay. During the time period that [the child]'s case was open, contested court hearings were set out for an extended period of time, often 3rd or 4th set. The Office has engaged in The Table of Ten effort, supported by the Court Improvement Training Academy (CITA) through the University Of Washington School Of Law. We started the Table of Ten in January 2010. The first issue the group agreed to change was the setting of dependency fact finding hearings within 75 days, as required by statute. Having a set court calendar for this type of hearings freed up the contested court docket. The second issue was the contested hearings. We established a procedure for a settlement hearing prior to the termination trial. This has also cleared up the contested court docket. Our court commissioner's time was increased from one day a week to a day and a half of court time a week.*

- *Lack of collaboration between AGO and court and [DCFS].*

The AGO has since provided trainings for social workers and providers on how to testify in trials, and has provided specific training to draft petitions. The parties involved with the dependency system meet monthly as part of the Table of Ten project.

- *Lack of documentation.*

There was insufficient documentation in the case file between the dates of January 2008 and October 2009. During this time period, case loads in the [DCFS] Office were very high. The social worker assigned to [the child] remembers carrying a case load of 50 children in the fall of 2007 through winter of 2008. Case loads were redistributed in late spring 2008 to about 30 children per CFSW worker and have steadily decreased since then. Case load numbers now reflect the majority of CFSW case workers are carrying case loads between 18 and 22 children. We have had a fluctuation in staffing levels since 2008. Training in good social work practice is an on-going effort for the office. The supervisory team has put together a handbook of procedures, providing step-by-step instructions on how to do several common processes and social work practices. Directions on what to document in a case note, the requirement for monthly documentation regarding child contact, parent contact, caregiver contact, and monthly supervisory reviews are just an example of what the handbook provides.

- *Rural Resources*

There continues to be a serious lack of resources for reunification work in rural offices. The [DCFS] Office covers [n] Counties, with two major town areas. Professional services (such as parenting classes) are usually limited to the city limits. This is a major obstacle when parents live elsewhere in the county and do not have transportation. There are limited transit services. To compensate, the [DCFS] Office utilizes volunteer transporters, however we have to be cautious of the amount of money spent towards transportation due to budget constraints. Another issue for services provision is a lack of culturally competent, multilingual services. [The child]'s mother is culturally Hispanic, although she is not limited English speaking (LEP) she would have benefited from services that were culturally matched. I am optimistic that the performance based contracting will bring a more equitable range of services for our families.

In an overview of office functioning and improvements, we believe the [DCFS] Office has made great progress in permanency since 2009. Efforts include the collaboration with Partners for Our Children, the Table of Ten project, and Solution Based Casework. Increased use of FTDMs, shared planning meetings and reunification planning meetings have all worked together to improve the length of stay data for our area. Your letter provided a chance to reflect on where we have come from and illuminated some areas where we need to continue to make progress.

SYSTEMIC ISSUE: FAILURE TO FULLY PROTECT SIBLINGS IN SEVERE SEXUAL ABUSE CASE

OFCO received a complaint regarding a child who had been sexually abused by her adoptive father. This complaint raised concerns about:

- The delay in filing for dependency on the child victim of abuse and
- The decision not to seek dependency as to a younger sibling and the welfare of this child who remained in the adoptive mother's care.

This case also illustrates difficulties resolving professional disagreement between DCFS staff and the Assistant Attorney General (AAG) as to case planning.

COMPLAINT SUMMARY

Mr. and Mrs. J are the adoptive parents of fourteen year old M and six year old K. During a doctor's appointment, M disclosed that she had been raped by her father. Mrs. J misled the doctor, a mandated reporter, that the rape had already been reported to the police while in fact, no report had been made to either law enforcement or CPS. Despite learning of the sexual abuse, Mrs. J allowed her husband to remain in the home.

Several days after the doctor's appointment, CPS received an intake from a school employee stating that M reported that she was raped by a family member. The CPS intake social worker contacted Mrs. J who confirmed that her husband admitted to sexually abusing M and that the abuse occurred in the family home.

Law enforcement and CPS interviews of the child and parents confirmed that: Mr. J sexually abused and repeatedly raped M over an extended period; exposed her to pornography; and covertly made video recordings of her; Mrs. J was aware of her husband's use of pornography and that she thought he allowed M to view pornography; that she had observed him engage in inappropriate physical contact with M; and that she had discovered a camera he installed to secretly record M; M told her mother immediately when the sexual abuse first occurred a year prior and Mrs. J did nothing to report this to the authorities or protect M.

Mr. J was arrested and charged with Child Molestation 2nd Degree, Rape of a Child 2nd Degree, Voyeurism, and Possession of Depiction of a Minor Engaged in Sexually Explicit Conduct 1st Degree.

Mrs. J displayed no empathy for her daughter stating that although she knew M was a victim, part of her believed M seduced her father. Mrs. J also stated that her first priority was to keep her husband out of jail so he could keep working and provide for the family. In fact, Mrs. J brought M to her husband's bail hearing to advocate for his release.

Despite concerns regarding Mrs. J's failure to protect M from abuse, CPS did not place either M or K in protective custody or seek court supervision by filing for dependency. Both the CPS social worker and law enforcement detective voiced concerns about the mother's failure to protect these children and the need to file for dependency. However, the DCFS management and the AAG determined that the criteria for filing a dependency action had not been met.

Two months after CPS received the referral reporting M's sexual abuse, CPS received an intake alleging physical abuse of M by her adoptive mother. M disclosed that her mother had struck her with a belt, leaving marks and bruises on her back and buttocks as punishment for sneaking food. M was then taken into protective custody and CPS filed for dependency. No action was taken however to protect K.

Upon completing its investigation, CPS concluded that allegations of sexual abuse by Mr. J are founded and that allegations of neglect for failing to protect and for physical abuse by Mrs. J are founded.

OFCO FINDINGS

Unreasonable delay in filing for dependency and seeking out-of-home placement of M

After interviewing both adoptive parents and M, CPS had sufficient information to conclude that the mother knew of the abuse, failed to report or protect her daughter and demonstrated a belief that M was in part to blame for the abuse. Based on these facts, there was sufficient evidence to allege that M is abused or neglected as defined in chapter 26.44 RCW and that she has no parent capable of adequately caring for her and is in circumstances which constitute a danger of substantial damage to her psychological or physical development. In fact, the CPS worker came to this same conclusion and urged the detective to place M in protective custody. CPS however did not file for dependency until six weeks later and after it had received an intake alleging physical abuse of M by her mother.

Failure to file for dependency as to K

The decision not to file for dependency on six year old K was clearly unreasonable under the circumstances. Mrs. J's complete disregard for M's safety and failure to take action to protect M from ongoing sexual abuse were a sufficient basis to allege that her younger child K was also at risk and warranted the court's protection. Specifically, the sexual abuse and exploitation of the older sibling M occurred over an extended period of time and with the mother's knowledge. Additionally, after Mr. J admitted to the sexual abuse, Mrs. J's actions demonstrated a greater concern for her husband's release from incarceration than for protecting the children. Court supervision and structure through a dependency action would have provided a heightened level of protection for both K and M and allowed for the implementation of a service plan addressing the needs of the entire family, including sibling contact.

CA RESPONSE

CA requested that OFCO reconsider these findings for the reasons summarized below:

Delay in filing for dependency and seeking out of home placement for M

DCFS consulted with an Assistant Attorney General on two occasions and shared information received from law enforcement, the prosecutor's office and other professionals. Although the situation was concerning, the AAG advised that there was inadequate legal sufficiency to file a dependency on either of the girls. The department concluded that during the initial phase of the investigation, there were no evidentiary facts to support that the mother failed to protect M. Specifically, the department determined that Mrs. J did not know that Mr. J was raping M until M's disclosure and therefore had not failed to protect her daughters.

Failure to file for dependency as to K

After M was taken into protective custody following the CPS intake alleging physical abuse by Mrs. J, the CA Area Administrator advised the CPS social worker to file a dependency petition on both M and K. However, the Assistant Attorney General determined that while the new information was sufficient to file for the dependency on M, there was inadequate legal sufficiency to file for the dependency on K. CA notes that the new information did not allege corporeal punishment/physical abuse of K nor was there evidence that K had been sexually abused or neglected.

After fully considering CA's response, OFCO affirmed its original findings that both the delay in filing for dependency and seeking out of home placement of M and the decision not to file for dependency on K were unreasonable.

VI. Improving the System

PART ONE: OFCO CRITICAL INCIDENT CASE REVIEWS

- Summary of Findings
- Child Fatality Reviews
    - OFCO Independent Child Fatality Review and CA Executive Child Fatality Review
    - Implementation Status of Child Fatality Review Recommendations
- Near Fatality Reviews
- Recurrent Maltreatment
    - Update on 2010 Systemic Finding

PART TWO: WORKING TO MAKE A DIFFERENCE

- Child Abuse and Neglect in Adoptive and Other Permanent Placements
- 2011 Legislative Update

"Thanks. Your work makes a difference and will continue to - thanks on behalf of my Indian Community."
-Community Professional

PART ONE: OFCO CRITICAL INCIDENT CASE REVIEWS

BACKGROUND

The Ombudsman conducts administrative reviews of:

- **Child Fatalities**[42]**-** When there is an open case on the family prior to the fatality incident or any CA history on the family within twelve months of the fatality, including information only referrals; the fatality occurred in a CA or Department of Early Learning (DEL) licensed, certified, or state operated facility.

- **Child Near Fatalities**[43]**-** 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.[44]

- **Recurrent Maltreatment**[45]**-** When families or children experience recurrent maltreatment- three founded reports of alleged abuse or neglect within the last twelve month period.

The Ombudsman treats each of these critical incident reviews- Child Fatalities, Near Fatalities and Recurrent Maltreatment, as emergent in order to assure the safety of any children remaining in the home. In this reporting period, OFCO conducted 177 administrative reviews of critical incident cases (76 child fatalities, 12 near fatalities and 89 cases of recurrent maltreatment).

REPORTING PERIOD FOR CHILD FATALITIES

This section discusses OFCO reviews of child fatalities occurring between January 1, 2010 and December 31, 2010. 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 review and reporting on these cases is therefore limited to the 2010 calendar year.

REPORTING PERIOD FOR CHILD NEAR FATALITIES

In 2011, OFCO reviewed twelve child near fatalities, occurring between January 1, 2011 and December 31, 2011. In order to better identify common factors in these cases, this section also analyzes data collected in near fatality reviews from 2008 through 2011.

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[42] RCW 74.13.640(1)(b) requires the department to consult with the Office of the Family and Children's Ombudsman to determine if a child fatality review should be conducted in any case in which it cannot be determined whether the child's death is the result of suspected child abuse or neglect.

[43]RCW 74.13.640(2) requires that the department must promptly notify the Ombudsman 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 request of the Office of the Family and Children's Ombudsman.

[44] RCW 74.13.500.

[45] RCW 26.44.030(13) requires CA to notify the Ombudsman of "three founded" cases.

REPORTING PERIOD FOR RECURRENT CHILD MALTREATMENT

For the period of September 1, 2010 through August 31, 2011, OFCO reviewed 89 cases of recurrent maltreatment.

OFCO'S ADMINISTRATIVE REVIEW PROCESS

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

OFCO'S PARTICIPATION IN INTERNAL CHILDREN'S ADMINISTRATION CRITICAL INCIDENT STAFFINGS

Beginning in January 2010, under the direction of the current Assistant Secretary, the Children's Administration established a protocol for convening immediate case staffings regarding child fatality and other critical incidents. The goal is for these staffings to occur on the first business day following the incident. In appreciation of OFCO's unique role, and welcoming greater transparency and oversight, CA has specifically included OFCO in these internal staffings, where important information and updates are shared.

OFCO'S PARTICIPATION IN EXTERNAL CHILD FATALITY AND CRITICAL INCIDENT CASE REVIEWS

In addition to OFCO's independent reviews, the Ombudsman participates in CA and local county child death and critical incident reviews across the state. These reviews provide the Ombudsman with a unique perspective both as to how reviews are conducted and on common factors in child fatalities and critical incidents.[46] When conducting critical incident reviews, OFCO focuses on whether child abuse and or neglect were contributing factors and if there were any opportunities for the child welfare system to assist the family and protect the child. This allows the Ombudsman to take action to protect children and develop recommendations to protect our state's most vulnerable population.

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

SUMMARY OF FINDINGS

FATALITY REVIEWS

- Fifty-eight percent of the child fatalities that OFCO reviewed were of children under the age of two years. OFCO found:
    - Unsafe sleep environment continues to be a significant risk factor in many infant deaths.
- Minority children continue to be overrepresented within the child welfare system and child fatalities are disproportionally high for American Indian and Alaskan Native and African American children.

NEAR FATALITY REVIEWS

- In 2011, OFCO reviewed twelve child near fatality cases, thirteen fewer near fatality cases than OFCO received and reviewed in 2010.
- From 2009 – 2011 forty-six percent of the near fatalities OFCO reviewed resulted from clear physical abuse or neglect.

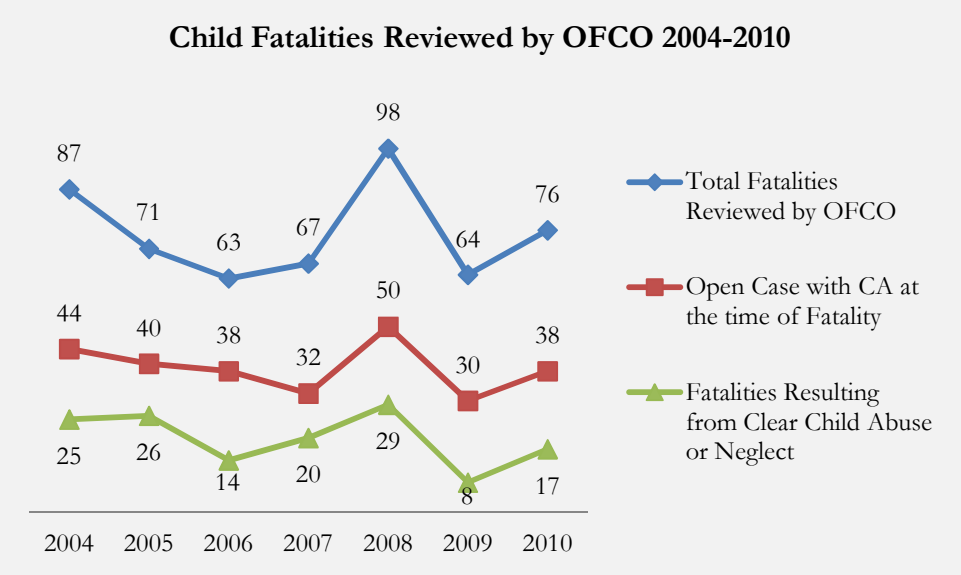
RECURRENT MALTREATMENT REVIEWS

- Child Protective Services routinely fails to complete Investigative Assessments within the 45-day deadline as required by policy. The timely completion of investigations is crucial to child safety and effective case planning.
- Caregiver substance abuse is the most prevalent risk factor (affecting fifty-five percent of the families) in these recurrent cases.

CHILD FATALITY REVIEWS

NUMBER OF FATALITIES REVIEWED BY OFCO

The Ombudsman reviews all fatalities of children whose family had an open case with DSHS CA at the time of death or within one year prior.[47] Since 2004, the number of fatalities reviewed by OFCO has fluctuated between 63 and 98 per year. OFCO typically reviews approximately eleven percent of the overall number of child deaths in Washington State.[48] Child fatalities reviewed from 2010 show an increase from 2009 in the number of child fatalities directly attributed to physical abuse or neglect, as well as an increase in the number of child fatalities with an open CA case.



Source: Office of the Family and Children's Ombudsman, November, 2011, based on analysis of DSHS CA data

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

OFCO reviews child fatalities to determine if child abuse and/or neglect contributed to the fatalities, and if so, how. While the deaths of these children were unexpected, they were not all caused by child abuse and/or neglect. A finding of clear physical abuse or neglect as a contributing factor in the child's death does not necessarily imply a failure on the part of DSHS CA. OFCO found that in 2010, physical abuse caused the child's death in five cases (seven percent) and neglect clearly contributed to the child's death in twelve cases (sixteen percent). OFCO also found that in an additional sixteen cases (21 percent) child abuse or neglect factors were present and may have contributed to the child's death.

Fifty percent of the fatalities were related to an open DCFS case and fifty percent of the cases were closed at the time of death but open with DCFS within the previous year. An additional four

[47] OFCO reviews both expected and unexpected deaths meeting these criteria. As a result, the number of total child fatalities reviewed by OFCO is higher than the number reviewed and reported on by DSHS.
[48] The total number of child deaths in WA State is: 719 in 2005; 683 in 2006; 700 in 2007; 777 in 2008; 701 in 2009; and "data unavailable" for 2010. http://www.dshs.wa.gov/pdf/ca/FatalitiesinWa.pdf

fatalities occurred in a daycare licensed by the Department of Early Learning (DEL).[49] Case examples are summarized in Appendix D.

CHILD FATALITY DEMOGRAPHICS AND DISPROPORTIONALITY

Consistent with data for all child deaths in Washington State, the majority of fatalities that OFCO reviewed in 2010 (58 percent) were of children under the age of two years. Forty-two percent were females and fifty-eight percent were males. Child fatalities continue to be disproportionally high for American Indian and Alaskan Native and African American children relative to their percentage of the overall state population. While American Indian and Alaskan Native children make up two percent of the children in Washington State, they represent nine percent of the child fatalities reviewed by OFCO. Similarly, African American children make up five percent of the state's child population yet represent nine percent of the child fatalities reviewed.

This pattern of racial disproportionality is found not only in child fatalities, but across the United States in all social welfare systems. The disproportionality in child fatalities may be reflective of the overrepresentation of children of color in the child welfare system, compared to their numbers in the population. Although abuse and neglect do not occur at higher rates for children of color compared to white children, they are more likely to be the subjects of referrals to Child Protective Services, they enter child welfare systems at higher rates, remain in care for longer periods of time, are less likely to be placed in a permanent placement than white children.[50]

RACE/ETHNICITY OF 2010 CHILD FATALITIES REVIEWED BY OFCO

	2010 Fatalities	Children in DCFS placement	WA child population
African American	9%	10%	5%
American Indian or Alaska Native	9%	12%	2%
Asian	5%	1%	7%
Caucasian	62%	58%	81%
Multi-Racial	13%	12%	6%
Caucasian and American Indian or Alaska Native	*9%*		
Caucasian and African American	*3%*		
Caucasian and African American and Other	*1%*		
Unknown or Other Race	1%	3%	0%
Hispanic	21%	16%	16%
Caucasian, Not Hispanic	47%		

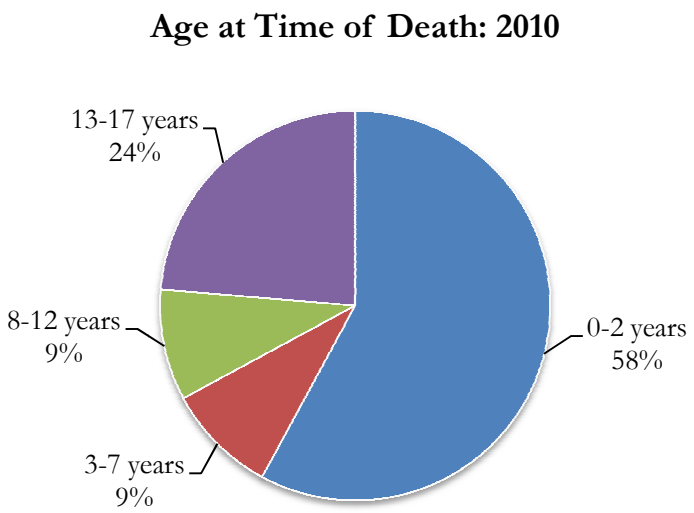
Source: Office of the Family and Children's Ombudsman, November 2011, based on analysis of DSHS CA data and WA State Children populations taken from Children's Administration Performance Report 2008: http://www.dshs.wa.gov/pdf/ca/08Report1.pdf

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

[50] Child Welfare Information Gateway. (2011). *Addressing Racial Disproportionality in Child Welfare*- Issue Brief, available at: http://www.childwelfare.gov/pubs/issue_briefs/racial_disproportionality/racial_disproportionality.pdf; Marna Miller. (2008). *Racial Disproportionality in Washington State's Child Welfare System.* Olympia: Washington State Institute for Public Policy, Document No. 08-06-3901, available at: http://www.wsipp.wa.gov/rptfiles/08-06-3901.pdf

AGE AT TIME OF DEATH

The majority of child fatalities reviewed by OFCO were of children two years of age or younger.



Source: Office of the Family and Children's Ombudsman, November 2011, based on analysis of DSHS CA data

INFANT SAFE SLEEP ENVIRONMENTS AND PUBLIC EDUCATION EFFORTS

The following case examples demonstrate the dangers of an unsafe sleep environment and the ongoing need for public outreach and education on infant sleep environment.[51] An unsafe sleep environment was documented in twenty cases (57 percent) of infant deaths OFCO reviewed in 2010. OFCO noted ten infant fatalities that occurred while bed-sharing and ten fatalities related to other types of unsafe sleep environments. For example:

- A one month old non-dependent infant was swaddled and placed to sleep with both parents in an adult bed. The Coroner determined the manner of death to be undetermined with co-sleeping as a factor in the death.
- A one month old non-dependent infant was co-sleeping with their mother on a couch. The mother woke up to find the infant covered with a pillow. The Coroner determined the manner of death was an accident, caused by mechanical asphyxia.
- A two month old non-dependent infant was found deceased face down in a foam bassinet. The bassinet had a poorly fitting mattress and the infant was found wedged into the corner of the bassinet. The Coroner ruled the manner of death to be an accident, caused by probably asphyxia.

In 2011, The American Academy of Pediatrics released updated information regarding safe sleep environments[52]. The American Academy of Pediatrics states infants should always be placed to sleep on their back in a smoke free environment and dressed in light clothing to avoid overheating. A crib or bassinet near the parent's bed is the safest place for the infant to sleep and makes it easier to breastfeed and bond with the infant. The crib or bassinet must be free of toys, soft bedding, blankets, and pillows.[53]

OFCO continues to participate in an Infant Safe Sleep Workgroup[54] facilitated by Representative Mary Helen Roberts with the purpose of promoting Safe Sleep Campaigns to educate the public on safe sleep environments for infants. The group hopes to provide this information to enable parents to make informed choices about their infant's sleep environment.

[51] Other details surrounding the death have been eliminated to highlight the issue related solely to the child's sleeping environment.
[52] http://www.aap.org/advocacy/releases/sids2011.htm
[53] http://www.healthychildcare.org/pdf/SIDSparentsafesleep.pdf
[54] Members include representatives from King County Public Health, Northwest Infant Survival and SIDS Alliance, Parent Trust for Washington Children, WA State Department of Health, WA State Department of Social and Health Services, Native American Women's Dialogue on Infant Mortality, King County Sheriff & Medical Examiner's Office, Seattle Children's Hospital, the Council for Children & Families, and Safe Kids King County.

OFCO INDEPENDENT CHILD FATALITY REVIEW AND CA EXECUTIVE CHILD FATALITY REVIEW

The Ombudsman reviews all fatalities of children whose family had an open case with the Department of Social and Health Services (DSHS) Children's Administration (CA) at the time of death or within one year prior. In the case summarized below, CA specifically requested that the Ombudsman conduct an independent child fatality review as just three months prior to the child's death, Child Protective Services (CPS) accepted for investigation a referral alleging child abuse and neglect by the mother. This CPS investigation remained open at the time of the child's death. In addition to the OFCO's child fatality review, CA conducted an Executive Child Fatality Review which was completed in September 2011.

OFCO INDEPENDENT CHILD FATALITY REVIEW: "MAIYA"

Susan is the mother of six year old Marcus (born in 2005), one year old Maiya (born in 2009) and two month old Sandra (born in 2011). Child Protective Services (CPS) first became involved with this family due to domestic violence by the father, and related child safety concerns and in 2005, Marcus was placed with a relative. The dependency was ultimately dismissed in 2008 after the relative caregiver obtained guardianship of Marcus.

In 2011, law enforcement responded to an emergency call from Susan that her daughter Maiya had vomited and was not breathing. Susan's boyfriend told a responding officer that Maiya had apparently drowned while he was attending to an infant in another room and that he began pumping Maiya's stomach to remove water. The child was rushed to the hospital, but could not be saved. The County Medical Examiner concluded that the manner of death is homicide, and that blunt force trauma to the victim's abdomen caused the fatal bleeding. The child likely died within three hours of being struck. Neither law enforcement nor the Medical Examiner found evidence of drowning. The mother's boyfriend was arrested and charged with Maiya's death.

A few months before Maiya's death, CPS received and screened in for a 72 hour investigation a referral regarding Susan and alleging: lack of supervision and injury to Maiya; physical neglect of Maiya; physical abuse of Marcus; and mental health issues interfering with the mother's ability to parent.

Summarized below are OFCO's findings and conclusions from this child fatality review as well as the findings and recommendations of the CA Executive child fatality review.

OFCO DETERMINED THAT CPS DID NOT ADEQUATELY INVESTIGATE ALLEGATIONS OF CHILD ABUSE AND NEGLECT RECEIVED 3 MONTHS PRIOR TO MAIYA'S DEATH. CPS has a duty to investigate screened in referrals alleging child abuse.[55] The scope of the investigation is not limited solely to the specific allegations identified in the referral. Rather, the social worker gathers a range of information necessary for risk assessment, family evaluation, and case planning.[56] Additionally, when assessing the risk of child abuse or neglect, the CPS social worker may consider not only the

[55] RCW 26.44.030; RCW 26.44.050; CA Case Services Policy Manual, Section 3210; CA Practices & Procedures Guide, Section 2331.
[56] CA Practices & Procedures Guide, Section 2331(C).

current allegations, but the family's history and the cumulative effect of the caregiver's pattern of conduct on the child.[57]

As discussed below, OFCO determined that CPS failed to: contact the referrer for additional information; contact professionals with information about the family; investigate allegations of physical abuse of Marcus; and complete an Investigative Summary. Additionally, case documents indicate that there was only a cursory review by the social worker's supervisor, which failed to correct any of these issues.

- **Failure to Contact Referrer**
  The assigned CPS social worker must contact the referrer if the intake information is insufficient or unclear. The social worker may also provide information about the outcome of the case to mandated referrers. In this case, the CPS social worker made one, unsuccessful attempt to call the mandated referrer. Additional information from the referrer was necessary to explore in more detail general allegations about: the mother's mental health and parental fitness; Marcus' statement to referrer describing physical abuse; and the referrer's concerns regarding Maiya's physical care, cleanliness and hygiene; and to resolve discrepancies as to the date of an alleged injury to Maiya. However, no further efforts were made to contact the referrer and these issues were not explored.

- **Failure to Contact Professionals**
  The assigned CPS social worker must interview professionals and other persons (physician, nurse, school personnel, child day care, relatives, etc.) who are reported to have or, the social worker believes, may have first-hand knowledge of the incident, the injury, or the family's circumstances. During this investigation, no such collateral contacts were made. Professionals with first-hand knowledge of Maiya's injury or the family's circumstances and who should have been interviewed include: the mother's case manager at a housing program who could have provided information about the mother's compliance with the program and any concerns regarding DV; the child's primary care physician, who could have addressed concerns about Maiya's general health and any treatment for an injury; the mother's medical provider who could have confirmed that the mother was receiving prenatal care and whether or not she should refrain from taking mental health medications while pregnant; and the psychologist who evaluated the mother, who could have provided information regarding the mother's mental health issues. These professionals were identified in the referral or during the CPS investigation, and the mother provided a release of information, yet there is no documentation of any attempts to contact these individuals.

- **Failure to Investigate Allegation of Physical Abuse of Marcus**
  According to the referral, Marcus said that his mother is really mean and beats him, yet this allegation was not investigated. The CPS social worker did not interview the referrer, Marcus or Marcus' relative guardian. While the mother was interviewed, there is no documentation that she was questioned about contact with her son Marcus and allegations of physical abuse or mistreatment. This allegation also raises questions about the guardian's ability to protect Marcus. DCFS records document that Marcus was subject to a dependency proceeding in 2005, was placed with a relative, and that the dependency was dismissed after a guardianship was established. However, there is no indication that the social worker

[57] RCW 26.44.020(14).

reviewed previous case records to determine if there are any restrictions on the guardian allowing contact between Marcus and his mother. Based on the child's alleged statement, it is unclear whether the guardian was allowing unsupervised contact between Marcus and his mother, whether the guardian was aware of Marcus' allegations of physical abuse and what if any steps the guardian took to protect the child. None of these concerns were addressed as this allegation was not investigated.

Following Maiya's death however, Marcus was interviewed and stated that his mother hits him with a broom and a belt, that his mother hit Maiya with a belt and slapped her face and that his mother's boyfriend hit both of them with a belt and with his hand. He also said that his guardian knew his mother and the mother's boyfriend were hitting him.

- **Lack of Adequate Supervisory Review**
  The CPS supervisor must review all cases to determine if: the case record and file are complete; the investigation is complete and no other action is necessary; and the 45-day rule requirement has been met. The supervisor may refer the case back for further investigation if the investigation is not complete or additional action is necessary. The only documented case review by a supervisor is a verbal staffing with the social worker, which occurred four days after the referral was received. None of the issues discussed above were identified by the supervisor. No extension was issued and no additional actions were required. It is noteworthy that both the social worker and supervisor document that the mother believed this referral was made against her by a relative in retaliation. This raises the question if the social worker and supervisor were biased in the mother's favor and dismissive of the allegations made in the referral.

- **Failure to Complete an Investigative Risk Assessment**
  The social worker is required to complete an investigative risk assessment on all investigations of child abuse and neglect upon completion of the investigation within 45 calendar days of receiving the intake unless the requirement is waived by the supervisor. There is no documentation that an Investigative Assessment was completed within 45 days or that a waiver was issued.

- **Failure to Document Case Investigation Activities in a Timely Manner**
  Social workers must document all case activity in FamLink within ten days of the date of the event or activity. All hand written notes must be discarded after the information has been entered into a FamLink. The CPS social worker and the CPS supervisor both entered FamLink Case Notes, post fatality, which described investigation activities occurring nearly three months earlier. Case notes entered post fatality bear the suspicion that they were written for the benefit of a subsequent fatality case review and not to provide an objective, near contemporaneous account of investigation activities and events.

Conclusion

The purpose of OFCO's review was not to determine whether a more thorough CPS investigation could or could not have prevented Maiya's death. Rather this review aimed to assess whether the CPS investigation was conducted in a manner consistent with state law and department policies. The value of conducting critical incident or child fatality case reviews is to identify practice errors as well as systemic issues in an effort to improve performance throughout the agency and better serve

children and families. In this case, the Ombudsman concluded that errors were related to existing policies and procedures not being followed.

CA EXECUTIVE CHILD FATALITY REVIEW FINDINGS AND RECOMMENDATIONS

(Below are the Findings and Recommendations section of the CA Executive Child Fatality Review. This review in its entirety is available on line at: http://www.dshs.wa.gov/pdf/ca/ecfr-nl.pdf)

The review committee made the following findings and recommendations based on interviews, review of the case records, and department policy and procedure, the Revised Code of Washington (RCW) and Washington Administrative Code (WAC).

FINDINGS:

Investigations

The review committee discussed at length the CPS investigations and service recommendations made in this case over the course of the family's involvement with CA. They found the following:

- During February and March 2011, high intake assignment impacted the CPS unit in which the February 2011 intake referencing this family was assigned. Key standards of a CPS investigation required by CA policy[58] did not appear to have occurred. Investigative standards should include:
    - Investigation of all allegations identified in the intake
    - Contact with the referrer to clarify information in the intake
    - Contact with collaterals that were reported to have or may have had firsthand knowledge of the family (e.g., medical providers and other professionals involved with the family, relatives)
    - Completion of the investigation within the required 45 days or an extension of this requirement approved by the supervisor
    - Monthly supervisory review as a means to monitor case progress and to determine if the investigation was not complete and what additional action was necessary
    - Documentation of case activities in a timely manner
- Subsequent to the initial contacts with the alleged victim and mother, there was approximately a 75 day period without any significant investigative follow-up activity or visit by the CPS social worker. During this time, the mother gave birth to another child, which the committee felt may have warranted another visit to the home.
- The review committee confirmed in cases where a child is dependent or a family is receiving voluntary services, CA policy is that each child in the home will be seen monthly. Current CPS investigations policy does not require monthly visits to a home when a case is open 30 or more days for CPS investigation only.

Supervision

- The review committee found after reviewing FamLink data regarding intake assignment in the Pierce West office and meeting with the social work supervisor that monthly supervisory consultation or staffings were difficult to maintain due to the unit's workload.

[58] CA Practices and Procedures Guide, Section 2331, Investigative Standards.

Workload

- The committee found after interviewing the social work supervisor, the ability of the CPS social worker to meet practice expectations appeared to be compromised by her caseload. The social worker was experienced. However, due to vacancies in the CPS section and the number of intakes needing to be assigned for investigation, the social worker was getting an average of 13.7 new intakes assigned for investigation between January and May 2011. The social worker had 32 open cases assigned to her at the time of the child's death. The COA standards recommend that a CPS social worker have no more than 30 active cases.
- The supervisor's availability to provide clinical case consultation, monitoring, and feedback to her staff on an ongoing and systematic basis may be impacted by the intake assignment process in the office. CPS supervisors rotate the responsibility of assigning intakes for the section on a weekly basis; much of their time appears to be spent duplicating the efforts of the intake supervisor.
- The supervisor manages a unit that primarily handles military cases, although they do handle civilian cases as well. Coordination with the military can often require additional requirements when conducting investigations, which may increase the investigator's or supervisor's workload.

RECOMMENDATIONS:

Practice

- CA may want to consider implementing a monthly visit practice for families who have a CPS case open longer than 30 days. Similar to cases involving dependent children and families receiving voluntary services, children in cases that are open to CPS should be seen monthly.

Supervision

- The review committee recommended that supervisors receive the FamLink report on a monthly basis regarding CPS investigations open for longer than 45 days without an extension as a means to support supervisors in monitoring workload. The committee recommended pulling a statewide report regarding the occurrence of monthly supervisory reviews by office and program area to determine where there may be barriers to completing the reviews.

Workload

- A review of the workflow process from CPS intake to assignment and investigation should occur in the Pierce West and East offices to determine if there are barriers and duplication of job duties.
- A statewide review should occur of the protocols and systemic issues related to coordination of investigations between CPS and the military. Consideration as to whether caseloads involving military cases should be weighted is recommended.

Training/Resources

- The review committee discussed the complexities of cases involving domestic violence. The development of the CA Social Worker's Practice Guide to Domestic Violence in 2010 was identified as a positive step in assisting CA social workers in their work with families experiencing domestic violence. However, the committee recommended that training be developed in collaboration with community partners and implemented for CA staff

regarding the Guide. Recommended training methods such as video or web based training can be developed to effectively and efficiently deliver the training.

- Based on funding availability and partnership with community agencies, a domestic violence advocate should be co-located in CA offices for the purpose of consultation, intervention, and planning on cases involving domestic violence. Research shows that domestic violence often coexists with child maltreatment.

IMPLEMENTATION STATUS OF CHILD FATALITY REVIEW RECOMMENDATIONS

In order to promote accountability and the consistent implementation of recommendations resulting from child fatality reviews, OFCO is required to issue an annual report to the Legislature on the implementation status of these recommendations.[59] In August 2011, OFCO published its report, covering ninety fatality reviews regarding child deaths that occurred between January 2009 and April 2010.[60] Discussed below is a summary of this report. The majority (sixty-six percent) of these fatalities was of children under the age of two and according to the medical examiner or coroner, unsafe sleep environment either caused or was a risk factor in thirty-eight percent (18 of 47) of infant deaths.

COMMON THEMES OF CHILD FATALITY REVIEW RECOMMENDATIONS

During this reporting period, fifty-two of the ninety CA child fatality reviews resulted in 111 recommendations. OFCO analyzed these recommendations to identify common themes and the number of times similar recommendations were made. Common recommendations were grouped in the following categories:

- Provide Training *(Topics such as: Infant Safe Sleep; ICWA Issues; and Risk Assessment and Safety Planning)*
- Effective Interventions with Families *(Ensuring Referrals and Access to Services; Engaging Families; Use of Evidence Based Practice; and Reducing Chronic Neglect)*
- Intake Screening Decisions *(Obtain Thorough Information at Intake; and Review Screening Decisions and Develop Consensus)*
- Safety Planning and Risk Assessment *(Infant Safe Sleep and Providing Cribs; Background Checks; Assess Safety of All Children in the Home; Report Illegal Activity to Law Enforcement)*
- Casework Practice *(Utilize Shared Decision Making; and Improve Case Transfer Process)*
- Community and Family Education *(Safe Sleep; Infant Care; SIDs; and Grief Loss)*
- Effective CPS Investigations *(Complete Investigations within Timelines; Make collateral Contacts to Verify Information; and Seek Medical Consultation when needed)*
- Partnerships with Community Professionals *(Coordinate Efforts with Law Enforcement, Tribes, and Public Health)*
- Child Fatality Investigations and Reviews *(Create Regional Specialized Child Fatality Review Teams; and Coordinate with Department of Early Learning)*

[59] RCW 43.06A.100.
[60] OFCO Report: Implementation Status of Child Fatality Recommendations, August 2011, available at: http://www.governor.wa.gov/ofco/reports/implementation_recommendations_2011.pdf

RECOMMENDATIONS IN NATIVE AMERICAN AND AFRICAN AMERICAN CHILD FATALITIES

As discussed in previous reports on child fatalities in Washington State, the number of deaths of Native American and African American children is disproportionally high.[61] In 2009, sixteen percent of the fatalities reviewed by OFCO were of Native American children, while Native American children made up only two percent of the Washington State population. Similarly, while African American children made up five percent of the overall state population, seventeen percent of the fatalities OFCO reviewed were of African American children. Given the high disproportionality of Native American and African American children's deaths, OFCO reviewed the fatality recommendations made regarding deaths of these children during the reporting period, to determine whether there appear to be any trends in these specific recommendations.

NATIVE AMERICAN CHILDREN

OFCO reviewed the deaths of seventeen Native American children. Twelve of these reviews produced thirty-three recommendations. OFCO found no apparent trend or pattern to these recommendations. Five of the fatalities, however, resulted in seven recommendations that specifically addressed the following Indian Child Welfare issues:

- Training for DCFS regarding LICWACs
- Training for tribal law enforcement on CPS policy and procedures
- Training/corrective action for DCFS staff regarding notifications to Tribes
- Training for DCFS ICW staff on ICW conflict resolution
- Family and community education regarding dealing with grief and loss
- Strengthening State-Tribal partnerships

AFRICAN AMERICAN CHILDREN

OFCO reviewed the deaths of thirteen African American. Nine of these reviews resulted in twelve recommendations. OFCO found no apparent trend or pattern to these recommendations. A possible exception was that four of the recommendations addressed a need for community and family education in the areas of safe sleeping environments for infants and resources to assist families in dealing with grief and loss.

IMPLEMENTATION STATUS OF CHILD FATALITY RECOMMENDATIONS

Based on CA's survey response to OFCO, the majority (eighty percent) of child fatality review recommendations have been completely implemented. Ten percent of the recommendations are reported to have been partially implemented, four percent had no implementation effort, and six percent will not be implemented.[62]

OFCO found however, that a large number of recommendations reported by CA to have been "completely implemented" were based on CA's determination that the recommended action represented an existing policy, procedure or practice. When a fatality review concludes that agency

[61] See OFCO's 2010 Annual Report, page 69, at http://www.governor.wa.gov/ofco/reports/2010/ofco_2010_annual.pdf and OFCO's 2009 Annual Report, page 103, at http://www.governor.wa.gov/ofco/reports/ofco_09_annual.pdf

[62] OFCO found that all of the recommendations that were not implemented were reasonable based on the recommendation being moot, lack of funding, or being outside of CA's control.

staff failed to follow existing policy or practice, OFCO recommends that CA should conduct a deeper analysis addressing issues such as:

- Was the policy not followed because of budget and/or time constraints, or ineffective supervision?
- Does the failure to follow policy represent inherent problems with the policy, such as redundancy, lack of specificity, or the existence of competing policies with no clear direction as to which takes priority?
- How is a recommendation to follow existing policy implemented?
- How are the "lessons learned" from the fatality communicated, and to which levels of staff?

ANALYSIS OF SELECTED CHILD FATALITY RECOMMENDATIONS

OFCO identified a number of recommendations and their implementation which stood out as being particularly well-crafted or effectively targeting common issues. These recommendations include:

- Family Education on Sudden Infant Death Syndrome
- Collaboration between CA and Public Health to inform clients about infant death risks
- Strengthening and improving care for medically fragile children
- Domestic Violence Training for CPS Supervisors

CHANGES TO THE CHILD FATALITY REVIEW PROCESS

During the 2011 legislative session, SHB 1105 was enacted which refines the scope of fatalities subject to child fatality reviews, provides greater access to relevant information and for the public dissemination of child fatality reports.

- **Scope of CA Child Fatality Reviews**
  CA is required to review child fatalities when the child's death was suspected to be caused by child abuse or neglect. Child fatality reviews will not be required when the child's death was unexpected, but clearly accidental and unrelated to abuse or neglect. The department must consult with the Ombudsman to determine if a review should be conducted if it is not clear whether a child's death was the result of child abuse or neglect. In the event of a near fatality of a child, the department must promptly notify the Ombudsman and may conduct a review at its discretion or at the request of the Ombudsman.

- **Autopsy Reports and Supervising Agency Records**
  The Secretary of DSHS is authorized to access an autopsy report for purposes of conducting a child fatality review. Additionally, the department and the fatality review team have access to all records and files from a supervising agency that provided services to the child while under contract with the DSHS.

- **Public Information and Transparency**
  A child fatality review is subject to public disclosure and must be posted on the department's public website. The department is authorized to redact confidential information contained in a child fatality review report to protect the privacy of victims of child abuse and neglect.

NEAR FATALITY REVIEWS

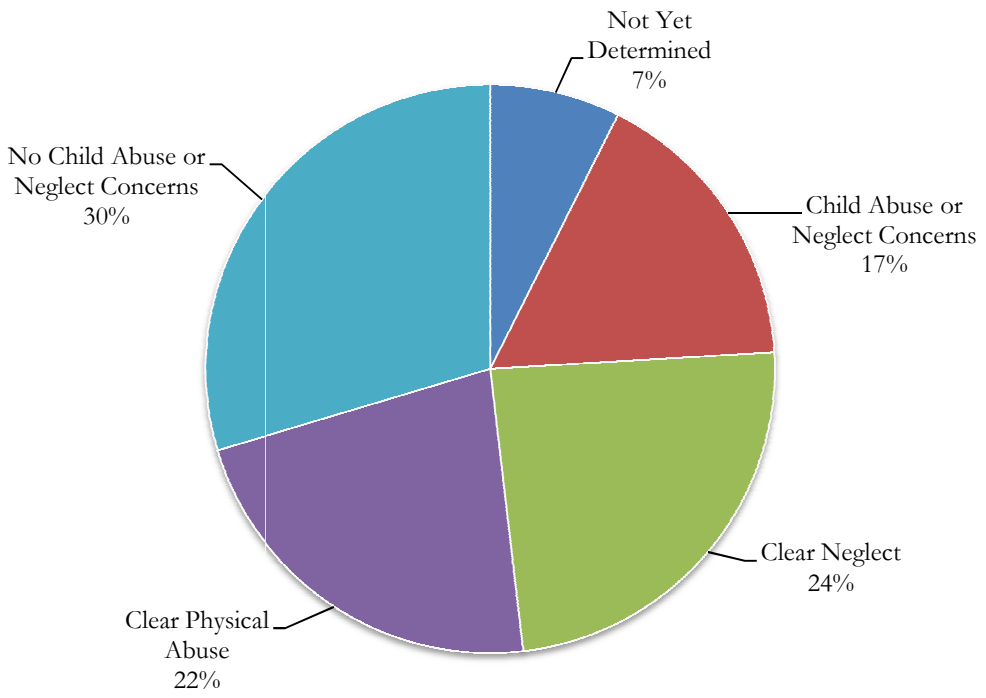
OFCO reviewed twelve near fatality cases in 2011. This is a decrease from 2010 when OFCO was notified of and reviewed twenty-five near fatality cases and from 2009 when OFCO reviewed seventeen such cases.

DID CHILD ABUSE OR NEGLECT CONTRIBUTE TO THE NEAR FATALITY?

Data from 2009 through 2011 shows that:

- Forty-six percent of near fatalities reviewed resulted from clear physical abuse or neglect and that child abuse or neglect factors were documented as concerns in an additional seventeen percent of the cases reviewed.
- Fifty-five percent were males and forty-five percent were females.
- Fifty-one percent involved children between the ages of birth to two years.

Child Abuse/Neglect Concerns Regarding Near Fatalities, 2009-2011
Total=54



Source: Office of the Family and Children's Ombudsman, November 2011, based on analysis of DSHS CA data

SYSTEMIC INVESTIGATION: RECURRENT MALTREATMENT

BACKGROUND

Beginning in 2008, DSHS/CA is required to notify OFCO of families or children who experience three founded[63] reports[64] of alleged abuse or neglect within the last twelve month period.[65] This notification requirement enables the Ombudsman to review problematic cases and intervene as needed. Additionally, a close review of cases of recurrent maltreatment can indicate whether Washington State's child welfare system is effective at reducing the recurrence of child maltreatment.[66]

STATUS OF IMPLEMENTATION

Despite DSHS/CA's efforts, OFCO has not received accurate, timely notification of all cases with three founded reports. Delays in notification from DSHS/CA limit OFCO's ability to review these cases and intervene where appropriate to ensure child safety or effective case planning. OFCO continues to work with CA to improve the notification procedure.

DISCUSSION

For the period of September 1, 2010 through August 31, 2011, OFCO received a total of 96 notifications, a fourteen percent increase from the same period ending in 2010. Seven of the notifications were the second notification regarding the same child or family, meaning that there was one or more subsequent founded report of maltreatment for the child or family within a one year time period. OFCO reviewed the cases of 89 families for "systemic investigation."[67]

Because these families often have had considerable or extended involvement with the child welfare system, it is not uncommon for OFCO to be involved in these cases through another channel, such as through a complaint or a fatality, near fatality, or critical incident notification. In 2011, out of 89 cases, OFCO had thirteen complaints or inquiries relating to the child or family, and three notifications of a fatality, near fatality, or other critical incident.

[63] "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).
[64] In this context, "report" means a "referral" to Child Protective Services, which DSHS/CA now calls an "intake."
[65] RCW 26.44.030(13).
[66] "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.*
[67] See WAC 112-10-070(c)(i) ("A systemic investigation is intended to produce information that will enable OFCO to identify systemic issues and recommend appropriate changes in law, policy, procedure, or practice.").

CASE EXAMPLE: WHAT DOES RECURRENT MALTREATMENT LOOK LIKE?

A family with four children, now ages eight, ten, twelve, and fourteen, had a total of ten founded reports of maltreatment within a six month period. The prior history includes two episodes of brief voluntary placement into foster care in Summer 2006 and a founded report of neglect in Fall 2006 which resulted in a dependency with out-of-home placement for all four children. The children were returned to their parents. The now fourteen year old youth was again dependent and placed in foster care from Fall 2008 until early 2010. This second dependency was dismissed in September 2010.

Over the ensuing four and a half months, CPS received the following four referrals:

1. Less than a week prior to the dismissal of the second dependency, a community member reported that the eight year old child had asked for a few dollars to get something to eat and indicated that his father is not home. This screened in for investigation.
2. Ten days after the first referral, a mental health treatment facility where the eight year old is a patient reported that a crack pipe with residue was found on the sink in a bathroom after the father's partner used the facility. The partner was seen waiting outside the bathroom and re-entering it after the witness left. The bathroom was then checked and the crack pipe was gone. CPS screened this referral out due to their being no information that the partner's alleged drug use was affecting the child.
3. Three days after this, hospital emergency room staff reported that the fourteen year old was admitted for suicidal ideation and disclosed that the father and step-mother were drinking daily and that her father verbally abuses her and has pushed her down the steps. The father and step-mother arrived at the hospital intoxicated with the other children. This screened in for investigation.
4. The following month, a school reported to CPS that a student who recently spent the night at the home disclosed sexualized behavior between the children in the home. This also screened in for investigation.

In response to these referrals, CPS held a Family Team Decision Making (FTDM) Meeting, which both the mother and the father attended. The father refused voluntary services. Nevertheless, CPS prepared a referral for Intensive Family Preservation Services. CPS continued to receive referrals:

5. A month after the FTDM, a suicide prevention hotline reported to CPS that the fourteen year old called and stated her home was unsafe. She alleged that her father and his partner offer drugs and alcohol to the four children and that the partner purchases sex toys and offers them to the children and offers to touch children in inappropriate places. The youth stated she feared retaliation if law enforcement responded to the home. This screened in for investigation.
6. Ten days later, a community member reported that the father is using crack cocaine again and the fourteen year old is caring for the younger siblings. It was further alleged that the father's partner was residing in the home. This screened in for investigation.
7. Two weeks after this, law enforcement reported that they had responded to a call from a young child reporting that his father was hitting his older sister. Although law enforcement had determined that there was no injury, and that the youth was being disciplined, law enforcement was concerned about the conditions of the home, and that the father and his partner were highly intoxicated. Law enforcement had contacted a relative to come and care for the children until the father sobered up and cleaned the home. CPS screened this in for investigation.

8. Two and a half weeks later, a neighbor reported to CPS that a young child had been to his home two times asking for food. This screened in for investigation.

A week after this seventh report within a four and a half month period that screened in for investigation, CPS convened a Child Protection Team (CPT) staffing. The CPT recommended services including counseling for the younger children, connecting the children with mentors, and closing the case.

9. The day after the CPT, a family friend reported to CPS that the fourteen year old showed up the night before with all of the family's laundry and asked to stay the night because her father was intoxicated and the home was without heat or hot water. The three younger siblings later called and asked to stay the night as well. The father reported that the children had been "kidnapped." When law enforcement arrived at the father's home to return the children to his care, they placed the children into protective custody because the home environment was found to be "dangerous" with cat feces, no beds, and only moldy food in the home. This screened in for CPS investigation.

Upon placement at a Crisis Residential Center (CRC), the fourteen year old disclosed that her father routinely hits her with his hand and also with bottles and knives. This was investigated by CPS and founded for physical abuse. She also then disclosed to CRC staff that a week earlier, she had been to the emergency room for stomach pains but that her father had made her leave prior to receiving any treatment. This was also investigated by CPS and founded for neglect.

Thereafter, CPS filed dependencies on the children and they remain in out-of-home placement. None of the investigative assessments and findings (eight founded for neglect and one for physical abuse against the father, and one for sexual abuse against his partner) was completed until after the children were removed, concurrently with the eighth screened-in report to CPS.

Although this may seem an extreme example (and having ten founded reports over this time period is very unusual), this case raises questions and concerns common to many of these recurrent maltreatment cases:

- **What does effective intervention look like?**
- **How does DSHS/CA provide services to a family that is resistant to intervention?**
- **Is removal from the home the only option?**
- **Should DSHS/CA have acted sooner?**

OFCO INTERVENTIONS IN RECURRENT MALTREATMENT CASES

OFCO INTERVENTION CASE 1:

In a recurrent maltreatment case, OFCO identified concerns regarding the case planning for an eleven year old dependent child with possible serious mental health issues. The case had a complicated history: the child had been removed from her mother (due to neglect, physical abuse, and sexual abuse), placed with her father, and then removed from her father (due to physical abuse). She was then placed back with her mother and maternal grandmother, and removed from that home (due to another incident of physical abuse).

Upon receiving notification of this case, OFCO asked DCFS CWS to ensure that the child's medications were reviewed, given reports regarding her mental health status and instability in foster placements. The child's psychiatric nurse then recommended hospitalization given the child's level of self-harm behavior and impulsivity. However, after assessing the child, the County Designated Mental Health Professional (CDMHP) declined to authorize psychiatric hospitalization. The child was then placed with a relative with whom her younger sister was placed, despite significant concerns for the younger sibling's safety. In-home BRS services were provided by a private agency. The relative placement lasted less than a week and the child was placed into several specialized treatment foster homes. At this juncture, the team of DCFS, private agency, and relatives proposed a plan to return the child to the home of her mother and maternal grandmother.

In addition to the services outlined by DCFS, OFCO recommended that DCFS not consider reunification with the mother and/or maternal grandmother until any pending law enforcement and/or CPS investigations were resolved and the mother had completed a psychological evaluation with a parenting component and followed all recommendations made in the evaluation.

Thereafter, the professionals involved in case planning disagreed as to whether the child could be maintained in the community and whether a Child Long-term Inpatient Program (CLIP) application packet should be prepared in an attempt to secure long-term treatment. After the child made allegations of physical abuse against her foster parent, the team decided to place her with her grandmother with her mother also residing in the home, despite the fact that none of the recommended services had yet to be completed and the CPS and law enforcement investigations against the mother and grandmother were still pending. OFCO has monitored this case for the past ten months and concerns about the child's mental health and whether she can be maintained in the community continue. In addition, there have been new allegations against the child's caregivers which have been investigated by CPS.

OFCO INTERVENTION CASE 2:

An eight year old child was the victim in three founded reports of physical abuse. The child disclosed that both his mother and step-father had caused his injuries. Following the first report, the mother and step-father failed to follow through with any of the recommended services. After the second report, the mother stated that she was "done" parenting the child and the DCFS social worker informed the family that if one more report was received, all three of their children would be removed. Shortly after this conversation, a sixteen year old sibling ran away and reported that her father hits her with a belt, rope, or anything else he can get his hands on. Despite the pending investigations regarding physical abuse against the eight year old in the home, this report screened out and was not investigated and the youth was released to her father's care. A few weeks later, the third report of physical abuse of the eight year old was received and the mother agreed to placing the child with his grandfather at least for the summer. The mother had been criminally convicted of assaulting the child and was on probation for a year.

OFCO contacted the DCFS CPS Supervisor and the Area Administrator expressing concerns about: the long-term plan for this child; the safety of the sixteen year old and two younger children who remained in the home; and the lack of services for this family.

Specifically, OFCO was concerned about DCFS CPS's decision not to file dependency petitions when the third report was received. DCFS agreed that the case would remain open, that the social worker would confirm that the eight year old continued to reside with his grandfather after the school year started, and to check on the two younger children before closing the case. If any issues arose, DCFS would likely file petitions on the three children. Thereafter, the eight year old returned to his parents care and DCFS filed dependency petitions, placing the eight year old in foster care and maintaining the two younger children in an in-home dependency. DCFS did not file a dependency petition for the sixteen year old sibling.

SUMMARY OF DATA:

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

- Reports of neglect constituted 73 percent of the founded reports, physical abuse 20 percent, and sexual abuse seven percent.[68]
- Neglect is more likely to recur than physical or sexual abuse.[69]
- Caregiver substance abuse is the most prevalent risk factor (affecting 55 percent of the families) in these recurrent cases.
- A significant percentage of families have had a previous dependency for either a parent (12 percent) or a child (34 percent).

2011 data includes notifications received by OFCO within its reporting year, which commences September 1st and ends August 31st. Data from 2010 and 2009[70] is provided for comparison.

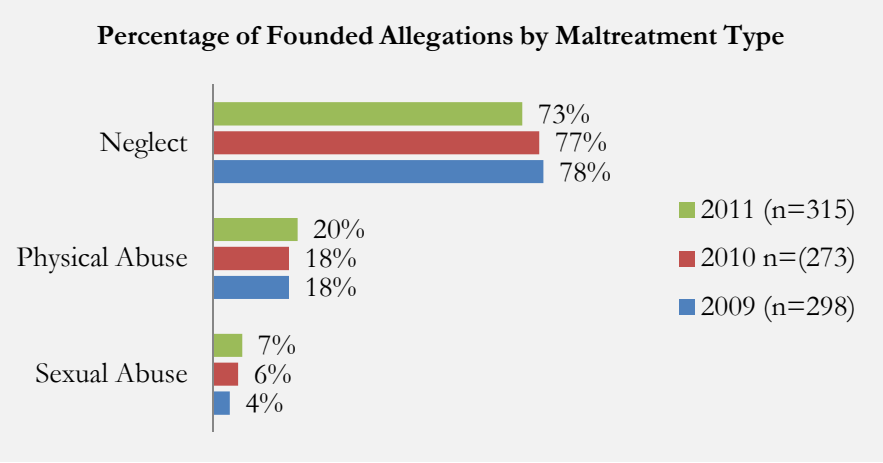
[68] In the federal government report, Child Maltreatment 2007, nationwide statistics showed: "During FFY 2007, 59.0 percent of victims experienced neglect, 10.8 percent were physically abused, 7.6 percent were sexually abused, 4.2 percent were psychologically maltreated, less than one percent were medically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

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

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

TYPE OF CHILD MALTREATMENT

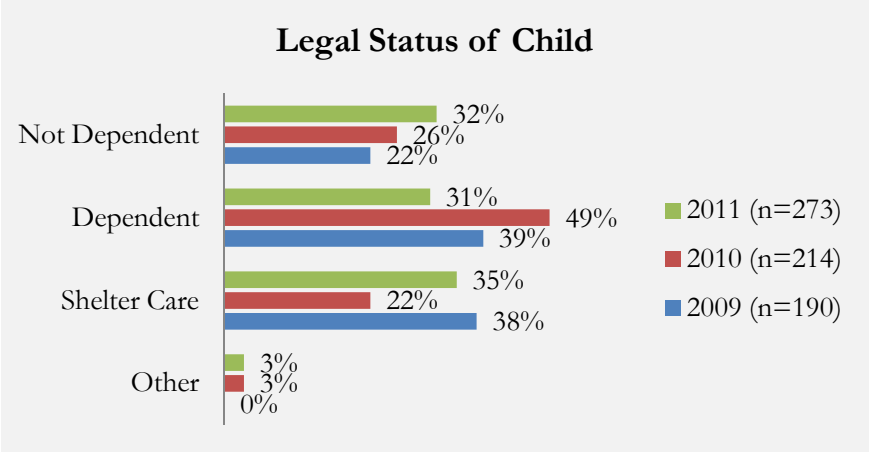
The graph below summarizes the type of maltreatment substantiated in the first, second, and third founded reports.[71] Consistent with previous findings, physical neglect is, by far, the most common type of maltreatment experienced by children in these recurrent cases, comprising nearly seventy-three percent of all founded reports examined by OFCO.



Source: Office of the Family and Children's Ombudsman, November 2011, based on analysis of DSHS CA data

LEGAL STATUS OF CHILDREN AT TIME OF NOTIFICATION

For a large majority (66 percent) of the cases reviewed, DSHS/CA had already taken affirmative legal action – either through an in-home or out-of-home dependency – to ensure the safety of the children.[72] Thirty-two percent of children identified were not dependent or in shelter care at the time OFCO received notification of the child or family's third founded report of child abuse or neglect.



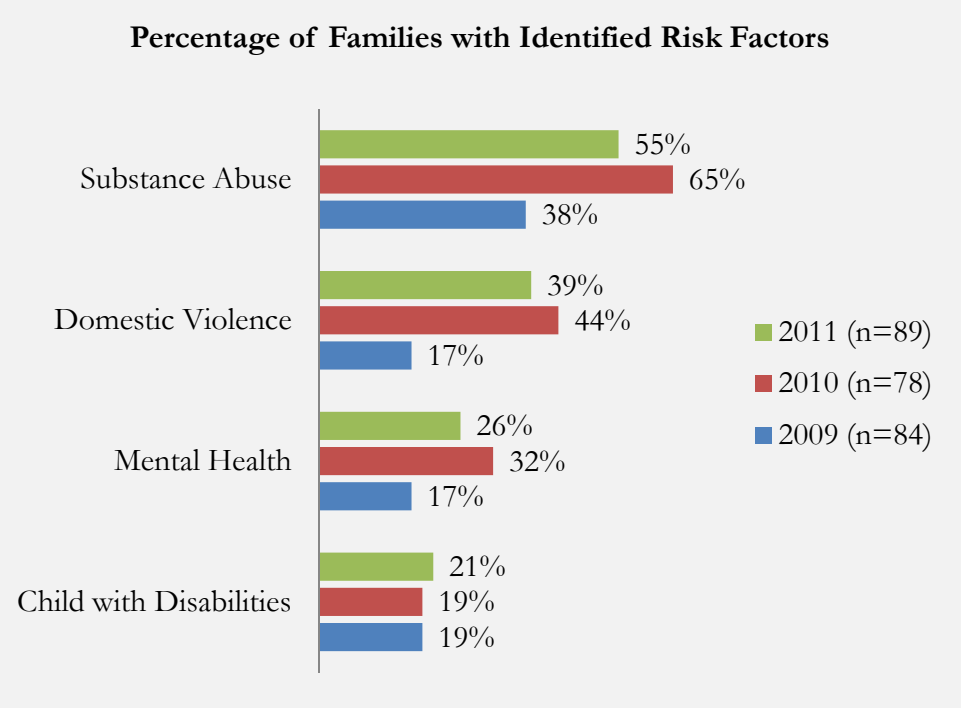
Source: Office of the Family and Children's Ombudsman, November 2011, based on analysis of DSHS CA data

[71] 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."

[72] Because of the time lag between when the report was received by DSHS/CA and when OFCO is notified of the third founded report, DSHS/CA has usually had sufficient time to determine whether or not legal action will be taken.

PRESENTING RISK FACTORS[73]

Substance abuse was identified as a risk factor in more than half (55 percent) of the families. These cases often involve parental abuse of alcohol or prescription medications. Thirty-nine percent of families experienced domestic violence and twenty-six percent experienced mental health issues. Each of these risk factors has decreased slightly compared to 2010, when each increased significantly compared to 2009. The percentage of families which have at least one child with a disability (21 percent) has remained the same compared to 2009.

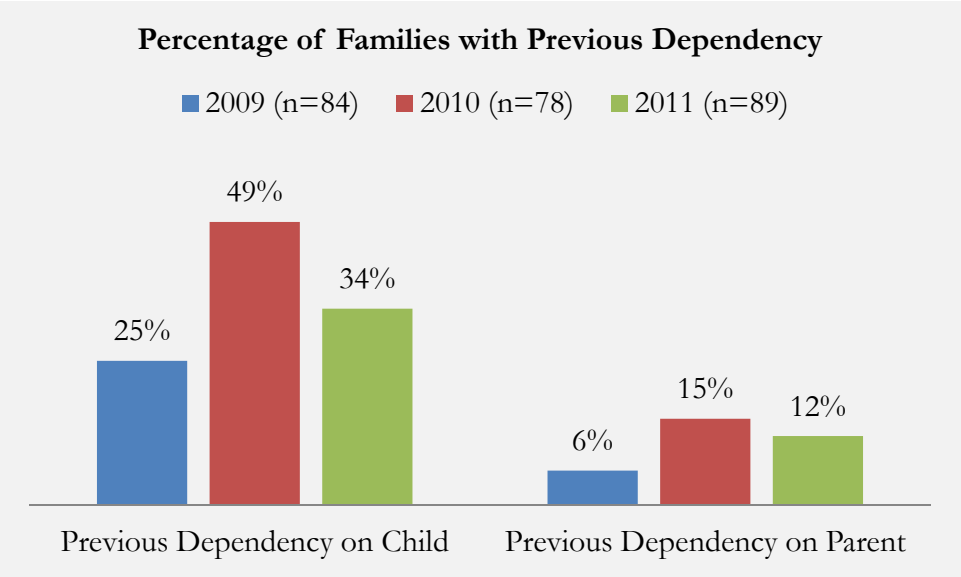


Source: Office of the Family and Children's Ombudsman, November 2011, based on analysis of DSHS CA data

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

PREVIOUS DEPENDENCIES

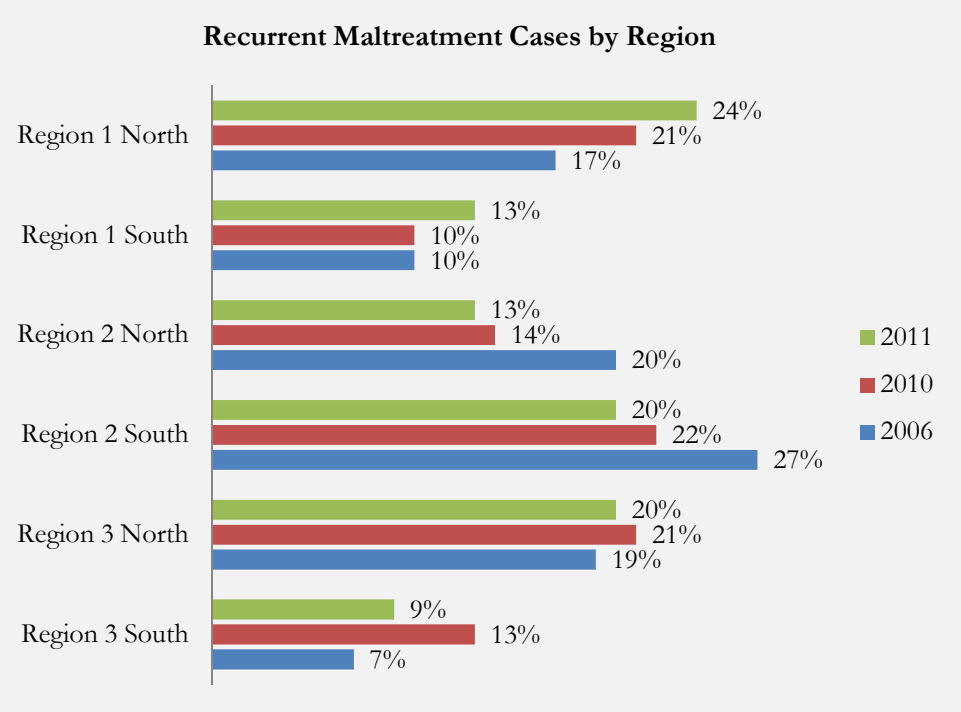
Another decrease from 2010 is the number of families who have experienced a prior dependency. In 2010, this number had nearly doubled from 2009. The number of families with at least one parent who was dependent as a child also slightly decreased, from fifteen percent to twelve percent.



Source: Office of the Family and Children's Ombudsman, November 2011, based on analysis of DSHS CA data

These cases involve a wide range of circumstances: parents who were in foster care as youths; parents who have had rights terminated to older children; children with previous out-of-home placement(s) and subsequent reunification(s); children who are placed with non-custodial parents or relatives; and adopted children, now the victims of abuse or neglect in their adoptive homes. In 2011, two of the recurrent maltreatment cases involved abuse or neglect which occurred in licensed foster homes and two involved abuse or neglect which occurred in licensed daycare facilities.

RECURRENT MALTREATMENT CASES BY DCFS REGION



Source: Office of the Family and Children's Ombudsman, November 2011, based on analysis of DSHS CA data

UPDATE ON 2010 SYSTEMIC FINDING:
LATE INVESTIGATIVE ASSESSMENTS LEAVE CHILDREN AT RISK OF HARM

OFCO FINDING IN 2010
In our review of cases with three founded reports of child abuse or neglect within one year, OFCO finds that Child Protective Services routinely fails to complete Investigative Assessments within the 45-day deadline required by policy. The timely completion of investigations is crucial to child safety and effective case planning.

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

RESPONSE FROM DSHS/CA
The Department is taking steps to obtain data on this practice issue to determine if it is a statewide trend. If this is a statewide trend, we will work with the regions to determine the cause for these delays and monitor staff compliance with policy. We know that workload or a law enforcement investigation can impact a worker's ability to close their cases in a timely manner, but we agree that this is critical practice issue that can impact child safety.

OFCO FINDING IN 2011
Child Protective Services continues to routinely fail to complete Investigative Assessments within the 45-day deadline required by policy, thus potentially jeopardizing child safety.

According to DSHS/CA policy, CPS Investigative Assessments must be completed within 45 days of DSHS/CA receiving the report of alleged abuse or neglect.[74] The supervisor must review all cases open to CPS to determine if the 45-day rule requirement has been met.[75] FamLink has an extensions/exceptions page where a supervisor can document an extension to the 45-day timeline and the reason why it is being granted.[76]

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

[74] Children's Administration Practices and Procedures Guide, Section 2540.
[75] Children's Administration Practices and Procedures Guide, Section 2610(C). This policy does not specify any reasons for an extension or exception.
[76] Some CPS supervisors may still document the reason an investigation is incomplete in a case note, which was the practice in the former CAMIS system.

For 2011, in 69 percent of the cases reviewed by OFCO with three founded reports, at least one Investigative Assessment remained incomplete past the 45-day deadline (a decrease from 75 percent in 2010). Nearly half (45 percent) of the 89 cases had two or more Investigative Assessments that were not completed on time. In a significant percentage, 28 percent, all three of the Investigative Assessments reviewed were untimely (which reflects an increase from 17 percent in 2010). The length of the delay varied; however, in some cases, CPS investigations remained open for months and even a year more than allowed by policy. Even in the few cases (four out of sixty) where the supervisor granted the appropriate extension/exception to the 45-day rule, delays in case planning, notice, and due process protections remain concerning.

CASE EXAMPLE: MALTREATMENT RECURS WHILE INVESTIGATIONS REMAIN OPEN

In August and September 2010, CPS screened in for investigation two separate reports from law enforcement regarding incidents of domestic violence which occurred in front of four year old and fourteen year old children. During the first reported incident, the mother's boyfriend had knocked the mother unconscious and the four year old child explained to law enforcement that "daddy was punching mommy in the head." Law enforcement was concerned due to the escalating level of violence, the boyfriend's history of domestic violence, and the mother's refusal of any assistance. The second reported incident involved the four year old child going to a neighbor to call 911 when the boyfriend was choking the mother. In early October 2010, CPS screened in a third report from a housing manager who reported that the four year old child runs around the complex unsupervised, the mother is heard yelling at the child and calling him names, and the mother has been seen grabbing and dragging the child, throwing him into the apartment, and throwing her boyfriend's clothes at the child out of anger. The mother refused all services. All three of these investigations remained open longer than the 45-day timeline provided by policy.

In December 2010, law enforcement again reported to CPS several further incidents of domestic violence between the mother and her boyfriend which occurred in the presence of the four year old child. The mother told the police that her boyfriend threatened to kill her if she called the police. Again, the four year old child sought assistance from a neighbor who generated the call to law enforcement.

All four of these investigations were later determined to be founded for neglect and the four year old child was temporarily removed from the home. In-home services were provided and the dependencies were recently dismissed.

This case illustrates how the lack of timely completion of investigations adversely affects child safety and the department's case planning, as well as the Ombudsman's ability to effectively intervene to ensure child safety and appropriate case planning upon notification of the third founded report under RCW 26.44.030(13). Had the investigative assessments been completed on time as per policy, the third report would have been determined to be founded by mid-November 2010. With three founded reports and the mother's complete refusal to participate in any services, DCFS may have had sufficient basis to file dependency petitions. Also, OFCO would have received notification of the case at that juncture and may have intervened to ensure that DCFS CPS was considering possibly filing for dependency. Such intervention with this family may have prevented the fourth incident of maltreatment.

PART TWO: WORKING TO MAKE A DIFFERENCE

CHILD ABUSE AND NEGLECT IN ADOPTIVE AND OTHER PERMANENT PLACEMENTS

Over the course of 2010, the Office of the Family and Children's Ombudsman noted a pattern of severe child abuse and neglect occurring in adoptive, pre-adoptive or guardianship placements and began tracking these cases. What is striking is that in these cases, the child abuse and neglect occurred in homes that had been scrutinized and approved as a licensed foster home, identified as a pre-adoptive placement for the child, and/or finalized by the court as an adoption or guardianship.

Identifying, assessing and finalizing a permanent placement for a child in state care is a complex process and often involves competing policy goals. In an effort to prevent children from languishing in the foster care system, state and federal law require the department to establish permanency within a specific time period.[77] Additionally, federal law provides a financial incentive for states to increase the number of children adopted from state care.[78] The department is also mandated to improve placement stability by reducing the number of out-of-home placements a child experiences.[79] The paramount concern of our child welfare system however is the health and safety of the child and the child's right to a safe, stable and permanent home.[80] Professionals in the child welfare system must therefore balance expediting a permanent outcome, and assuring the safety and welfare of the child. This becomes more difficult when there are identified concerns regarding the long term viability of a placement, but that do not necessarily require the child's immediate removal from the home.

Some child welfare professionals have raised concern that initiatives to increase adoptions and decrease the time children spend in foster care, such as the shortened timeframes to file for termination of parental rights under the Adoption and Safe Families Act might lead to inadequate selection and preparation of adoptive homes. Additionally, parents adopting children with special needs often face challenges such as finding necessary services in their community and paying for such services.[81]

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[77] RCW 13.34.145(1)(c) states: "Permanency planning goals should be achieved at the earliest possible date, preferably before the child has been in out-of-home care for fifteen months. In cases where parental rights have been terminated, the child is legally free for adoption, and adoption has been identified as the primary permanency planning goal, it shall be a goal to complete the adoption within six months following entry of the termination order." The Adoption and Safe Families Act (ASFA) of 1997, Pub. L. No. 105-89, 111 Stat. 2115, requires that the child welfare agency file for termination of parental rights if a child is in foster care for 15 of the most recent 22 months.

[78] ASFA, Pub. L. No. 105-89, 111 Stat. 2115.

[79] BRAAM Settlement Agreement, See http://braamkids.org/SettlementAgreement.pdf; http://www.dshs.wa.gov/ca/about/imp_settlement.asp

[80] RCW 13.34.020.

[81] *Adoption Disruption and Dissolution*, Child Welfare Information Gateway (2004) Available online at http://www.childwelfare.gov/pubs/s_disrup.cfm). See also, *Where Are We Now?: A Post-ASFA Examination of Adoption Disruption,* Livingston Smith, MSSW, LCSW, Howard, PhD, Garnier, PhD and Ryan, PhD, Adoption Quarterly, Vol. 9(4) 2006. Available online at http://aq.haworthpress.com

ADOPTION TRENDS IN WASHINGTON STATE

In Washington State, the number of adoptions of children involved with the state child welfare agency has increased by 94 percent from 2002 to 2009 and saw a 66 percent increase from 2008 to 2009. Nationally, there was a more moderate increase in adoptions of 12 percent from 2002 to 2009.

Adoptions of Children with Public Child Welfare Agency Involvement by State[82]
FY 2002 - FY 2009

	2002	2003	2004	2005	2006	2007	2008	2009
WA ST	1,074	1,320	1,244	1,293	1,195	1,291	1,261	2,091
US TOTAL	51,419	49,629	51,019	51,629	50,633	52,657	55,303	57,466

The significant increase in adoptions in Washington State however has not resulted in a decrease in the number of children in foster care waiting to be adopted. In fact, between 2002 and 2009, the number of Washington State children in foster care waiting to be adopted has increased by eight percent, while nationally the number of children waiting to be adopted has decreased by fourteen percent.

Children in Public Foster Care who are Waiting to be Adopted[83]
FY 2002 - FY 2009

	2002	2003	2004	2005	2006	2007	2008	2009
WA ST	2,649	2,369	2,317	2,167	2,361	2,837	3,025	2,865
US TOTAL	133,894	130,637	130,352	130,667	135,352	133,640	125,668	114,562

CHILD ABUSE AND NEGLECT IN ADOPTIVE AND PERMANENT PLACEMENTS: CASE SUMMARIES

Described below are cases in which children suffered severe abuse and or neglect in adoptive or permanent placements. OFCO learned of eleven of these children's cases in 2011, three in 2010 and one in 2009. This section of our report does not examine whether or not action by a state child welfare agency could have prevented harm to a child. Rather the purpose is to summarize the history of each case, identify various allegations of abuse or neglect and describe areas of concern regarding the child's placement.

Common elements related to child abuse and neglect noted in several of these cases include:

- Child locked in a room;
- Withholding food from the child;
- Disparaging remarks about the child and discrediting the child as a liar;
- Exaggerating or misstating the child's negative behaviors;
- Forcing the child to remain outside the home; denying the child access to toilet facilities;

[82] US DHHS (2010) http://www.acf.hhs.gov/programs/cb/stats_research/afcars/adoptchild09.pdf
[83] US DHHS (2010) http://www.acf.hhs.gov/programs/cb/stats_research/afcars/waiting2009.pdf
For the purposes of this table, "a child waiting to be adopted" includes children in foster care on the last day of the Federal Fiscal Year who have a goal of adoption and/or whose parental rights have been terminated. It excludes children 16 years old and older, whose parental rights have been terminated and who have a goal of emancipation.

- Isolating the child from the community, such as by removing the child from public school;
- High conflict-hostile relationship between the parent/caregiver and child welfare agency workers; and
- The parent/caregiver's financial stress.

OFCO believes that further analysis may provide answers to questions such as:

- Are incident rates of child abuse and neglect in adoptive homes commensurate with incident rates in biological parent homes?
- Is a child's age, race or gender associated with a higher risk of child abuse or neglect in permanent placements?
- Do permanency goals and initiatives to increase adoptions have unintended consequences on child safety?
- Are existing laws and policies governing the selection and establishment of adoptive placements sufficient to safeguard the child's safety and well being?
- Are child welfare agencies able to maintain adequate data regarding long term outcomes of children adopted from the foster care system?[84] and
- Are there red flags that warrant heightened scrutiny in the adoption process?

In October 2011, OFCO brought these issues to the attention of the Governor's Office and Children's Administration and recommended that Washington State in partnership with private child welfare agencies convene a work group of experts and leaders within the child welfare community to examine these issues in greater detail. At Governor Gregoire's request, CA is working with OFCO to address these concerns.

In a letter dated October 17, 2011 to Children's Administration Colleagues, Assistant Secretary Denise Revels Robinson addressed concerns about a recent case in which an adoptive mother and step-father had been charged with multiple counts of assault and unlawful imprisonment of their adopted children. This letter states in part:

> *Governor Chris Gregoire and DSHS Secretary Susan Dreyfus have asked me to look at concerns raised by the Office of Family and Children's Ombudsman about abuse occurring in adoptive homes. Concerns are in three areas: those involving children adopted from other countries, those from other states and those from Washington's foster care system. Regarding Washington's adoptions, we are looking at how we assess and ensure that the children and the family are the right match. We are in the process of implementing unified home studies, in which we have one comprehensive, quality home study for foster homes and possible subsequent adoption.*

[84] Accurate data on failed adoptions can be difficult to obtain, because a child's records may be closed, first and last names and social security number may be changed, and other identifying information may be modified.

ADOPTION CASES

BK – 9 years old

BK became dependent in Washington State in 2003. At six years of age, she was adopted in 2007 by a relative living outside of the State. The relative who adopted BK had two biological sons who were eight and ten years older than the adopted child. At the age of nine years, BK was beaten to death by her seventeen year old adoptive brother.

The adoption home study of this relative, conducted by the other state, failed to mention prior history of child abuse in this home. Prior to the adoption, an allegation of child abuse by the father for beating his son with a belt was founded for physical abuse. While the relative divorced her husband after this incident, the home study states that the relative has contact with the father and that they remain friends working together for their sons.

After BK was placed out-of-state in this relative's home, and after the adoption was finalized there were eight referrals for child abuse and/or neglect reported to the other state's child welfare agency. The state did not investigate any of these referrals. The school nurse contacted the state child welfare agency several times with concerns because of ongoing injuries to the child. Many details are unknown at this time because the fatality occurred out of state, but it is known that the child endured:

- Multiple injuries while placed in the out-of-state relative's home. The child reported being kicked, thrown, hit in the head with a shovel, bruises to her face and body were observed.
- Child was accused of stealing food.
- Child's clothes and toys were kept outside.
- Child was forced to stay outside in inclement weather.
- Adoptive parent had knowledge of child's ongoing physical abuse by an older sibling and failed to protect.

The sibling admitted to killing BK and has been sentenced to 50 years in prison.

AD and BD – 16 year old twins

AD and BD, teenage twins, were adopted in another state when they were approximately two years old. There is significant CPS history on the family prior to the children being placed into protective custody. Previous allegations included: multiple allegations of physical abuse and other inappropriate discipline, parents withholding food, and concerns about the children being under weight and overall well-being.

When interviewed the adoptive mother spoke with open hostility about the children. The mother described that the family no longer attend certain community events due to people making comments about how sad and malnourished the adopted children looked. The children were homeschooled as the mother did not want the teachers feeling sorry for them because they are "all sad" and looked like they are starved at home. The mother referred to the adopted twins as "monsters" and reported that one child had multiple mental health disorders. Previous contacts with the child's school did not substantiate the behaviors reported by the mother.

The adoptive mother and her current husband physically punished the adopted children with a board made of splintered wood. When law enforcement found the board, the bottom third was covered in dried blood. In addition to being physically punished, the twins were subject to discipline which included:

- Food withheld as punishment. When fed, the youth were given moldy food, or inadequate amounts of food which the youth would ration.
- Food was kept in locked refrigerator and pantry. The youth would "steal" food when they had not eaten for one to two days. The social worker observed a can of open corn in an adopted child's bedroom which had been pried open with scissors.
- The adopted children were locked in their bedrooms and forced to urinate and defecate in the room.
- The biological children in the home were not subject to abuse or mistreatment.

DCFS filed for dependency and the parents were incarcerated on assault and maltreatment charges.

MB – 10 years old

In 2008, at eight years of age, MB was adopted in a different state. The adoptive parents sent MB to live in Washington with their adult son and his paramour. In 2011, CPS received a referral and found that MB weighed fifty-one pounds and was severely malnourished with several non-accidental injuries, indicating physical abuse. There were no CPS referrals related to MB in Washington State prior to her removal from the home. Allegations against the caregiver in Washington State include:

- Child had multiple marks from the WA caregiver hitting the child with an extension cord, belts and wires. The child was also burned with cigarettes.
- Caregiver stated that the child had Fetal Alcohol Syndrome (FAS) as an explanation for why the child was so thin. No medical documentation has been found to support child is FAS.
- Child slept in the bathtub and outside.
- Caregiver withheld food.
- Child was made to wear diapers.
- Child was given medication that was not prescribed to her. No medical treatment was sought for a known kidney infection.

JD – 17 years old, MD – 14 years old and LD – 12 years old

SD and RD were licensed foster parents in Washington State for seven years. In addition to their three biological children, they adopted five girls: JD and two other children who are now adults were adopted in 2000; and MD and LD were adopted in 2003.

Post-adoption, CPS received two referrals, one describing family conflict and a second referral alleging withholding food, inappropriate discipline and emotional abuse of a child. In 2011 CPS received a referral alleging that the father sexually abused two of the adopted children, MD and LD. CPS then removed the three adopted children JD, MD and LD.
The CPS investigation determined:

- Sexual abuse of the children by the adoptive father occurred over several years;
- The adoptive mother knew of the sexual abuse and failed to protect;
- The adoptive mother told the children not to tell anyone about the sexual abuse;

- Children report they were hit with a board with nails sticking out;
- The adoptive mother told the children she would kill them if she could get away with it;
- The parents claim that MD has FAS, lies and steals food, has killed animals and urinates in inappropriate places;
- MD was locked in her room, with no furniture, and the windows boarded-up with a bucket to use as a toilet;
- The parents failed to obtain routine dental care for JD, resulting in braces calcifying to her teeth; and
- One of the children was isolated from the community, homeschooled and not involved in extracurricular activities.

The adoptive father committed suicide and the adoptive mother was arrested for unlawful imprisonment and criminal mistreatment.

BN – 17 years old and CN – 18 years old

GM has adopted ten children between the ages of nine and eighteen. In 1997, two children, BN and CN were adopted in Washington State while GM was a licensed foster parent. Eight children were adopted in another state.

During a CPS investigation in 2011, the children disclosed being:

- Taped to a chair;
- Hit with a broomstick;
- Put in a closet; and
- Forced by the mother to touch a sibling's private parts.

Following a DLR/CPS investigation, allegations of child neglect by GM were founded.

GH – 13 years old and EH – 9 years old

Thirteen year old GH and her nine year old brother EH came to Washington State through an international adoption in 2008. There are also seven biological children between the ages of seven and eighteen years old in this family.

GH died from hypothermia in the front yard of her family's home. On the night of her death, GH had been outside for an extended period of time as punishment for "being rebellious". Prior to her death, the family reports GH had been pretending to be cold and pretending to have trouble walking. The family states that she took off her clothes and was throwing herself on the ground, they were checking on her every 10-15 minutes. An autopsy found a knot on GH's head and parallel lines on her legs possibly from being hit with something. GH had lost thirty pounds in one year prior to her death.

The parents and oldest siblings physically punished the children with plumbing pipes and a glue stick. In addition to being physically punished, GH and her adopted brother also endured:

- Food withheld as punishment. When fed, youth was given cold leftovers and frozen vegetables.

- Youth was made to use an outhouse that was placed on the family's property instead of the bathroom inside house. This was punishment for youth using the bathroom and touching things without washing her hands.
- Youth locked in closets and the bathroom and made to sleep in the barn.
- Youth was excluded from celebrating family holidays.
- Youth was often made to eat outside and was locked out of house.
- Parent cut off GH's hair as a punishment.

The adoptive parents were arrested and charged with homicide by abuse and assault of a child.

TJ – 13 years old, NJ – 11 years old, GJ – 8 years old and MJ – 8 years old

Adoptive parents of TJ, NJ, GJ and MJ were licensed foster parents in Washington State for six years and the children were adopted in Washington State.

Thirteen year old TJ was taken to the emergency room and was severely malnourished, hypothermic and weighed forty-nine pounds. He also had two broken ribs and evidence of healed rib fractures and a very low body temperature. Three other adopted siblings were also malnourished. TJ disclosed:

- Getting in trouble for stealing food.
- Not getting enough to eat. There were days when they would get nothing to eat but a piece of bread and their stomachs would hurt. TJ ate dog food and was forced to drink his own urine.
- Not being allowed to go to the bathroom unsupervised and often wetting his bed because he did not like going to the bathroom supervised. He was made to wash the bedding outside in extreme temperatures. He was made to stand in the middle of the living room on a plastic bag and would urinate on himself when not given permission to use the bathroom.
- Not given warm clothing to wear in cold weather.
- Not being allowed to eat when the other children would eat.
- Being locked out of house on the porch as a form of punishment and had cold water poured on them if they made noise
- All of the children were home schooled, had little outside interaction and were socially isolated.
- Child was spanked with paddle, sometimes until he bled.
- Family has biological children that were not treated in this way.

The adoptive parents have been criminally charged and there is a no contact order with the children in effect.

LW – 6 years old and FW – 10 years old

Siblings LW and FW were adopted by their foster parent in 2010. CWS allowed the adoption of these children despite the following concerns:

- The foster parent expressed significant concerns about her ability to manage the behavior of the children, particularly the six year old, with the limited support available through adoption support.

- The foster parent's financial situation was tenuous and it was clear she was reliant on either foster care payments or adoption support payments for basic living expenses. The foster parent claimed she was not provided with full information about the children's history and psychological status, and she was not being sufficiently compensated for their care.

Four months after the children were adopted CPS received a referral alleging physical abuse and emotional abuse of FW by the adoptive mother. The CPS investigation revealed additional concerns:

- Withholding of food as punishment and the children's lack of weight gain;
- Adoptive mother described FW as having multiple mental disorders;
- Child pulling out clumps of his hair; and
- Physical discipline of a traumatized child

CPS determined that the allegation of physical abuse was founded. The adoptive mother continued to use physical discipline FW despite signing a safety plan not to do so. LW and FW remain in the home and the family received support services.

MH – 15 years old

MH was adopted at four years of age. The adoptive parents relinquished their parental rights to MH when she was fifteen years old. The adoptive mother described the youth as having animal-like behaviors at the time they adopted her. As a child, the youth was diagnosed with Reactive Attachment Disorder, Oppositional Disorder, Attention Deficit Disorder and Dissociative Disorder.

The adoptive parents sent the youth out-of-state three times due to her alleged behaviors. The youth was sent out-of-state at the age of seven and two years later returned to the adoptive home. Eight months after the child's return to the adoptive home, she was sent out of state for two more years. One month after returning home, the youth was sent out of state for the second time. The youth returned home when the facility she was sent to closed. The youth was not receiving any therapy after she returned to the home at age twelve.

In her adoptive home, the youth was

- locked in her bedroom
- forced to get permission to shower, eat and read
- choked and spanked
- deprived of food
- socially delayed due to isolation

MJ – 14 years old and KJ – 6 years old

MJ was removed from the home after law enforcement and CPS learned of ongoing sexual abuse of MJ by her adoptive father and the adoptive mother's failure to protect. MJ's younger sibling KJ remains in the care of her adoptive mother.

CPS received a referral that MJ had been raped by a family member. The CPS and law enforcement investigations determined that the father:

- Exposed MJ with pornography;

- Set up cameras to covertly record MJ and incidents of her sexual abuse; and
- Sexually exploited and raped MJ repeatedly over an eight month period.

The CPS investigation also determined that the mother:

- Knew of the father's sexual abuse of MJ and failed protect;
- Was aware that the father set up a camera to record MJ and failed to protect;
- Mislead medical professionals to believe that the sexual abuse had already been reported to CPS and law enforcement;
- Allowed the father to remain in the home after learning of the ongoing sexual abuse;
- Enlisted MJ to advocate for the father's release from jail;
- Blamed MJ for the abuse; and
- Hit MJ with a belt leaving marks and bruises.

Other areas of concern include:

- Social isolation of the children;
- Caregivers discrediting child's credibility;
- Lack of hygiene and unsanitary conditions of child's living area; and
- The use of food as a tool of manipulation and punishment.

The adoptive father was convicted of rape and other multiple charges related to MJ's sexual abuse.

RN – 4 years old

The adoptive parents were relatives of RN and the dependency court originally placed the child in their care over DCFS objection and concerns regarding the relatives' criminal histories. The relatives obtained a private home study and adopted this child in 2008 over continued DCFS objection.

CPS later learned that:

- The adoptive mother:
    - Sent the child to other people's homes to live for extended periods of time;
    - Stated that she hates child and wishes she never adopted her;
    - Beats the child;
    - Doesn't feed her or give her liquids every day; and
    - Locks her in the closet.
- The adoptive father had relapsed on meth;
- The child had been seen with multiple bruises and injuries, including injuries to her face.

The parents voluntarily placed RN into care with a relative, and DCFS later filed a dependency.

The adoptive mother was criminally charged with assault of a child.

LD – 4 years old and CS – 18 years old

WS and DS are licensed foster parents. They have adopted three children and they planned to adopt LD, a four year old, legally free foster child who was in their care. Before LD's adoption was finalized, DLR/CPS substantiated allegations of abuse/neglect by WS and DS of their teenage

adopted daughter CS. The Department concluded that it could not in good faith, recommend another child be adopted by these parents and therefore, LD was removed from this foster/pre-adopt home.

In 2010, DLR/CPS received several reports alleging:

- The mother hit CS in the face with a closed fist;
- The father pushed her up against a wall and held her there for several minutes;
- The parents on several occasions locked CS outside of the home;
- The parents placed CS in a homeless teen shelter (CS reportedly has the mental age of 7-9 years old and is naive). CS missed the curfew and lacked shelter for the night. The parents would not allow C back in the home and showed no regard for her safety.
- CS' mother slapped her on the face several times with an open hand and pushed her.
- CS' mother grabbed her by the hair and hit her head against the mirror.
- CS' father was present and failed to protect her from physical abuse.
- A consulting Doctor said that CS had a "clinical diagnosis" of a mild concussion.

DLR/CPS concluded the allegation of neglect and physical abuse were founded and their foster care license was revoked.

HS and AS – 4 year old twins

In 2009, CWS approved adoption of two children HS and AS by their foster parents, despite the concerns of numerous involved professionals. The foster parents had previously unsuccessfully requested to be considered for adoption of their grandchildren. A month after the children were adopted, CPS received a referral alleging physical abuse of the children. The children were subsequently removed due to physical abuse. OFCO made an adverse finding against the department for approving the couple's adoption home study despite documentation of the following concerns:

- The adoptive mother's marital history with men who were physically abusive or abused substances;
- The adoptive father's mental health history and high conflict and extended custody battle over his daughter which included allegations of sexual and physical abuse;
- A "valid" foster care licensing infraction for providing poor hygiene (infrequent bathing and head lice) for the dependent children they later adopted;
- The CWS worker's concerns about the children's unhealthy physical appearance (dark circles under their eyes, low weight, poor skin tone) and delayed development (speech and walking) in the foster home prior to their adoption, as well as the lack of a physically and emotionally nurturing environment in the home;
- The CWS worker's concerns regarding the lack of attachment between the children and the adoptive mother;
- Concerns about the foster parents' failure to ensure the children's consistent medical care, for example, failure to follow up on treatment of a seizure disorder and failure to involve the children in recommended therapeutic services;
- CWS worker's concerns that the foster mother continued to speak of the children having multiple medical conditions despite medical testing indicating the absence of these conditions;

- Concerns about an inappropriate focus by the foster mother on controlling and limiting the children's intake and selection of foods;
- Lack of cooperation by the foster parents with the children's visits with their older sibling who had been living in the same placement until being moved to a grandparent;

The adoptive parents' parental rights were terminated and their foster care license was revoked.

PRE-ADOPTIVE PLACEMENT CASE

Foster Parent AT

"AT" was a licensed foster parent who planned to adopt two sibling groups of five foster children, who are now 8, 11, 14, 15 and 20 years old. Four of the five children were eventually removed from AT's care due to founded allegations of negligent treatment and maltreatment of a child. Allegations included that the foster parent:

- Hit child in the face, leaving bruises;
- Pulled children's hair, slapped children across the face and made children tell school staff they were beating each other up;
- Threw child to the ground;
- Inequitable and harsh punishment of the children;
    - Emotional abuse;
    - Child punished for "stealing food";
    - Children isolated from friends;
    - Children called foul names; and
    - Child forced to urinate and defecate outside and pick up their fecal matter with plastic bags as punishment.

Other concerns include:

- Exaggerating child's behaviors
    - For example, AT described one child as "very ill," and "very sociopathic," stealing, lying, destroying property and requiring constant supervision. School staff and subsequent foster parent report no such behaviors.
    - Significant mental health diagnosis of child and prescription of psychotropic medications based primarily on AT's description of the child's behaviors.
- Inadequate source of independent income. Foster parents are required to have sufficient regular income to maintain their own family, without the foster care payments made for the children in care. It is unclear if AT met this requirement. She had previously declared bankruptcy and appeared to be dependent on foster care reimbursements for basic living expenses.

Following a DLR/CPS investigation, allegations of child abuse and neglect by this foster parent were founded and her foster care license was revoked.

GUARDIANSHIP CASE

SN – 14 years old

At the age of thirteen, SN had been living in a guardianship with his former foster parent since 2008 and had resided in this foster home since 2005. This foster parent previously had a guardianship of another teen which was terminated after the placement disrupted. There had also been other disruptions of long term teen foster care placements in this home.

The guardian described SN as having many behavior problems including stealing, lying, urinating and defecating in his room. SN had an alarm on his bedroom door and no bedding on his bed. One referral to CPS alleged that he had to urinate in a coffee can in his bedroom as he was not allowed to leave his room at night to go to the bathroom. The guardian denied he was not allowed to leave his room at night for the bathroom, though he was frequently confined to his room for punishment. SN stated that the guardian would get angry if he woke her up going to the bathroom at night, so they agreed that he would use the coffee can instead.

SN was eventually moved from this placement at his request and the guardianship was vacated. SN's Body Mass Index was below the 10th percentile in the latter months of his guardianship. SN and other foster children placed in the foster home later disclosed:

- Kitchen cabinets being locked so children could not help themselves to food
- Child in trouble for stealing food at night
- Child was getting many failing grades at school, did not participate in sports
- Foster parent and her boyfriend often eating different (better) food than what was given to foster children
- Foster children were not allowed to eat snacks with the foster parent's family prior to the main dish at 4th July celebration
- Foster children ages 9-18 having to be in bed by 7:30 or 8pm, even on weekends and in summer
- Child put on multiple psychotropic medications at guardian's request, prescribed by a nurse practitioner at the community mental health center
- Basic supplies such as toilet paper and feminine products were rationed in foster home
- Foster parent had multiple boyfriends coming to the home, some of whom scared the foster children.

Since being removed from the guardian's care, SN is at normal weight, is off all but one of the psychotropic medications, is receiving several "A" grades at school, excelling in sports, and participating in several extramural activities.

2011 LEGISLATIVE ACTIVITIES

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

During the 2010 legislative session, the Ombudsman reviewed, analyzed, and commented on several pieces of proposed legislation. OFCO provided written or verbal testimony on the following bills:[85]

ENACTED LEGISLATION

SB 5656: CREATING A STATE INDIAN CHILD WELFARE ACT: *(Effective July 22, 2011)*

OFCO routinely investigates various issues regarding Indian children, families and tribes involved with the state child welfare system. These issues were highlighted in the Ombudsman's 2006 Annual Report. OFCO noted the following systemic concerns:

- Over representation of Indian children in the child welfare system;
- Disproportionally high rate of Indian child fatalities;
- Delays in establishing permanency for Indian children;
- Philosophical differences over what constitutes the "best interest of the child" for Indian children;
- Disagreement over whether a child qualifies as an "Indian child" under the Indian Child Welfare Act; and
- Confusion by stakeholders over which specific laws and policies apply to a case.

Additionally, the 2006 Report identifies the most common complaint issues brought to our attention, which were whether the department:

- Honored the tribe's decision whether or not the child is an "Indian child";
- Provided proper and timely notice to the tribe;
- Followed placement preferences set forth in the ICWA;
- Unreasonably removed a child from a non-Native placement;
- Maintained regular contact with the tribe and/or collaborated with the tribe;
- Made "active efforts" to prevent the breakup of the Indian family; and
- Adequately promoted the best interests of the child by presenting reports and recommendations in cases before a tribal court, when the department continues to provide child welfare services.

By establishing a Washington State Indian Child Welfare Act, this legislation helps assure the consistent application and enforcement of federal and state laws and policies designed to protect the best interests of Indian children and promote the stability and security of Indian tribes and Native families. Specifically, SB 5656:

- Reiterates that tribal membership is determined by the tribe and that the tribe's decision is final;

[85] The Ombudsman's written testimony is available at http://www.governor.wa.gov/ofco/legislation/default.asp.

- Requires a "good faith effort" to determine whether the child is an Indian child, including consulting with the parents, persons with whom the child resides and any other person who may have knowledge about the child's heritage;
- Requires that the Indian child's tribe receive notice of any child custody proceeding and of their right to intervene;
- Defines the term "active efforts" and specifies that this requires timely and affirmative efforts to provide reasonably available and culturally appropriate preventative, remedial or rehabilitative services to the family and not simply handing the parent a list of referrals; and
- Clarifies that any potential harm resulting from interfering with the bond between a child and foster care provider is not a basis for terminating the parental rights to an Indian child.

HB 1105: ADDRESSING CHILD FATALITY REVIEW IN CHILD WELFARE CASES *(Effective July 22, 2011)*

In our 2005 Annual Report, OFCO highlighted concerns about the child fatality review process and the access to information relevant to the child's death. SHB 1105 strengthen the DSHS CA child fatality review process, provides greater access to information and promotes accountability and transparency. Specifically, SHB 1105:

- **Modifies which child Fatalities DSHS must review.** Rather than conduct a review in "the event of an unexpected death," the department now reviews deaths that are "suspected to be caused by child abuse or neglect". The department must consult with OFCO to determine if a child fatality review should be conducted in any case in which it cannot be determined whether the child's death is the result of suspected child abuse or neglect. The department may conduct a review of any near fatality at its discretion or at the request of the OFCO.
- **Requires that child fatality reviews be posted on the department's public website.** This section both protects individual privacy as confidential information may be redacted as required by state laws, and promotes transparency of the review process and the conduct of the child welfare system.
- **Provides greater access to information for child fatality review teams.** DSHS is authorized to examine and obtain copies of confidential reports and records of autopsies or post mortems. Additionally, if the child was placed with or received services from a supervising agency pursuant to a contract with the department, the fatality review team can access all records and files regarding the child produced or retained by the supervising agency.

HB 1128: PROVIDING FOR EXTENDED FOSTER CARE *(Effective July 22, 2011)*

The Ombudsman expressed concerns about the plight of the 300–400 foster youth who turn and eighteen and "age out" of our foster care system each year. Many of these youth lack basic services, education or training to successfully transition into adulthood. Over half of youth who aged out of foster care experienced one or more episodes of homelessness, and nearly thirty percent were incarcerated at some point.[86] HB 1128 responds to the needs of foster youth who would otherwise "age out" by extending foster care services on a voluntary basis to youth ages 18-21 years old who are involved in educational or employment programs, or incapable of these activities due to a

[86] *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

medical condition. Extending foster care services to age 21 is essential to prepare these youth for early adulthood and improve their chances for success.

HB 1697: PROVIDING FOR UNANNOUNCED VISITS TO HOMES WITH DEPENDENT CHILDREN
(Effective July 22, 2011)

This legislation strengthens oversight of the placement of dependent children through random, unannounced home visits. This requirement applies to all placements of dependent children, including those children residing with a parent in an in-home dependency, as well as for children placed with a relative, kin or foster parent. Unannounced visits are only required for "no less than ten percent" of current caregivers and is therefore not unduly burdensome for the department, supervising agency or caregiver.

HB 1774: RECOGNIZING ADOPTED SIBLINGS AND ADOPTIVE PARENTS AS RELATIVES
(Effective July 22, 2011)

When entering the child welfare system, siblings are often separated through foster care or adoptive placements. This is particularly true when siblings or half siblings come to the department's attention at different times. This legislation aims to address the needless separation of siblings by directing the department to consider placement of a dependent child with a person with whom the child's sibling or half-sibling is placed or with the adoptive parent of the child's sibling or half-sibling as long as such placement is in the child's best interest.

LEGISLATIVE WORK SESSION

OFCO TESTIMONY ADDRESSING "INFANT SAFE SLEEP"

In February 2011, the Director Ombudsman testified at an Infant Safe Sleep Work Session held by the House Committee on Early Learning and Human Services. The Ombudsman's testimony[87]:

- Summarized findings of child fatality reviews, highlighting concern that sixty-six percent of the fatalities that OFCO reviewed in 2009 are of children under the age of two years. Of the infant fatalities reviewed by OFCO in 2009, the medical examiner or coroner identified sleep environment as the cause of death or a contributing factor in forty-one percent of infant deaths.
- Reviewed previous OFCO recommendations concerning Safe Sleep Environment, such as:
    - Strengthen efforts such as public education campaigns to promote infant "safe sleep." (*OFCO 2010 Annual Report)*
    - Improve CPS intake protocol and address common risk factors identified in child death reviews. For example CPS intake workers should gather information about the child's sleeping environment, the parent's substance abuse history and the gestation of the infant to help determine the level of risk. (*OFCO 2009 Annual Report*)
    - Require CA to report on the implementation of OFCO child fatality review recommendations. (*OFCO 2005 Annual Report*) This recommendation was enacted in 2008, and OFCO is required to report on the implementation status of CA fatality recommendations.

[87] OFCO Testimony before the House Committee on Early Learning & Human Services, Infant Safe Sleep Work Session, February 4, 2011. Available at: http://www.governor.wa.gov/ofco/legislation/2011/default.asp

The Ombudsman also discussed Children's Administration's own recommendations and efforts to address sleep environment, including:

- "Infant Safe Sleep" has been added to the CA Academy mandatory training to staff;
- In one region, policy requires intake social workers to ask about sleep environment on calls concerning infants;
- Several regions have cribs available to give to families in need; and
- Heightened awareness of safe sleep environment, evidenced by increased documentation in case notes of the child's sleep environment and conversations with the parents about creating a safe sleep environment for infants.

V. APPENDIX

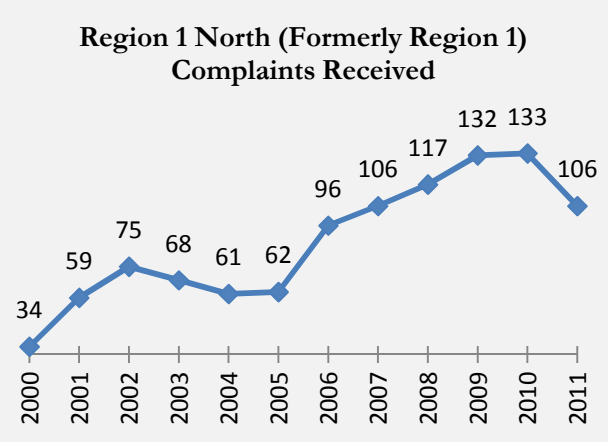
Appendix A:
Complaints Received by Region 2010-2011

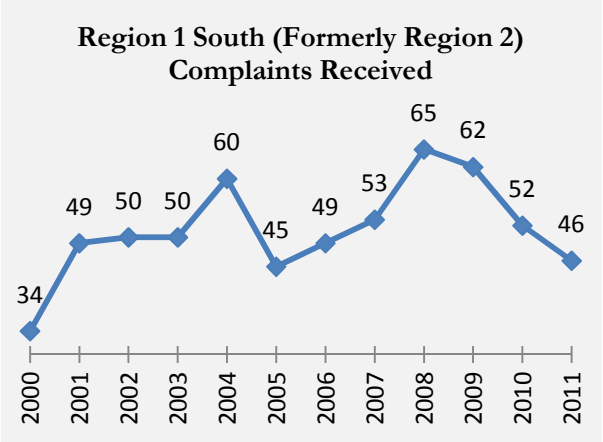
Appendix B:
Race/Ethnicity of Children Identified in Complaints to OFCO

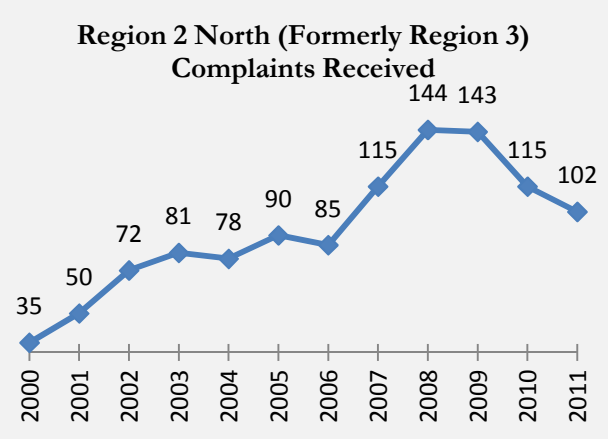
Appendix C:
Adverse Finding of the Ombudsman, By Region and Issue

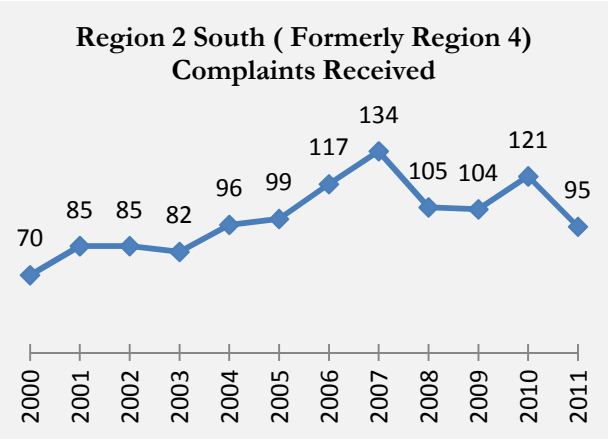
Appendix D:
Data Gathered From Child Fatalities and Near Fatalities Examined by OFCO

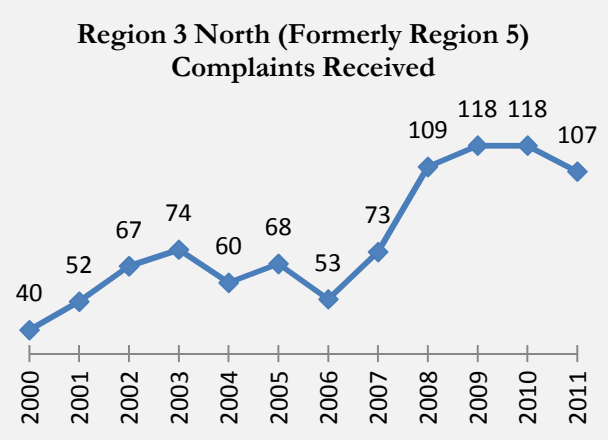
APPENDIX A: COMPLAINTS RECEIVED BY REGION 2000-2011

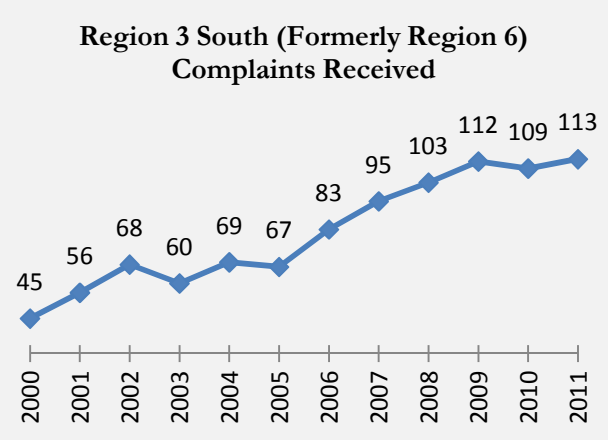












APPENDIX B: RACE/ETHNICITY OF CHILDREN IDENTIFIED IN COMPLAINTS TO OFCO

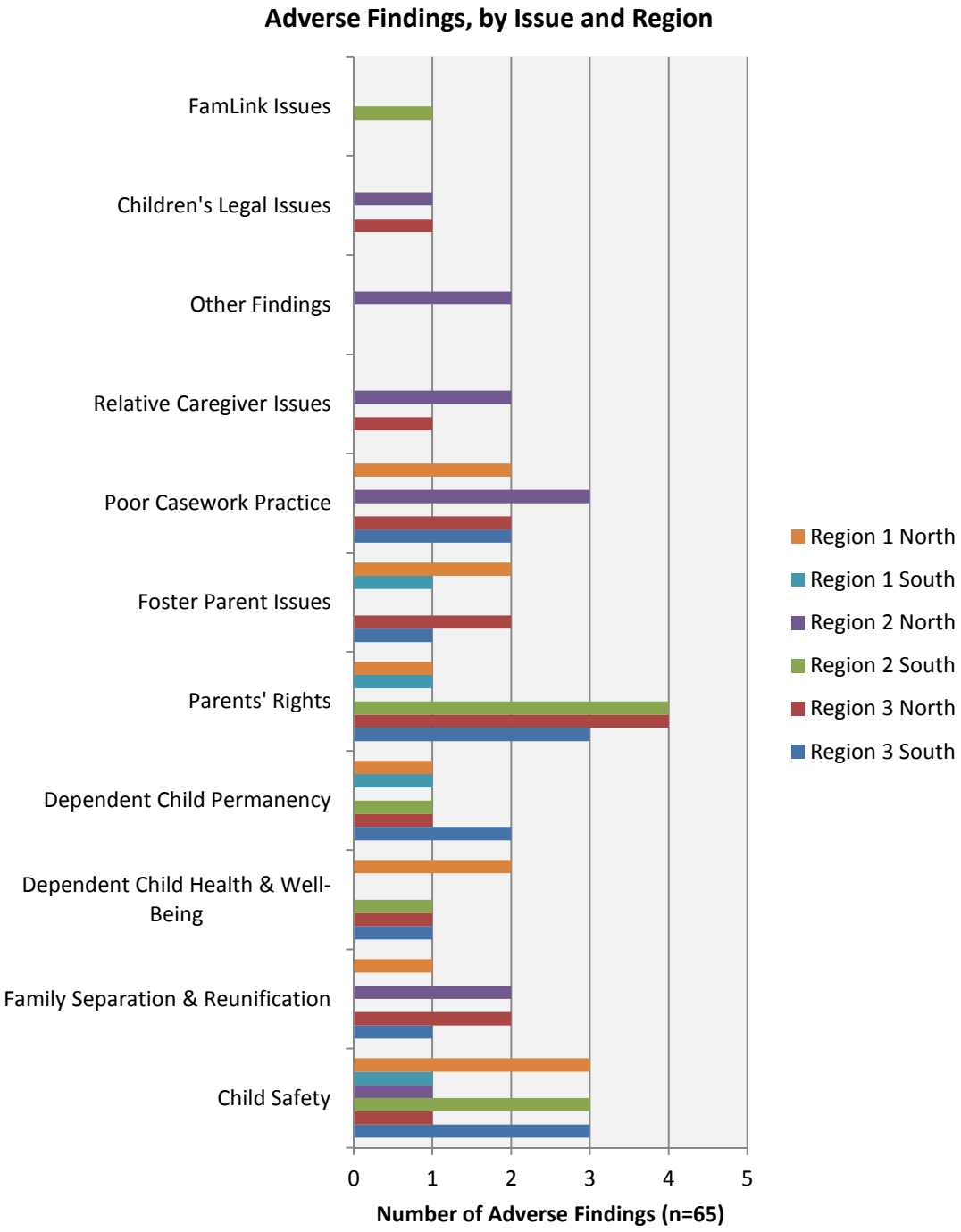
Detailed breakdown of race/ethnicity of children identified in complaints to OFCO:

Not Hispanic	87.1%
African American	9.2%
African American & Native Hawaiian Pacific Islander	0.9%
African American & American Indian or Alaska Native	0.6%
African American & American Indian or Alaska Native & Caucasian	0.4%
African American & Asian	0.3%
African American & Some Other Race	0.3%
American Indian or Alaska Native	4.5%
American Indian or Alaska Native & Asian	0.4%
American Indian or Alaska Native & Some Other Race	0.1%
Asian	1.1%
Caucasian	57.3%
Caucasian & African American	3.4%
Caucasian & American Indian or Alaska Native	4.1%
Caucasian & Asian	1.2%
Caucasian & Native Hawaiian Pacific Islander	0.1%
Native Hawaiian Pacific Islander	1.0%
Other Race	0.2%
Declined to Answer	1.9%

Hispanic	12.9%
African American	0.2%
African American & American Indian or Alaska Native	0.3%
African American & American Indian or Alaska Native & Caucasian	0.3%
American Indian or Alaska Native	0.8%
Caucasian	9.4%
Caucasian & African American	0.4%
Caucasian & American Indian or Alaska Native	1.2%
Other Race	0.1%
Declined to Answer	0.1%

APPENDIX C: ADVERSE FINDINGS, BY ISSUE AND DSHS REGION

The following table highlights findings across regions by issue category. Meaningful conclusions cannot be drawn from such small numbers; nevertheless, regions may find it helpful to know what types of complaint issues were substantiated by OFCO in their particular region.

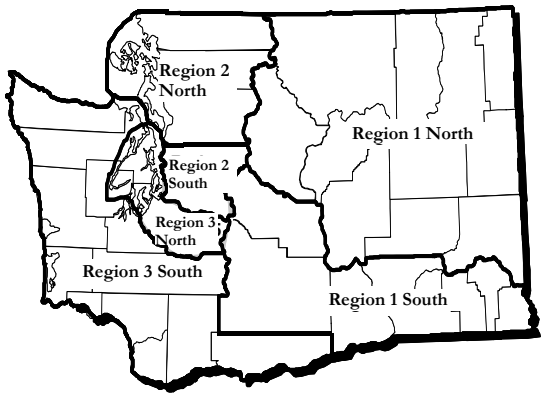


Source: Office of the Family and Children's Ombudsman, October 2011

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

FATALITIES BY DSHS REGION

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



Regional Offices:	Children served by CA Region[88]:
Region 1 – Spokane	14,739
Region 2 – Yakima	11,331
Region 3 – Everett	16,006
Region 4 – Seattle	18,724
Region 5 – Tacoma	15,189
Region 6 – Vancouver	18,073

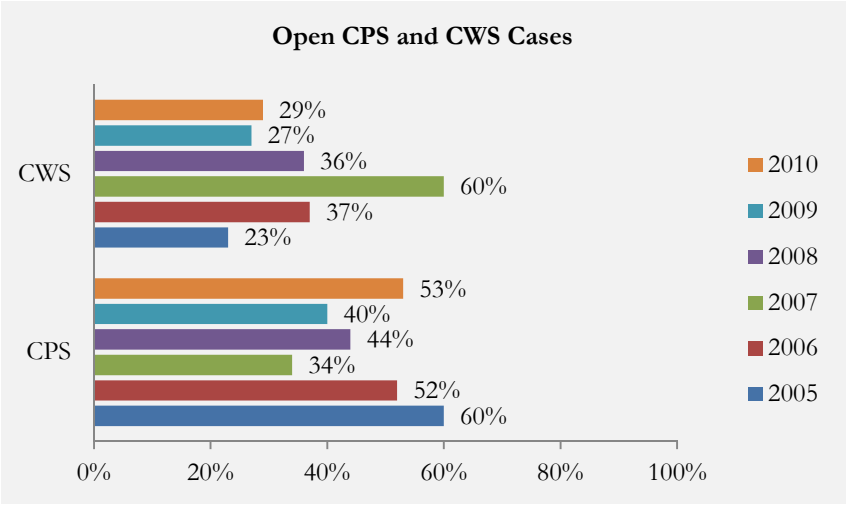
OFCO CHILD FATALITY REVIEWS BY REGION

	2004	2005	2006	2007	2008	2009	2010
Region 1 North (Formerly Region 1)	17	9	9	3	9	13	10
Region 1 South (Formerly Region 2)	7	10	7	10	15	2	11
Region 2 North (Formerly Region 3)	14	13	9	16	17	15	11
Region 2 South (Formerly Region 4)	13	16	13	9	15	17	14
Region 3 North (Formerly Region 5)	22	7	15	18	23	11	13
Region 3 South (Formerly Region 6)	14	16	10	11	19	6	17
Total	**87**	**71**	**63**	**67**	**98**	**64**	**76**

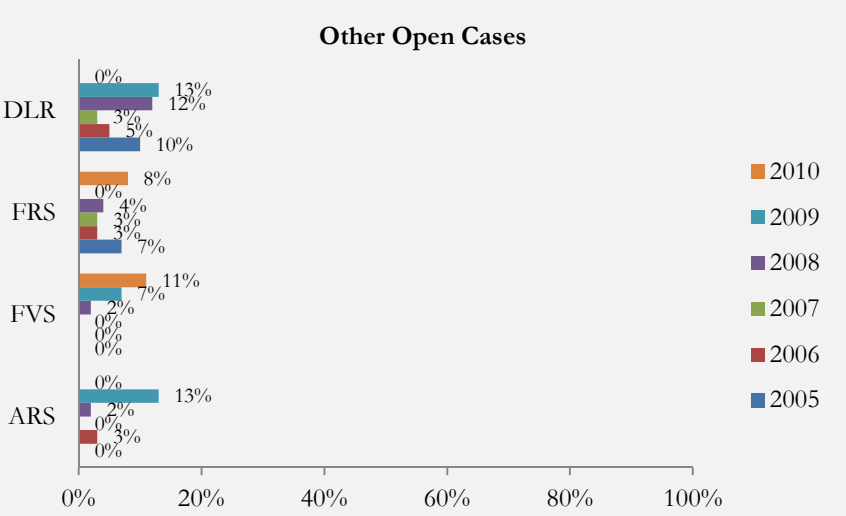
Source: Office of the Family and Children's Ombudsman, November 2011, based on analysis of DSHS CA data

Source: Office of the Family and Children's Ombudsman, November 2011, based on analysis of DSHS CA data

[88] 2007 data. http://clientdata.rda.dshs.wa.gov/



Source: Office of the Family and Children's Ombudsman, November 2011, based on analysis of DSHS CA data

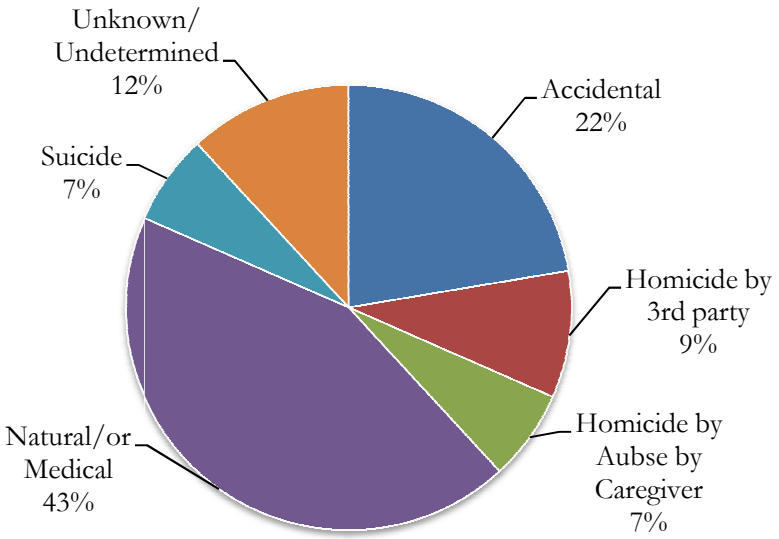


Source: Office of the Family and Children's Ombudsman, November 2011, based on analysis of DSHS CA data

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 primary categories: 1) unknown/undetermined, 2) natural/medical, 3) accidental, 4) homicide and 5) suicide. 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, a death caused by drug overdose could also be determined to have the manner of death as suicide, or unknown/undetermined if it is unclear. The graph below shows the breakdown by manner of death of the fatalities in 2010.

Manner of Death, 2010



Source: Office of the Family and Children's Ombudsman, November 2011, based on analysis of DSHS CA data

CASE EXAMPLES

After review, OFCO makes a determination if the child fatality is related to clear physical abuse, clear neglect, or OFCO has concerns that physical abuse and/or neglect may have contributed to the death. The following are case examples of child fatalities related to clear physical abuse, clear neglect, or child abuse and/or neglect concerns.[89] OFCO added a category this year to capture fatalities that documented prenatal substance use, but the substance use was not connected the cause of death. While the prenatal drug use was not considered medically connected to the death, OFCO is concerned about the high number of infant fatalities where prenatal drug use is present.

Clear Physical Abuse-Related Fatality

- A two year old non-dependent child's death was caused by blunt force trauma to his abdomen[90]. The mother's boyfriend was providing care for this child and three other children. DCFS did not have an open case at the time of death. In the month prior to the child's death, two referrals had been called into CPS intake regarding bruising on this child and a sibling. The referent mentioned the mother's boyfriend, but neither referral recorded his name. Both intakes screened out for investigation. The boyfriend has been arrested and charged with the murder of this child.

Clear Neglect-Related Fatalities

- A seven year old non-dependent child died in a car accident[91]. The child's mother was driving the car under the influence of alcohol. At the time of the child's death, there was an open CPS case on the family regarding allegations that the mother was drinking alcohol and driving with her children in the car.

Child Abuse/Neglect Concerns

- A three year old non-dependent child died of undetermined cause. The child was found deceased in her bed, she had not been checked on for fourteen hours. Two weeks prior to the death, CPS closed a case with an unfounded finding regarding allegations of unsanitary home conditions. The mother declined voluntary services. At the time of the death, the house was described as an unsanitary living environment for children. While there were many dangers to the children in the home, there is no indication that the conditions directly caused the death of this child.

- A two month old non-dependent infant was found deceased face down on a twin bed. The infant had been swaddled, placed on some pillows, and covered with a comforter. Three weeks prior to the death, CPS intake received a referral alleging a bruise with swelling on the infant's face. This did not screen in for investigation, based on the doctor stating the parent's explanation of the injury was plausible. The cause of death is undetermined.

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

[90] Child Fatality Review conducted by the Children's Administration can be accessed at: http://www.dshs.wa.gov/pdf/ca/bm_ECFR.pdf

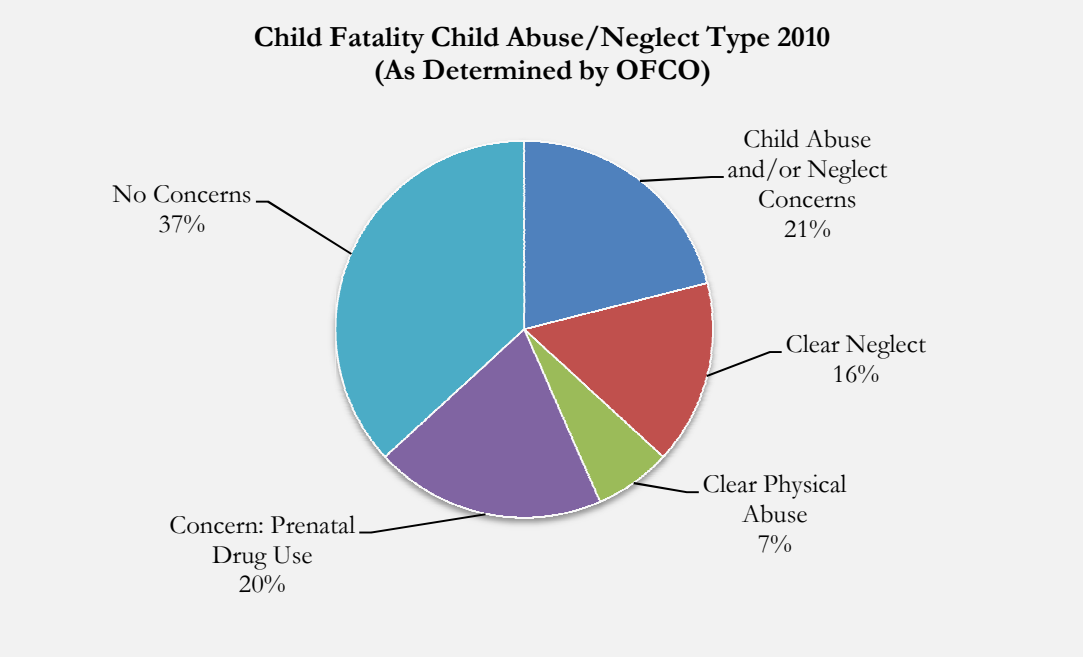
[91] Child Fatality Review conducted by the Children's Administration can be accessed at: http://www.dshs.wa.gov/pdf/ca/casch-ecfr.pdf

Concern: Prenatal Drug Use

- A two month old non-dependent infant died of natural causes related to premature birth. The mother tested positive for illegal substances at birth and did not receive any prenatal care. The infant was born with minor medical issues.

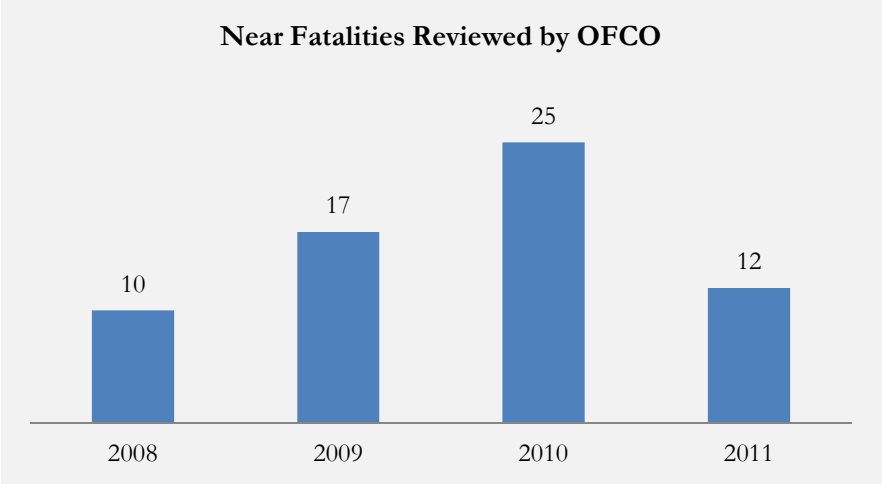
- A one month old non-dependent infant died of natural causes. The infant was born premature with multiple medical issues. CPS had an open Risk-Only case at the time of death regarding allegations that the mother tested positive for opiates at the birth of this infant.

- A two week old non-dependent infant died from natural causes. The infant was born with multiple medical complications and was never released from the hospital. Both the mother and the infant tested positive for methamphetamine and cocaine at birth. Two referrals were called into CPS Intake during the mother's pregnancy[92] alleging drug use by the mother. CPS did open a case at the birth of the infant based on the mother and infant testing positive for illegal substances at birth.

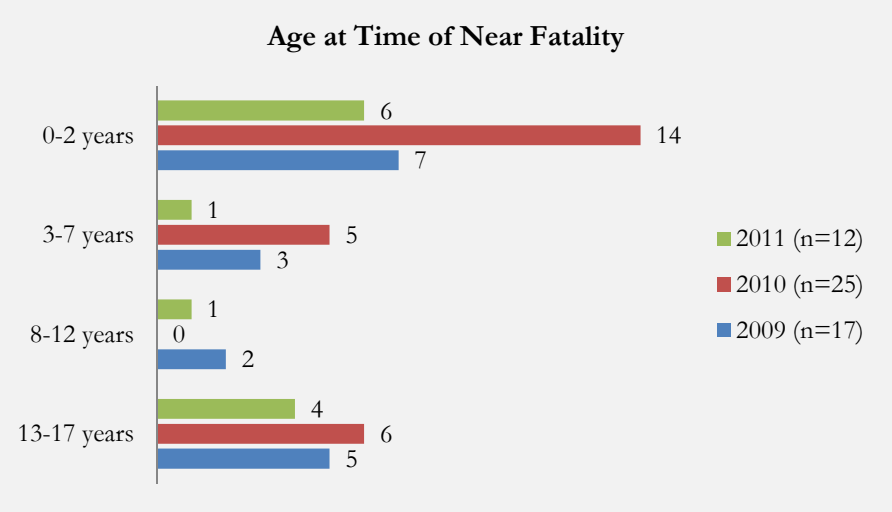


Source: Office of the Family and Children's Ombudsman, November 2011, based on analysis of DSHS CA data

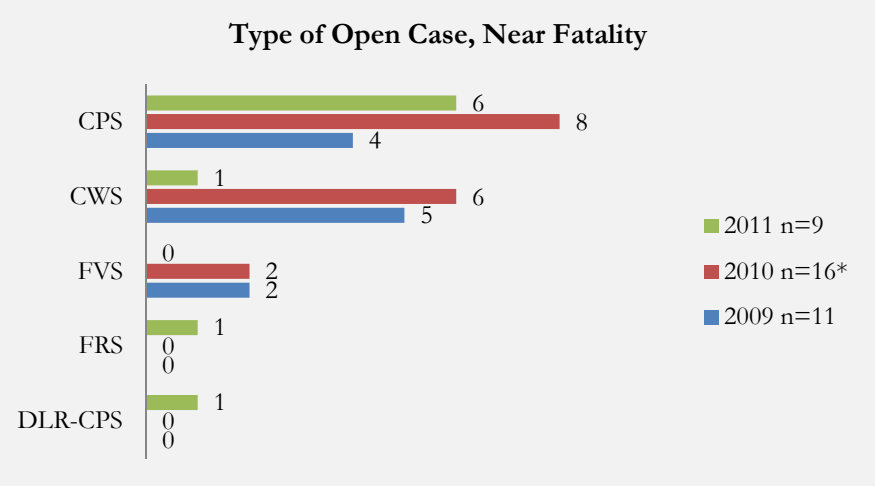
[92] Per CA policy, referrals called into CPS alleging substance abuse by a pregnant woman do not screen in for investigation. http://www.dshs.wa.gov/CA/pubs/mnl_pnpg/chapter2_2500.asp



Source: Office of the Family and Children's Ombudsman, December 2011, based on analysis of DSHS CA data



Source: Office of the Family and Children's Ombudsman, December 2011, based on analysis of DSHS CA data



Source: Office of the Family and Children's Ombudsman, December 2011, based on analysis of DSHS CA data

*One near fatality occurred in a licensed DEL facility. This is not included in the DCFS total.