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

2012 Annual Report

Mary Meinig, Director Ombudsman

www.governor.wa.gov/ofco

STATE OF WASHINGTON
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January 2013

To the Residents of Washington State:

I am pleased to submit the 2012 Annual Report of the Office of the Family and Children's Ombudsman. This report provides an account of OFCO's activities from September 1, 2011 to August 31, 2012 and our recommendations to improve the child welfare system.

During this reporting period, OFCO completed 522 complaint investigations regarding 805 children and 498 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 separation and reunification of families and the safety of children living at home or in substitute care were by far the most frequently identified issues in complaints.

In addition to complaint investigations, OFCO monitors practices and procedures within the child welfare system and makes recommendations to better serve children and families. Systemic issues and recommendations discussed in this report include: ways to improve the adoption process and protect children; ensuring that Child Protective Services investigations are completed in a timely manner; and improving efforts to place children with relatives.

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 Children's Administration Assistant Secretary Denise Revels Robinson and her leadership and dedication to improving the safety and welfare of children and families.

I would also like to welcome Governor Inslee and his staff. OFCO looks forward to working with the Governor's office on initiatives to strengthen the child welfare system. 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

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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, 2011, through August 31, 2012; OFCO's administrative reviews of child fatality cases (January through December, 2011); and administrative review of near fatalities (January through December, 2012). 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 accessing 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. The Ombudsman also has the discretion to decline to investigate any complaint.

System Oversight and Improvement:

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

Annual Reports:

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

[1] RCW 43.06A and RCW 26.44.030.

INQUIRIES AND COMPLAINT INVESTIGATIONS

OFCO received 1,255 contacts from families and citizens seeking assistance or information about the child welfare system in 2011. Approximately 44 percent of these contacts were formal complaints requesting an Ombudsman investigation. Between September 1, 2011 and August 31, 2012, OFCO completed 522 complaint investigations regarding 805 children and 498 families. These investigations resulted in 41 adverse findings against the department. As in previous years, the separation and reunification of families and the safety of children living at home or in substitute care were by far the most frequently identified issues in complaints. 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.

Twenty-five complaints required intervention by the Ombudsman. In an additional 24 complaints, the Ombudsman provided substantial assistance to resolve the complaint issue. The vast majority of complaints in which the Ombudsman intervened or assisted resulted in the complaint issue being resolved.

The November 2009 inter-agency agreement between OFCO and DSHS 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. This year, the Ombudsman made 41 formal adverse findings against the CA.

REVIEW OF CRITICAL INCIDENTS

The Ombudsman conducts administrative reviews of cases of recurrent child maltreatment as well as of all fatalities both involving child abuse or neglect and cases unrelated to child maltreatment, and near fatalities of children whose family had an open case with DSHS within a year prior to the child's death. During this reporting period OFCO conducted 187 administrative reviews of critical incident cases – 60 child fatalities, 16 near fatalities and 111 cases of recurrent maltreatment. Through these reviews, the Ombudsman identifies common factors and systemic issues regarding these critical incidents. Key points discussed in this section of the annual report include:

- In 2011, OFCO reviewed 60 child fatality cases, both involving child abuse or neglect and cases unrelated to child maltreatment. This represents a 21 percent decrease from 2010, and the lowest number since 2004.
- It is concerning however that while the number of child fatality cases has decreased, there has been a steady increase in the number of child fatalities directly attributed to physical abuse or neglect, from 8 fatalities in 2009, to 17 in 2010, and to 23 in 2011. It is important to keep in mind that child fatality reviews include both cases that were open at the time of the child's death as well as those that had been open within a year prior.

- OFCO received 111 notifications of recurrent maltreatment in its 2012 reporting period, a 15.6 percent increase over the same period last year.
- Neglect continues to constitute the largest number of the founded reports and is more likely to recur than physical or sexual abuse.
- Caregiver substance abuse remains the most prevalent risk factor in cases of recurrent maltreatment.

WORKING TO MAKE A DIFFERENCE

Recommendations From the Report on Severe Abuse of Adopted Children

In response to OFCO's 2011 Annual Report discussing severe abuse of adopted children, OFCO and CA established a committee to examine this issue in greater detail and make recommendations to improve the adoption process. The committee's recommendations focus on: State Oversight of Child Placing Agencies; Assessing Prospective Adoptive Families; and Training and Post Adoption Support and Services. This report provides a summary of the committee's activities and specific recommendations. Two of these recommendations and possible strategies for implementation are discussed in more detail: *Tracking Adoption Disruption and Dissolution,* and *Strengthening Qualifications and Training Requirements for Individuals Conducting Adoption Home Studies and Post Placement Reports.*

Barriers to Placement with Out-of-State Relatives Delays Permanency

The Ombudsman frequently receives complaints from a child's relative seeking placement of the child. In some cases, the relative resides out-of-state. While state law recognizes a preference for placing children with relatives, the decision to place a child with an out-of-state relative can be exceptionally difficult and often involves consideration of multiple goals such as: respecting parental preferences, limiting the number of out-of-home placements, maintaining sibling groups in the same home, and the child's bonding and attachment with a non-relative caregiver. Overarching principles recognizing the long term benefits of promoting relationships between children and their extended families should guide these decisions.

Delays in Completing CPS Investigations Leave Children at Risk of Harm

Over the past three years, the Ombudsman has found that Child Protective Services routinely fails to complete investigations of child abuse or neglect within 45 days as required by policy or within 90 days as required by state law. The timely completion of investigations is crucial to child safety and effective case planning, and ensures due process for alleged subjects of the investigation (often parents) who may be anxious to resolve allegations of maltreatment. As a step to address this problem, the Ombudsman recommends that the department produce quarterly reports for each DCFS office identifying the number of CPS investigations that are open beyond 90 days, 120 days and 150 days. Additionally, the CPS social worker should be required to conduct monthly health and safety visits with the alleged child victim, in all CPS investigations open beyond 45 days and these visits should occur in the home where the child resides.

Life-Long Impact of a CPS Finding of Child Abuse or Neglect

The Ombudsman regularly receives complaints from individuals seeking to overturn or expunge CPS findings that they abused or neglected a child. Such findings can have life-long consequences impacting the individual's ability to obtain employment working with children or the elderly, or to provide relative care for a dependent child. The Ombudsman believes this issue merits further study and consideration of establishing a procedure to vacate or expunge a CPS finding of child maltreatment under certain circumstances.

Child Welfare Legislation

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

- The reinvestment of savings resulting from reductions in foster care into child welfare programs to strengthen and preserve families and improve outcomes for children.
- Greater flexibility to our state child welfare system to engage families, other than through a CPS investigation, and effectively reduce the incidence and risk of child maltreatment.
- Extending foster care and providing the stability necessary for a foster youth to pursue postsecondary education until he or she turns 21 years of age.

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*, implementing performance-based contracts for child welfare services and establishing pilot projects contracting with private agencies for child welfare case management services; serving as a member of the *Title IV-E Wavier Advisory Committee* to make recommendations regarding Washington State's successful application for a federal demonstration project; and participating in Executive Child Fatality and Near-Fatality Reviews.

KEY FINDINGS AND RECOMMENDATIONS

Recommendations from the Committee on Severe Abuse of Adopted Children
In response to OFCO's 2011 Annual Report discussing severe abuse of adopted children, OFCO and CA established a committee to examine this issue in greater detail and make recommendations to improve the adoption process. The committee's recommendations focus on: State Oversight of Child Placing Agencies; Assessing Prospective Adoptive Families; and Training and Post Adoption Support and Services.

Failure to Complete CPS Investigations in a Timely Manner Leaves Children at Risk
The Ombudsman finds that Child Protective Services routinely fails to complete investigations of child abuse or neglect within 90 days as required by state law. Twenty-six percent of all CPS investigations initiated between September 1, 2011 and June 1, 2012 remained open more than 90 days. A full 10 percent remained open more than 150 days. The Ombudsman recommends that the department:

- Produce quarterly reports for each DCFS office identifying the number of CPS investigations remaining open beyond 90 days, 120 days and 150 days.
- Require CPS social workers to conduct monthly health and safety visits with the alleged child victim, in all CPS investigations open beyond 45 days, to occur in the home where the child resides.

A CPS Finding of Child Maltreatment has a Life-Long Impact
The Ombudsman regularly receives complaints from individuals seeking to overturn or expunge CPS findings that they abused or neglected a child. These individuals are often shocked to learn that a finding of child abuse or neglect, made many years ago, remains on their record and can prevent them from working or volunteering with children or other vulnerable populations, or from being a placement option for a child in state care. While the subject of a finding of child abuse or neglect is entitled to an administrative review to determine if there is a sufficient evidentiary basis for the finding, there is currently no procedure that allows a person to have a CPS finding reviewed and expunged years later, based on positive changes the person has made in their life. Establishing a procedure to expunge a finding of child maltreatment, under certain circumstances, warrants further study.

Critical Incident Case Reviews
OFCO conducted 187 administrative reviews of critical incident cases – 60 child fatalities (cases involving child abuse or neglect, and cases not related to child maltreatment), 16 near fatalities and 111 cases of recurrent maltreatment. While the number of child fatalities reviewed by OFCO dropped significantly, the Ombudsman noted an increase in the number of child fatalities attributable to child abuse or neglect. OFCO also saw an increase in the number of recurrent maltreatment cases from last year. Neglect continues to constitute the largest number of the founded reports and caregiver substance abuse remains the most prevalent risk factor associated with recurrent maltreatment.

TERMS AND ACRONYMS

AAG	Assistant Attorney General
AIRS	Administrative Incident Reporting System
ARS	Alternative Response System
ARY	At Risk Youth
BRS	Behavior Rehabilitation Services
CA	Children's Administration
CA/N	Child Abuse and Neglect
CASA	Court Appointed Special Advocate
CDR	Child Death Review
CFR	Child Fatality Review
CHINS	Child in Need of Services
CNFR	Child Near-Fatality Review
CPS	Child Protective Services
CPT	Child Protection Team
CFWS or CWS	Child and Family Welfare Services or Child Welfare Services
DBHR	Division of Behavioral Health and Recovery
DCFS	Division of Children and Family Services
DDD	Division of Developmental Disabilities
DEL	Department of Early Learning
Dependent Child	A child for whom the state is acting as the legal parent.
DOH	Department of Health
DLR	Division of Licensed Resources
DSHS	Department of Social and Health Services
ECFR	Executive Child Fatality Review
ECNFR	Executive Child Near-Fatality Review
EFSS	Early Family Support Services
FamLink	CA's computerized database introduced in late January 2009
FRS	Family Reconciliation Services
FVS	Family Voluntary Services
GAL	Guardian Ad Litem
ICPC	Interstate Compact for the Placement of Children
OFCO	Office of the Family and Children's Ombudsman
SDM	Structured Decision Making
VSA	Voluntary Service Agreement

I. ROLE OF THE OMBUDSMAN

"I believe your office is one of the best resources in the entire child welfare system."

~ Foster Parent

ROLE OF THE OMBUDSMAN

The Washington State Legislature created the Office of the Family and Children's Ombudsman (OFCO) in 1996, in response to two high profile incidents that indicated a need for oversight of the child welfare system.[2] The Ombudsman provides 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 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. Although OFCO is organizationally located within the Office of the Governor, it conducts its operations independently of the Governor's Office in Olympia. OFCO is a separate agency from DSHS.

- **Impartiality.** The Ombudsman acts as a *neutral investigator* of complaints, rather than as an advocate for citizens who file complaints, or for the governmental agencies investigated. This neutrality reinforces the credibility of OFCO.

- **Confidentiality.** OFCO maintains the confidentiality of complainants unless such confidentiality is waived. This protection makes citizens, including professionals within DSHS, more likely to contact OFCO and to speak candidly about their concerns.

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

AUTHORITY

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

[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 sexual abuse between youths at the DSHS-licensed OK Boys Ranch. The establishment of the office also coincided with growing concerns about DSHS' role and practices in the Wenatchee child sexual abuse investigations.

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

[4] See also RCW 13.50.100(6).

confidentiality of OFCO's investigative records and the identities of individuals who contact the office. This encourages individuals to come forward with information and concerns without fear of possible retaliation. Additional duties have been assigned to OFCO by the Legislature in recent years regarding the reporting and review of child fatalities, near fatalities, and recurrent maltreatment.[5]

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

WORK ACTIVITIES

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

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

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

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

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

[5] See RCW 74.13.640(1)(b); 74.13.640(2); and 26.44.030(13). These duties are discussed in detail in Section IV of this report, see page 85.

II. LISTENING TO FAMILIES AND CITIZENS

- Inquiries and Complaints
- Complaint Profiles
- Complaint Issues

"I feel that if I had not contacted the Ombudsman, we would still be waiting."

~ Grandparent

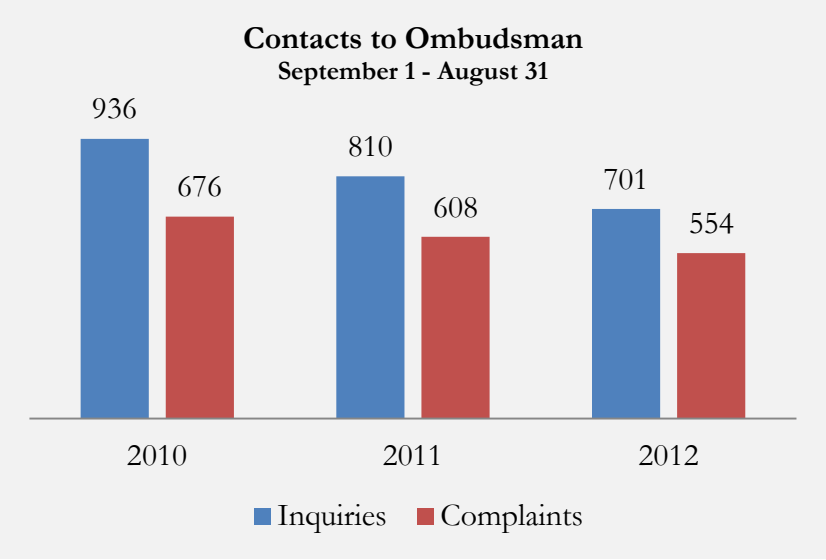
INQUIRIES AND COMPLAINTS

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 2012 reporting year.[6] Data from previous reporting years is included for comparison.

CONTACTS TO THE OMBUDSMAN

Families and citizens contacted the Ombudsman **1,255** times in 2012. Of these contacts, 56 percent were **inquiries** made by people seeking information, and 44 percent were formal complaints seeking an investigation by an Ombudsman. Although the number of contacts to OFCO has decreased, it should be noted that due to several months' absence of OFCO's administrative staff this year, OFCO did not document inquiries as consistently as in previous years.



Source: Office of the Family and Children's Ombudsman, September 2012

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.

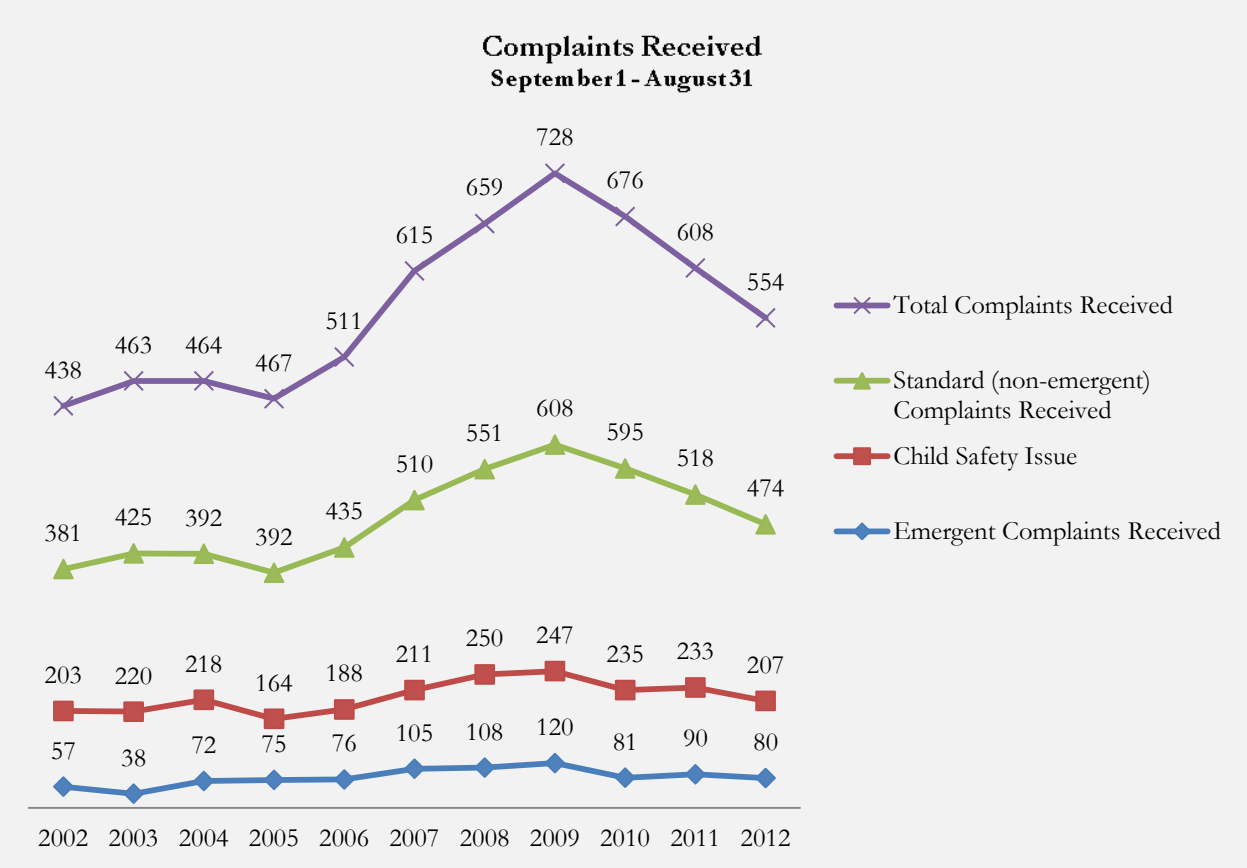
[6] The Ombudsman's annual reporting period is September 1 to August 31.

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 554 complaints in 2012. Of these, **14 percent were emergent (80 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 **(207 complaints, or 37 percent)**.



Source: Office of the Family and Children's Ombudsman, September 2012

As shown in the above chart, complaints filed with OFCO have **decreased steadily** since an all-time high of 728 complaints in 2009, but in 2012 the number of complaints was still higher than 2006 or any year prior. Notwithstanding this drop in complaints, the percentage of emergent complaints and those involving child safety has remained consistent over the years. Changes at OFCO in the last couple of years may well have contributed to the lower number of complaints filed: OFCO's small staff ranged from eight to four people at various times, due to a combination of factors including budget cuts, family and other leaves of absence, or staffing changes; OFCO also moved to new premises in February, 2012. As a result of having fewer staff, OFCO increased its

efforts to refer citizens to other community resources where appropriate, and devoted less time to community outreach (for example, presentations to community groups about OFCO's services), which typically generates an increase in complaints.

Regardless of internal changes at OFCO, the decrease in complaints since 2009 may be attributable to a number of changes and improvements in the child welfare system in the last few years. Some examples include:[7]

- The work of the *Braam* Oversight Panel in implementing the *Braam* Foster Care Settlement Agreement, and the ongoing work being done to ensure that CA continues efforts to meet key outcomes that have not been achieved, through the renegotiated final settlement agreement effective through 2013[8];
- Stronger efforts to find relative caregivers, work with them more effectively and increase the use of relative placements for children in out-of-home care;
- Governor Gregoire's mandate (including other government accountability measures[9]) to ensure that children are seen within 24-72 hours of a report being made to Child Protective Services;
- Major casework practice improvements such as making monthly visits to children in out-of-home care, the use of Family Team Decision Meetings, redesigning the investigative and case management roles to get families into services more quickly, policies to better engage fathers in their children's lives, and better tracking of foster children's health care and education;
- The foster parent and relative caregiver satisfaction survey conducted through the *Braam* Panel,[10] identifying gaps in support and services to foster parents and CA's development of a plan to address these issues;
- In response to a new law passed in 2007,[11] the initiation of quarterly regional and statewide meetings between foster parents, the Foster Parent Association of Washington State (FPAWS), and the CA Assistant Secretary, as well as ongoing advocacy and assistance to foster parents by FPAWS;
- New initiatives by DSHS and CA leadership to increase agency transparency and responsiveness to constituent concerns;
- Central Case Reviews conducted by CA since 2006 to improve casework practice;
- CA case reviews requested by OFCO at DCFS offices flagged as trouble spots;
- The program improvement plans developed as a result of the federal Child and Family Service Reviews conducted in 2006 and again in 2010, with the 2010 review showing several performance improvements since 2006;[12] and
- Concrete improvements in legal representation for indigent parents involved in dependencies, achieved through the Parent Representation Program of the Washington State Office of Public Defense, resulting in speedier court hearings and a 53 percent increase in the rate of family reunifications.[13]

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[7] This list is far from exhaustive but identifies some examples observed by OFCO of the many changes aimed at improving the child welfare system that have been brought about in the last few years.
[8] See http://braampanel.org/.
[9] The Governor's performance reviews referred to as Government Management Accountability and Performance (GMAP) were initiated to improve government performance and accountability, and included several measures to increase protections for vulnerable children and adults. See http://www.dshs.wa.gov/ca/about/imp_gmap.asp.
[10] See http://braampanel.org/survey.asp.
[11] RCW 74.13.031(16)
[12] See http://www.dshs.wa.gov/ca/CFSR/about.asp for more information.
[13] For the full report, see http://www.americanbar.org/content/dam/aba/migrated/child/PublicDocuments/03aprilccw.authcheckdam.pdf

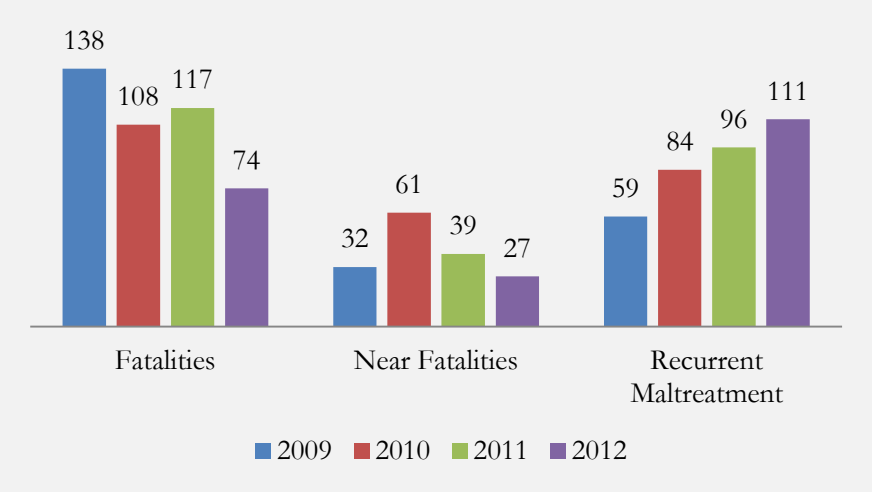
MANDATED NOTIFICATION OF CRITICAL INCIDENTS

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 notifications received and cases reviewed by OFCO during the last three 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.[14]

DSHS/CA Notifications Received During OFCO Reporting Year, 2009-2012
September 1 – August 31



Source: Office of the Family and Children's Ombudsman, September 2012

[14] For further discussion of these criteria and fatality reviews, see OFCO Critical Incident Case Reviews, page 85.

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 90 percent of complaints in 2012.[15]

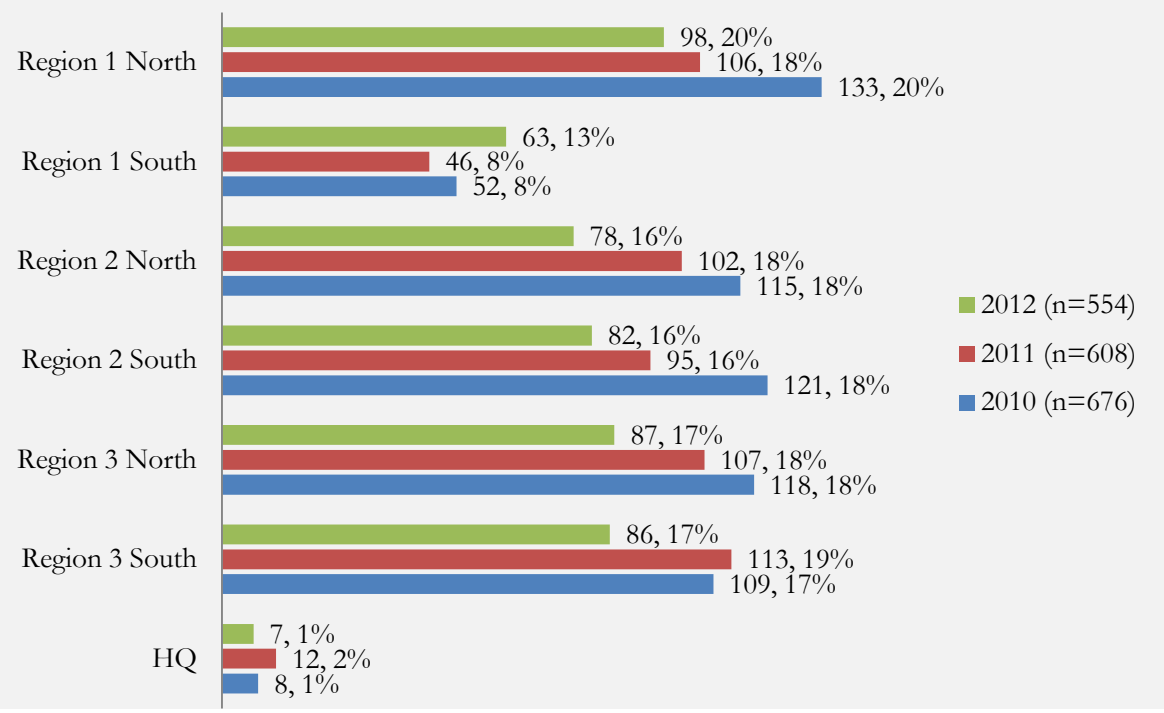
Of the complaints against CA, 99 percent were directed at DCFS (up from 96 percent in 2011), which includes Child Protective Services (CPS), Child and Family Welfare and Adoption Services (CFWS or CWS), Family Reconciliation Services (FRS), and Family Voluntary Services (FVS). A small percentage of complaints (one percent, down from three percent in 2011) 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.

There were no complaints directed at the Department of Early Learning (DEL), compared with four such complaints last year. 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.

[15] 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 2012 reporting year, complaints were divided evenly between Region 1 (33 percent), Region 2 (32 percent), and Region 3 (34 percent), with the remaining one percent being directed at CA Headquarters. The sub-regions showed greater differences: while complaints decreased in all sub-regions except Region 1 South, the breakdown between sub-regions (again with the exception of Region 1 South) was very similar to the two years prior. Region 1 South showed a sharp increase to 13 percent of total complaints, compared with 2010 and 2011 when this region accounted for eight percent of total complaints. The decrease in complaints in the five other sub-regions reflects the overall decrease in the number of complaints received by OFCO. For historical comparisons, complaints in each region since 2000 are shown in Appendix A.



Source: Office of the Family and Children's Ombudsman, September 2012

Regional Offices	*Population* [16]	*Clients served By CA* [17]
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

[16] Taken from 2010 US Census http://quickfacts.census.gov/qfd/states/53000.html
[17] Taken from 2010 CA data, see http://clientdata.rda.dshs.wa.gov/

COMPLAINTS RECEIVED BY DCFS OFFICE AND REGION 2011-2012

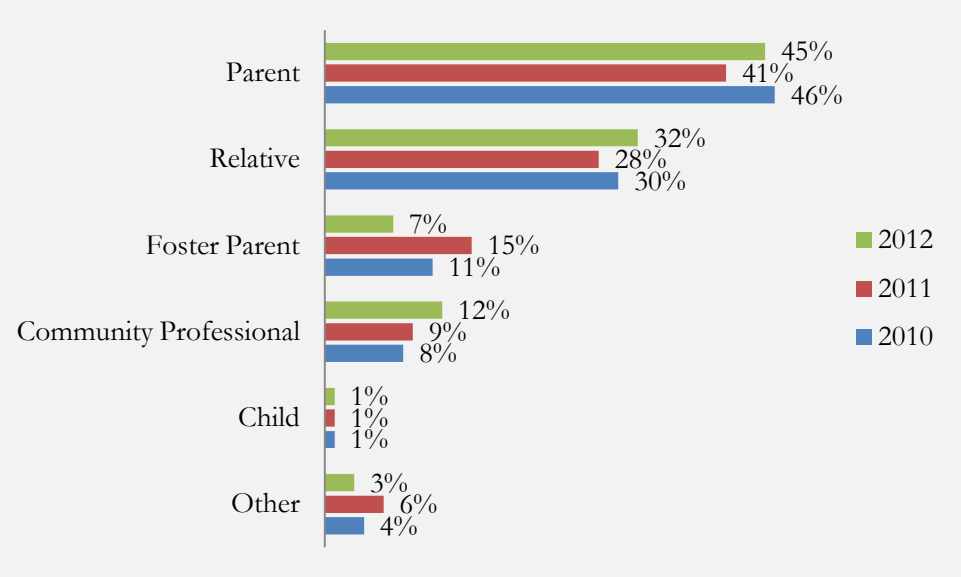
	2011		2012	
	DCFS	DLR	DCFS	DLR
Region 1 North Total	**103**	**3**	**94**	**4**
Spokane	60	1	57	4
Colville	17	-	14	-
Moses Lake	9	-	14	-
Wenatchee	4	1	4	-
Colfax	-	-	1	-
Newport	5	-	2	-
Omak	6	1	1	-
Clarkston	-	-	1	-
Region 1 South Total	**43**	**3**	**61**	**2**
Yakima	16	2	22	2
Richland/Tri-Cities	13	-	20	-
Walla Walla	5	-	11	-
Toppenish	-	-	1	-
Ellensburg	3	-	3	-
Sunnyside	4	-	1	-
White Salmon	1	-	2	-
Goldendale	1	1	1	-
Region 2 North Total	**95**	**7**	**76**	**2**
Everett	35	5	25	1
Bellingham	18	-	7	-
Lynnwood	9	1	8	-
Arlington/Smokey Point	7	-	10	-
Mount Vernon	13	1	11	1
Monroe/Sky Valley	8	-	13	-
Oak Harbor	5	-	-	-
Friday Harbor	-	-	2	-
Statewide	**10**	**2**	**6**	**1**
CA Headquarters	5	2	3	1
Central Intake	5	-	3	-

	2011		2012	
	DCFS	DLR	DCFS	DLR
Region 2 South Total	**90**	**5**	**78**	**4**
King South/Kent	25	-	18	1
Martin Luther King Jr.	13	-	8	-
King West	17	-	12	-
King East/Bellevue	19	-	17	1
Office of Indian Child Welfare	3	-	11	-
Seattle Centralized Services	11	5	12	2
White Center	2	-	-	-
Region 3 North Total	**103**	**4**	**83**	**4**
Centralized Services	1	4	5	2
Pierce East	33	-	36	-
Pierce West	46	-	20	-
Bremerton/Kitsap	23	-	22	2
Region 3 South Total	**100**	**13**	**84**	**2**
Vancouver	33	3	30	1
Aberdeen	18	1	12	-
Port Angeles	7	-	5	-
Centralia	5	1	5	-
Tumwater	14	-	11	-
Kelso	12	1	11	-
Shelton	3	-	3	-
Stevenson	-	-	2	-
Lacey/Olympia	5	7	1	1
South Bend	1	-	-	-
Long Beach	-	-	2	-
Port Townsend	2	-	-	-
Forks	-	-	-	-

COMPLAINT 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. This year saw a slight increase in complaints made by community professionals, and a significant decrease in complaints made by foster parents. The latter may be attributable to the initiation of quarterly statewide meetings between the CA Assistant Secretary and foster parents to address their issues and concerns, as well as outreach and assistance provided to foster parents by the Foster Parent Association of Washington State (FPAWS). We continue to have few children contacting the Ombudsman on their own behalf.



Source: Office of the Family and Children's Ombudsman, September 2012

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 hearing from 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.

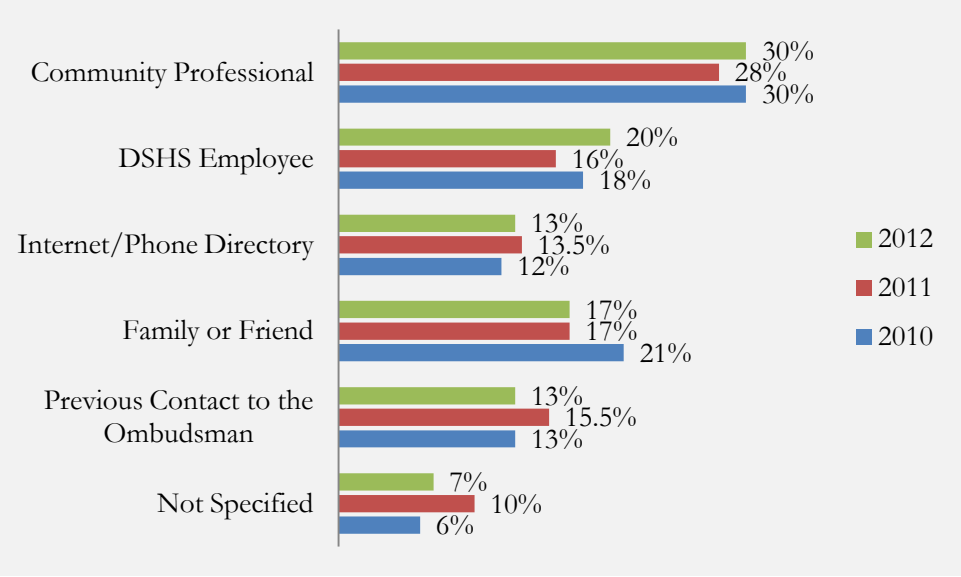
Race/Ethnicity	OFCO 2012	Total WA Population[18]
Caucasian	73.8%	77.3%
African American	12.3%	3.6%
American Indian/Alaska Native	6.9%	1.5%
Asian	1.1%	7.2%
Native Hawaiian and Other Pacific Islander	0.1%	0.6%
Other	0.2%	0%
Multi-Racial	0.5%	6.0%
Declined to Answer	0.9%	--
Hispanic	4.5%	15.5%
Caucasian, not Hispanic	61.0%	72.5%

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 served by the CA (see page 25), complaints to OFCO appear to be more evenly representative of children in the child welfare system.

[18] Taken from US Census data at http://quickfacts.census.gov/qfd/states/53000.html

HOW THEY HEARD ABOUT THE OMBUDSMAN

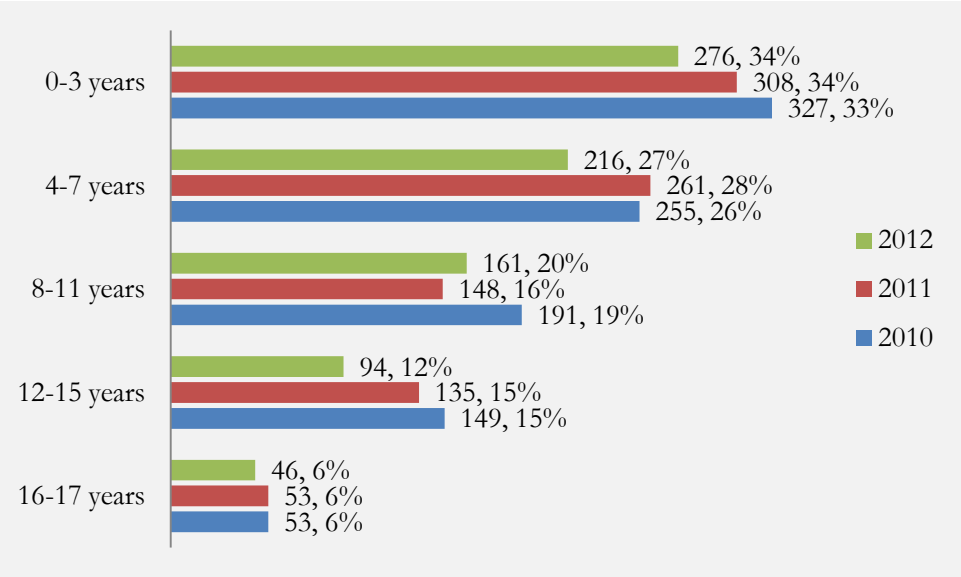
The majority of individuals filing complaints with the Ombudsman indicated that they were referred to the office by someone else. Almost a third (30 percent) of complainants reported that they were referred by a **community professional/service provider** (e.g., teacher, counselor, child care provider, doctor, private agency social worker, mental health professional, attorney, CASA/GAL, legislator's office). Over the last three years, a consistent number of individuals (12 to 13 percent) found OFCO through an **internet search or a phone directory**, as was the case with referrals from **family or friends** (17 percent) in the last two years, a decrease since 2010 (21 percent). Slightly fewer individuals knew about OFCO from a **previous contact** (13 percent, compared with 15.5 percent last year). More individuals were referred by a **DSHS employee** (20 percent) compared with previous years. The remaining complainants did not specify how they heard about OFCO.



Source: Office of the Family and Children's Ombudsman, September 2012

AGE OF CHILDREN IDENTIFIED IN COMPLAINTS

As in previous years, almost two-thirds (61 percent) of the children identified in complaints to the Ombudsman were seven years of age or younger. Older adolescents (ages 16-17) continue to be identified in much smaller numbers; consistently six percent of all children in the last three years.



Source: Office of the Family and Children's Ombudsman, September 2012
Note: Children identified in more than one complaint are counted more than once.
Note: 1 percent of children were 18 years or older in the last three years.

RACE/ETHNICITY OF CHILDREN IDENTIFIED IN COMPLAINTS

Because children may be identified with more than one race, it is difficult to accurately measure whether complaints to OFCO are 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, African American and Asian/Pacific Islander children are over-represented in complaints to the Ombudsman compared with the number of children in placement, and Hispanic children are under-represented. 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, while Asian/Pacific Island children are under-represented.

Race/Ethnicity	OFCO 2012	Children in Out-of-Home Care[19]	WA Child Population[20]
Caucasian	77.1%	59.7%	80.6%
African American	19.6%	9.8%	4.5%
American Indian or Alaska Native	10.9%	12.1%	2.0%
Asian or Pacific Islander	3.5%	1.4%	6.8%
Other	1.9%	3.4%	0%
Multi-Racial[21]	16.5%	11.8%	6.0%
Declined to Answer	1.4%	1.7%	--
Hispanic	10.7%	15.5%	15.5%
Caucasian, Not Hispanic	68.4%		72.5%

[19] Race of children in placement, taken from Children's Administration Performance Report 2008 http://www.dshs.wa.gov/pdf/ca/08Report1.pdf

[20] Race of general child population in Washington, taken from CA Performance Report 2008, ibid.

[21] 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.[22]

As in previous years, issues involving the **separation and reunification of families** (raised **255** times in complaints) and the **safety of children living at home or in substitute care** (raised **210** times in complaints), were by far the most frequently identified issues in complaints to the Ombudsman. As a percentage of total complaints, complaint issues involving **child safety** remained at a **similar level to last year** (about 38 percent), while complaint issues involving **family separation decreased slightly** (about 46 percent in 2012, compared with 48.5 percent in 2011).

Concerns about the *safety of non-dependent children reported for maltreatment in their parents' care* have **decreased steadily** since 2010, while concerns about the *safety of dependent children in out-of-home care* **increased slightly** compared to the last two years. In 2011 and 2012, OFCO tracked complaints about safety concerns during visits with parents as a distinct category, since we received a consistent number of complaints raising this concern (5 complaints in each year). Regarding 30-day health and safety visits to children in out-of-home care, it should be noted that OFCO found many more than one instance 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* **dropped significantly, to the lowest level since pre-2009**.
- 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* **dropped back to 2010 levels after a 24 percent increase** in complaints about this issue in 2011.
- Complaints about *failure to provide contact between children and their families* **decreased slightly** in 2012.
- Complaints about the agency's *failure to reunite families* **went back down to 2009-10 levels.**

Concerns about the **well-being and permanency of dependent children** (**raised 75 times** in complaints in 2012) have **dropped sharply** since 2009 (167 times) and 2010 (161 times). All sub-categories within this broad category decreased significantly in frequency, except for two issues – those involving independent living services, and adoptions. In general, it appears that families and other stakeholders in the child welfare community are *more satisfied with the agency's placement decisions, permanency planning, and services to dependent children*.

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

[22] 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).

complaints that identify multiple issues. Nevertheless, some changes regarding complaint issues may be worth noting. Complaints about **foster parent retaliation have dropped again** from seven in 2010 to five in 2011 and **two in 2012**; complaints about **licensing issues dropped** back to 2010 levels after almost tripling last year. Complaints regarding **lack of support of foster parents** also **decreased significantly**. Complaints about **communication failures by agency staff** remain the highest category of complaints about agency staff/services, although complaints about various forms of **unprofessional conduct or unreasonable demands by staff decreased to five** complaints in 2012, from nine in 2011 and 21 such complaints in 2010. Complaints about **unwarranted or unreasonable CPS investigations jumped** from four such complaints in 2011, to **eighteen in 2012**. OFCO received **no complaints about lack of coordination between DSHS Divisions** in 2012, down from seven in 2011.

FREQUENTLY IDENTIFIED COMPLAINT ISSUES	NUMBER OF COMPLAINTS		
	2010 (n=676)	2011 (n=608)	2012 (n=554)
CHILD SAFETY	**235**	**233**	**210**
Failure to protect children from parental abuse or neglect	**150**	**139**	**118**
Physical abuse	50	43	38
Sexual abuse	29	30	25
Emotional abuse	13	12	5
Neglect/lack of supervision	51	47	49
Other	7	7	2
Developmentally disabled child in need of protection	0	2	1
Children with no parent willing/capable of providing care	9	11	7
Failure to address safety concerns involving children in foster care or other non-institutional care	48	42	51
Child safety during visits with parent	--[23]	5	5
Failure to address safety concerns involving child being returned to parental care	25	28	27
Safety of children in institutions/facilities (non child-care)	3	1	2
Safety of children in child care facilities (Department of Early Learning)	3	2	1
Failure by agency to conduct 30-day health and safety visits to child in out-of-home care	--[24]	2	1
Inadequate services to maintain safety of children in home	--[25]	1	0

[23] Not separately tracked in 2010
[24] Not separately tracked in 2010
[25] Not separately tracked in 2010

	2010 (n=676)	2011 (n=608)	2012 (n=554)
DEPENDENT CHILD HEALTH, WELL-BEING AND PERMANENCY	**161**	**117**	**75**
Unnecessary/inappropriate change of child's placement, inadequate transition to new placement	35	47	28
Placement instability/multiple moves in foster care	7	2	3
Failure to provide child with medical, mental health, educational or other services, or inadequate service plan	41	31	15
Unreasonable delay in achieving permanency	9	5	3
Inappropriate permanency plan /other permanency issues	26	12	11
ICPC[26] issues	4	3	2
Foster Care to 21, independent living service issues	3	2	1
Failure to provide appropriate adoption support services/other adoption issues	33	15	15
Inadequate services to dependent/non-dependent children in institutions and facilities	14	0	0

FAMILY SEPARATION AND REUNIFICATION	**313**	**295**	**255**
Unnecessary removal of child from parental care	66	58	36
Unnecessary removal of child from relative placement	18	14	16
Failure to place child with relative	62	77	61
Failure to place child with sibling/s	--[27]	--	4
Failure to place child with other parent	0	1	1
Other inappropriate placement of child	25	18	20
Failure to provide appropriate contact between child and parent/other family members (excluding siblings)	57	41	37
Failure to provide contact with siblings	8	2	4
Failure to reunite family	65	76	67
Inappropriate termination of parental rights	2	5	7
Concerns regarding voluntary placement and/or service agreements for non-dependent children	8	2	2
Other family separation concerns	2	1	3

[26] 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.

[27] Tracked under "failure to place child with relative" in 2010 and 2011.

	2010 (n=676)	2011 (n=608)	2012 (n=554)
COMPLAINTS ABOUT AGENCY SERVICES	**49**	**64**	**64**
Inadequate CPS investigation	1	3	0
Unwarranted/unreasonable CPS investigation	--[28]	4	18
Delay in completing CPS investigation	3	4	1
Unreasonable CPS findings	29	30	28
Poor case management, high caseworker turnover, other poor service issues	1	3	2
Lack of coordination between DSHS Divisions	4	7	0
Inaccurate agency records	9	13	15
OTHER COMPLAINT ISSUES	**143**	**158**	**115**
Foster parent retaliation	7	5	2
Foster care licensing issues	9	28	9
Lack of support/services to foster parent, other foster parent issues	13	19	4
Retaliation against relative caregiver	1	0	0
Lack of support/services, other issues related to relative/suitable other/fictive kin caregiver	6	8	11
Breach of confidentiality by agency	14	18	15
Unprofessional conduct, harassment, retaliation or bias/discrimination by agency staff	10	7	4
Heavy-handedness, unreasonable demands on family by agency staff	11	2	1
Children's legal issues	12	8	4
Violation of parent's rights	9	10	9
Failure to provide parent with services/other parent issues	9	8	12
Communication failures	38	39	43
FamLink[29]-related issues (mostly delay in payment to foster parents/providers)	3	0	0
Child care licensing issues (DEL)	--[30]	3	0
Inadequate child fatality review	0	1	0
Violations of the Indian Child Welfare Act	--[31]	2	1

[28] Not tracked separately in 2010
[29] FamLink is CA's database (SACWIS system) which replaced the CAMIS system in late January 2009
[30] Not tracked separately in 2010
[31] In previous years this issue was tracked under children's legal issues

III. TAKING ACTION ON BEHALF OF VULNERABLE CHILDREN AND FAMILIES

INVESTIGATING COMPLAINTS

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

"You all saved my granddaughter years ago from DCFS. By the way, she is doing great thanks to your office."

~ Grandmother

INVESTIGATING COMPLAINTS

The Ombudsman reviews every complaint received to determine whether it falls within OFCO's jurisdiction.[32] Through impartial investigation and analysis, the Ombudsman determines an appropriate response such as:

- 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.
- When 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 OFCO's jurisdiction.
2. The action did occur.
3. The action violated law, policy or procedure, or was clearly inappropriate or clearly unreasonable under the circumstances.
4. The action was harmful to a child's safety, health, well-being, or right to a permanent family; or harmful to appropriate family preservation/reunification or family contact.

[32] The Ombudsman may also initiate an investigation without a complaint. During the 2012 reporting period, OFCO initiated ten investigations.

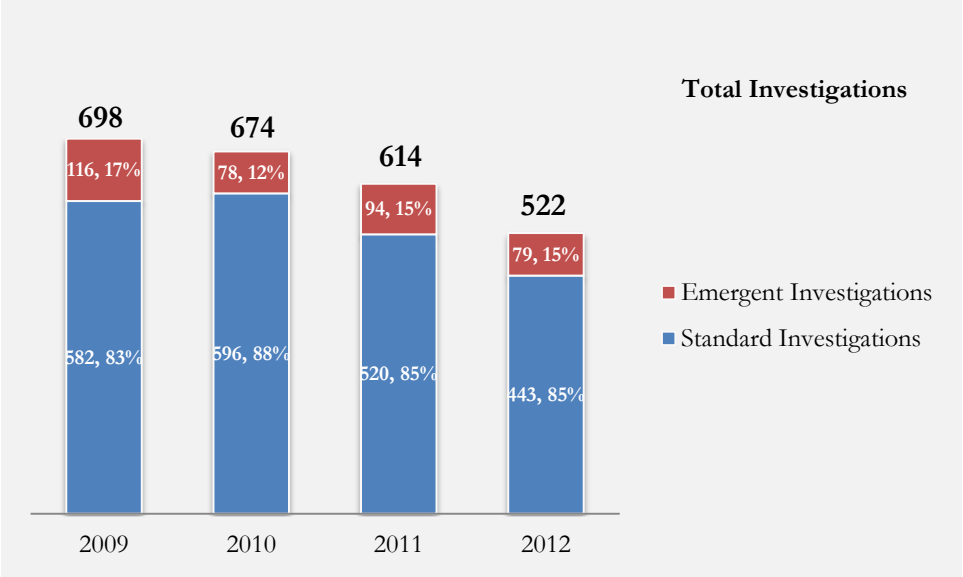
COMPLETED INVESTIGATIONS AND RESULTS

COMPLETED INVESTIGATIONS

OFCO completed **522 complaint investigations** in 2012. These investigations involved **805 children and more than 498 families**. As in previous years, the majority of these investigations were **standard non-emergent investigations** (85 percent).

Again in 2012, about one out of every seven investigations (15 percent) met OFCO's criteria for initiating an **emergent investigation,** i.e. when the allegations in the complaint involve either a child's immediate safety or an urgent situation where timely intervention by 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 2012, the Ombudsman intervened or provided assistance to resolve concerns in 21.5 percent of emergent complaints, compared with 7.2 percent of non-emergent complaints. Of the emergent complaints, 14 percent were resolved without Ombudsman intervention or assistance.

Type of Investigations Completed
September 1 to August 31
Numbers for 2012: Emergent – 79 (15%); non-Emergent 443(85%)



Source: Office of the Family and Children's Ombudsman, September 2012

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.

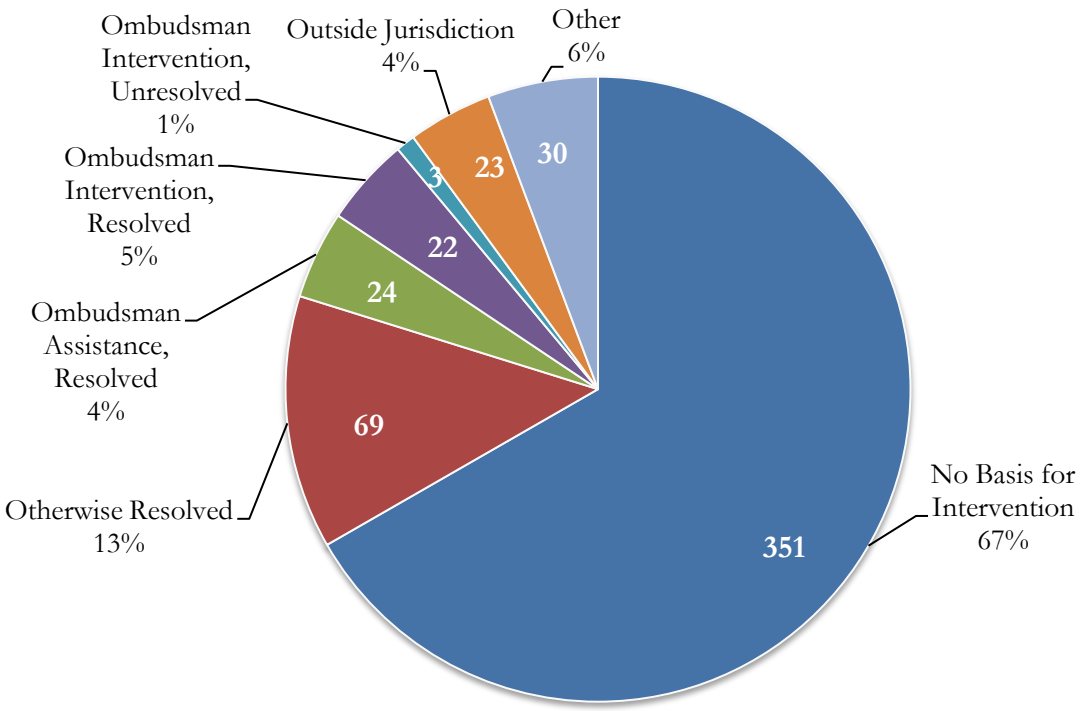
- **No Basis for Intervention:** The complaint issue was unsubstantiated, and the Ombudsman found no agency errors in reviewing the case. The Ombudsman explained why the alleged action is not a violation of law or policy or unreasonable under the circumstances and helped the complainant better understand 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 four years. The Ombudsman **assisted or intervened** to resolve the situation in almost **ten percent of complaints** in 2012. This represents **49 complaints**. The Ombudsman found **no basis for further action in 67 percent** of complaints this year (compared to 71 percent in 2011 and 64 percent in 2010).

Investigations Results
Total Complaints=522



Source: Office of the Family and Children's Ombudsman, September 2012

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. **Twenty-five complaints required intervention by the Ombudsman.**[33] 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 three 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 (94 percent)**. Here are three examples:

EXAMPLE 1: TEENS PROTECTED AND UNSUITABLE FOSTER HOME CLOSED

OFCO received a complaint about the safety of two teenaged siblings who had been placed in a dependency guardianship with licensed foster parents for several years. One of the youths disclosed inappropriate touching by her foster father. During the DLR/CPS investigation into these allegations, the youth disclosed that her foster father had told her she needed to "rearrange things" if she didn't want him to go to jail, and her foster mother had told her to "knock it off." The youth felt that both of her foster parents were very angry with her for disclosing the inappropriate touching. DLR and DCFS decided that the girls could remain in the home with a safety plan in place that required the foster mother to ensure that the youth had no unsupervised contact with the foster father. But during safety visits to the home by DCFS social workers, the foster mother expressed extreme hostility towards the youth, defended her husband, and accused the youth of lying. Both siblings told the social workers that they did not feel safe in the home due to the foster mother's anger.

The Ombudsman found the decision to leave the two youths in this home despite safety concerns and the foster mother's open hostility to be clearly unreasonable. The Ombudsman asked CA Headquarters to review the DLR and DCFS decision to leave the youths in the home. As a result, DCFS began seeking an appropriate placement for the two siblings and they were moved two days later, after a Family Team Decision-Making Meeting could be held. The siblings did not return to this home and the guardianship was later vacated.

DLR/CPS completed its investigation and determined that the allegations of sexual abuse by the foster father were unfounded. However, the investigation raised significant concerns about the character and fitness of the foster parents to provide appropriate care to dependent children. The Ombudsman learned that DLR was planning to enter into a compliance agreement with the foster parents and maintain their foster care license. **The Ombudsman contacted CA Headquarters and asked that management review any decision to maintain this foster license given the considerable character and fitness concerns.** As a result, DLR is in the process of revoking the foster home license.

[33] This represents 4.8% of complaints, similar to last year's numbers totaling 5%.

EXAMPLE 2: FAMILY REUNIFICATION FACILITATED

A complainant alleged that DCFS/CFWS was failing to return a 15-year-old dependent youth to his mother's care, despite the fact that the mother had completed services and was now capable of caring for her son. Because the mother lived in a neighboring state, placing the youth with her required an approved ICPC home study, which was in progress but not yet completed. Furthermore, the complainant was concerned that the youth's behavior in his BRS group home was deteriorating to the point that he was at risk of being committed to juvenile detention due to probation violations and a juvenile offender charge resulting from his behavior at the group home.

DCFS was not recommending the immediate return of this youth to his mother's care, for two reasons: First, the mother's ICPC home study was not completed. Second, DCFS believed that the youth's behavior problems at the group home and school indicated that he was not ready to be placed with his mother in a less structured environment. Although an immediate placement with the mother was not feasible, **the Ombudsman questioned the agency's authority to delay reunification despite the parent's completion of all court-ordered services to address the parental deficiencies identified in the dependency action**. Thereafter, a compromise was reached between the youth, his mother, and the professionals involved with the youth. DCFS was able to secure a new placement for the youth in a group home in the state where the mother lives. This allowed for increased visitation and the mother's regular participation in the youth's therapeutic treatment. DCFS agreed to consider returning the youth home after three months if he could demonstrate positive behaviors and the mother's home study was approved.

EXAMPLE 3: MISTAKEN INFORMATION CORRECTED

OFCO received a complaint alleging that mistaken information in DCFS records was being used against a 16-year-old youth. Specifically, in 2008, CPS received a report describing sexual behavior between two four-year-old children, "David M" and "Jane S", which allegedly occurred at a daycare facility. Three years later, in May 2011, CPS received a report alleging that "David S", then 15 years old, inappropriately touched now seven-year-old Jane S. In closing this 2011 investigation, the CPS social worker had described David S's extensive history of concerning behavior, including the 2008 allegation which actually concerned "David M", not "David S".

OFCO concluded that erroneously attributing the 2008 Intake to David S was clearly unreasonable. Even a casual review of the 2008 intake shows a different last name and a significant age difference between David M and David S. Additionally, according to the complainant, this error had a significant adverse impact on David S and his involvement with the juvenile justice system.

OFCO contacted the CA Area Administrator (AA) to bring this error to her attention. Because the information could not now be corrected in the DCFS case information system, the AA wrote to David S's parent, and provided several copies of a letter the parent could distribute as needed, correcting the error. The AA also offered to discuss this issue, upon obtaining a release of information, with anyone in need of additional information or clarification. Finally, the AA stated that a copy of the correspondence with the parent would be placed in the case file and a case note addressing this error and describing corrective actions taken would be entered in FamLink.

FEW INTERVENTIONS BY THE OMBUDSMAN REMAIN UNRESOLVED

In **five complaints in which the Ombudsman assisted or intervened**, the agency did not change its position. In two of these cases, the Ombudsman determined that the agency's decision not to change its position was ultimately acceptable. For example:

MOVE FROM LONG-TERM PRE-ADOPTIVE FOSTER HOME

OFCO received several different complaints regarding the removal of two legally free siblings, ages eight and five, from their pre-adoptive foster home. The children had been placed in this foster home for three years. The agency's stated reason for the removal was that an allegation that an older child in the home had inappropriately touched the five-year-old created safety concerns. However, a safety/supervision plan had been put into place following the incident that was intended to address those safety concerns and it was unclear why DCFS now considered the safety plan insufficient. The foster parent had been licensed for many years and had never had licensing complaints until the current adoption social worker was assigned to the case. When the Ombudsman reviewed the case, the DCFS records showed that both children were experiencing difficulties since being removed from this home, and that the siblings were now separated after several placement changes in short succession.

The Ombudsman contacted the Deputy Regional Administrator to request managerial review of the case given the children's long-term placement in the pre-adoptive foster home and their subsequent instability in foster home placements, which resulted in the siblings being separated. The Ombudsman also inquired whether foster homes within the foster parent's network of respite providers and community members who knew the children had been considered for placement.

The DCFS Adoptions Area Administrator (AA) responded that concerns regarding the home had been mounting for the last couple of years and that the current DLR/CPS investigation was one of a series of CPS and licensing investigations concerning the caregivers. DCFS had previously provided services in the pre-adoptive home as well as an evaluation by the Foster Care Assessment Program, in an effort to address the identified concerns and preserve this placement. DCFS had also offered the former pre-adoptive caregiver the opportunity to complete a psychological evaluation to inform decision-making about adoption of these children.

The AA also reported that community members who knew the children were considered for placement, but that none of those who came forward as potential placement possibilities had sufficient bedrooms to accommodate the children. The AA invited any persons who knew the children and who were interested in adopting them to contact the AA directly.

The Ombudsman continued to monitor this case for several months to ensure that the children's placements and behaviors were stabilizing and that DCFS was making efforts to reunify the siblings. In the meantime, circumstances grew more complicated with respect to the previous pre-adoptive placement. The caregiver completed a psychological evaluation that recommended against placing these or any other foster

children in the home. This contributed to DCFS's decision to deny her adoption home study. Thus, in the end, DCFS reasonably concluded that it could not support returning the children to their previous placement.

The children are now placed together (after ten months apart) in a pre-adoptive home. **A critical factor of these children's experiences in foster care has been placement instability.** For the older child, his current placement is his fourth placement since leaving the long-term placement (and his thirteenth placement overall, in addition to two failed reunification attempts). For the younger child, this is also his fourth placement since the long-term placement (his ninth since entering foster care, in addition to one failed reunification).

The agency **did not change its position** despite Ombudsman intervention or assistance in three **complaints** in 2012, and the complaint or other problematic issue identified by the Ombudsman **remained unresolved**. This kind of scenario often involves complex cases in which there are multiple stakeholders in addition to CA who can impact the outcome of the case. The details of the exchange between OFCO and CA regarding the unresolved issues in one of these cases are provided on pages 57-61.

OMBUDSMAN OFFERS ASSISTANCE TO RESOLVE COMPLAINTS WITHOUT "INTERVENING"

Complaints receiving "Ombudsman Assistance" are different from complaints in which the Ombudsman intervened, as the agency's conduct was not a clear violation of law or policy or clearly unreasonable. Even so, the complaint had validity justifying the Ombudsman's assistance in resolving the concerns. In 2012, **24 complaints** 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*. This represents **4.6 percent of complaints**, **an increase since 2011**, when the Ombudsman provided direct assistance to resolve a complaint in three percent of complaints.

For example:

INFORMATION SHARING BETWEEN DCFS AND FAMILY COURT DECISION-MAKERS

While CPS was investigating sexual abuse allegations by a father against 7-year-old adopted twins, the parents were also involved in a child custody action in family court. The children's family court guardian ad litem (GAL) was planning to recommend reinstating unsupervised visits between the father and the children, based on initial determinations that their disclosures were not credible. During recent forensic interviews however, the children had provided more credible details of the abuse. The Ombudsman was concerned that the family court GAL might not have the most current information regarding the children's disclosures of sexual abuse, as well as their descriptions of drug use and gun violence in the father's home. The Ombudsman contacted the CPS supervisor and social worker to ensure that the GAL had received all relevant information including the children's most recent statements. At the family court hearing, the judge ordered no contact between the children and their father until the CPS and law enforcement investigations were complete.

COMPLAINTS RESOLVED WITHOUT SIGNIFICANT ASSISTANCE BY THE OMBUDSMAN

In 2012, **13 percent of complaints were resolved between the agency and the complainant without significant assistance or intervention by the Ombudsman**. In most of these 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:

FAILURE TO REPORT SUSPECTED CHILD ABUSE

OFCO determined that several mandated reporters, including CA contracted service providers, and a DCFS/CFWS supervisor and social worker, failed to report suspected child abuse of an eight-month-old dependent child. While facilitating parent-child visits, the person who transported the child as well as the person supervising the visits observed extensive bruising on the infant's ears. The visit transporter also spoke with the foster parent about the bruising and felt that the foster parent's explanation did not seem consistent with the child's injuries. Despite this, neither the visit transporter nor the visit supervisor made a report to CPS.[34] The visit supervisor stated that she informed the child's CFWS social worker and supervisor about the child's injuries. However, neither the social worker nor the supervisor made a report to CPS. As a result, CPS did not receive an intake regarding these unusual and unexplained injuries until two weeks after the bruising was first observed. By that time, cell phone photos were the only evidence available for the DLR/CPS investigator and medical professionals. This delay hampered DLR/CPS's ability to determine whether the child was physically abused.

The Ombudsman contacted the DLR/CPS supervisor involved in this investigation about the mandated reporters' failure to report suspected child abuse. OFCO learned that DLR/CPS had already taken corrective action with the contractor providing transportation and supervision for parent-child visits, as to their responsibility to report suspected child abuse or neglect. Also, the Area Administrators for DLR/CPS and CFWS were addressing this issue with the CA employees who allegedly failed to report suspected child abuse. Thus, the agency resolved this issue to the Ombudsman's satisfaction and no further action was needed.

[34] See RCW 26.44.030(1)

OMBUDSMAN FINDS NO BASIS FOR INTERVENTION

In 2012, 67 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.[35] Regardless, 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:

FAILURE TO PLACE CHILD WITH A RELATIVE IS DETERMINED TO BE REASONABLE UNDER THE CIRCUMSTANCES

A relative contacted OFCO regarding DCFS/CFWS's failure to place a 12-year-old dependent youth with her. The relative was already caring for the youth's newborn sibling, and the 12-year-old had expressed his desire to live with this relative. Although state law and policy supports placement of dependent children with relatives (as well as placing siblings together) when possible, DCFS policy requires that a relative home study be completed prior to placement unless the placement is urgent or emergent. Because the 12-year-old was already living in a foster home, DCFS was unable to recommend placement with this relative until a home study was completed and approved. A home study was in progress; thus, the Ombudsman found that DCFS was following its policies and procedures, and had no basis for further intervention regarding this issue.

During the course of OFCO's investigation, the Ombudsman learned that the 12-year-old youth did not have an attorney to represent his wishes. The Ombudsman contacted the CFWS supervisor to ensure that the assigned social worker discussed this with the youth and report to the court if the youth requested an attorney. The Ombudsman also learned that this DCFS office was experiencing an 8-9 month backlog for relative home studies. Ultimately, given this delay, the parents brought a motion to the court requesting that the youth be placed with the relative over DCFS objection. The youth was assigned an attorney and the court ruled in favor of the relative placement.

PROFESSIONAL DISAGREEMENT REGARDING TRANSITION PLANNING

In another example, the Ombudsman found no violation of law, policy, or procedure regarding DCFS/CFWS' plan to move 1-year-old and 3-year-old dependent children from one foster home to another. The children were initially placed out of region due to a shortage of foster homes near their community. From the outset of this placement, DCFS sought an appropriate local placement and planned to move the children as soon as possible in order to facilitate visits and reunification. Although it was unfortunate that the children had to be moved, the move was reasonable in light of DCFS's legal obligations to make reasonable efforts to reunify children with their parents.

This complaint also illustrates how professionals can reasonably disagree regarding how to plan transitions between placements for young children. Here, an infant mental health therapist working with the children in their foster home recommended a gradual transition of at least a week to allow the children to meet the

[35] This percentage was lower than in 2011, when 71 percent of investigations were closed as unsubstantiated or with no basis for intervention by the Ombudsman.

new foster parents and say good-bye in their current home and community. The therapist also recommended that the children be allowed some contact with their previous foster parents after the move to minimize trauma. DCFS, the children's guardian ad litem (GAL), and the parents believed that moving the children right away with no transition period would be better given the ages of the children and the fact that they had only been placed in this foster home for 5 months. The GAL did not believe the children should even be told that they were moving. After the therapist contacted the DCFS Area Administrator directly to discuss the transition plan, the transition was extended to provide the foster family the weekend to prepare the children for the move, including introducing them to the new foster parents.

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 disclose information to caregivers regarding a child's behaviors	CFWS failed to provide the foster parents of a 6-year-old dependent child with information regarding the child's behavioral problems, which required close supervision. The foster parents' child was subsequently harmed by the foster child. CFWS also failed to provide key information to the group home where the child was moved, about the child's past behaviors and supervision needs. Full information had not been included as required by policy, on the Child Information/Placement Referral form for either of the two placements.	The Ombudsman contacted the supervisor and social worker to request that the relevant information be shared with the child's current placement.	The social worker outlined the child's needs in writing to the group home where the child is placed.
Failure to staff high-risk case with Child Protection Team (CPT)	A case involving physical abuse of a 2-year-old child was not staffed by a CPT because inaccurate information was used to complete the risk assessment tool. As a result, the case was transferred to Family Voluntary Services without review by the CPT. The Ombudsman found that the case should have been assessed as high-risk to child safety, as the parent appeared to be continuing a relationship with the perpetrator and minimizing the perpetrator's role in causing the injury to the child.	The Ombudsman contacted the CPS supervisor and requested that the level of risk in this case be reassessed based on accurate information, and that the case be presented to the CPT.	The case was presented to the next scheduled CPT, which recommended that child be referred to a HeadStart program to increase protective factors for the child.
Failure to assist parent to protect children from physical abuse	CPS failed to help a mother protect her two children, ages 10 and 11, from physical abuse by their father. The father had also previously abused the mother when they were married. CPS erroneously informed the mother that CPS did not provide parents with letters to help them obtain orders of protection in family court. This is contrary to policy laid out in the Domestic Violence Practice Guide.	The Ombudsman contacted the Area Administrator about ways to support the mother in her attempt to obtain a protection order for her children.	The CPS social worker drafted a letter for the mother and agreed to make copies of the case file for the mother to provide to the court.

Erroneous information submitted to court	CFWS asked the court to move an 18-month-old dependent child from the relative placement where she had been placed since birth. In support of this motion, the CFWS social worker's declaration to the court stated that the relative caregiver had a history of two involuntary psychiatric commitments. The Ombudsman found that the medical records did not support this statement.	The Ombudsman contacted the CFWS supervisor and brought this error to her attention.	The supervisor reviewed the declaration and the medical records and agreed with OFCO's investigative finding. The supervisor corrected the information in a revised declaration, which was submitted to the court prior to the hearing. The court denied DCFS' request to move the child.

OMBUDSMAN IN ACTION: FACILITATING RESOLUTION

Key Issue	Investigative Finding	Ombudsman Action	Outcome
Lack of educational continuity for youth with special needs during time of crisis and placement out-of-county	CPS filed a dependency petition for a 15-year-old youth and placed her in an adjacent county. As a result of the out-of-county placement, she was unable to continue attending her original high school, where she received special education services and was making progress. The Ombudsman found that CA was unreasonably failing to explore other options for the youth to have educational continuity.	The Ombudsman contacted the Area Administrator (AA) to inquire about other options that would allow the youth to continue to attend her school. The Ombudsman also facilitated direct contact between the youth's school and the AA.	CA worked cooperatively with school staff and arranged transportation from the youth's placement to her school.
Inaccurate records create a barrier to permanency	A grandparent had been the relative placement for her two dependent grandchildren, ages 4 and 12, for more than a year. The children were thriving in the grandparent's care and a relative guardianship was determined as the optimal permanency plan for the children. However, a CPS finding of child abuse or neglect from the mid-1990's appeared on the grandparent's record, disqualifying her for a foster care license and consideration as a permanent placement option for the children. After careful investigation, the Ombudsman determined that the CPS finding of child abuse or neglect was likely an error.	The Ombudsman contacted the Deputy Regional Administrator, who agreed that the finding appeared to be inaccurate. The deputy agreed that a resolution needed to be sought to allow the permanency plan for the children to be achieved.	DCFS agreed to enter a written explanation into the case file addressing the inaccurate finding, and allowing the foster care licensing process for the grandparent to go forward.
Failure to provide reasonable contact between dependent children and an out-of-state parent	CFWS failed to facilitate reasonable contact between two dependent children, ages 1 and 3, and their parent, who had relocated out-of-state. The parent had no contact with the children for two months following the move.	The Ombudsman contacted the CFWS supervisor several times about facilitating visits and telephone contact between the children and parent.	The supervisor approved a weeklong visit for the children with their parent, and phone visits were arranged utilizing Skype.

Unnecessary CPS involvement with family	CPS opposed a family's plan to place an unborn infant with his grandparents upon the child's birth. The mother had an ongoing dependency action for her older children and was prohibited from having contact with minors; the father was deployed overseas. CPS had concerns about the grandparents based on prior CPS history and the family's reluctance to provide CPS with copies of the documents authorizing the grandparents to take custody of the child. CPS planned to wait until the child was born and then conduct a relative home study to assess the grandparents for placement.	The Ombudsman contacted the Area Administrator and recommended that the department meet with the family as soon as possible, and not wait until the infant is born.	A Family Team Decision-Making Meeting was held and CPS's concerns were resolved. Arrangements were finalized for the grandparents to take custody of the infant upon birth without DCFS's involvement.

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

Key Issue	Investigative Finding	Ombudsman Action	Outcome
Inappropriate permanency plan for dependent child	CFWS requested that the permanency plan for a 9-year-old dependent child be changed to third party custody. The parents opposed this plan. The Ombudsman found this to be contrary to agency policy requiring parental consent for third party custody of dependent children.	The Ombudsman contacted the Regional Administrator to request a review of the case and provide clarification regarding policy on third party custody.	After review, the agency management agreed that CFWS's request for third party custody as the primary plan without first obtaining the parents' consent was an error. CFWS changed its recommendation to guardianship. The court ordered two primary permanency goals: guardianship and reunification. The child was ultimately reunified with her parents.
Failure to investigate allegation of child neglect	CPS screened out for investigation several reports alleging lack of supervision, inadequate, food, truancy, and hygiene concerns for two non-dependent children, ages ten and fourteen. The Ombudsman was concerned that CPS would screen out a new referral reporting similar allegations.	The Ombudsman contacted the CPS supervisor to ensure that the latest referral would be reviewed and screened for investigation consistent with department policy.	The referral was accepted for investigation and the children were placed into protective custody based on clear evidence of neglect.
Failure to consider relatives for placement of a legally free child	CFWS refused to consider a grandmother as a placement for an 11-year-old dependent child. This child had been in foster care for six years and had been placed in eleven different homes. The Ombudsman found that no permanent placement for the child had been identified and CFWS did not have a good reason for not considering this relative.	The Ombudsman contacted the Area Administrator and requested that CFWS consider conducting a new relative search and consider relatives for placement of this legally free child.	The grandmother was referred for a relative home study.

Failure to provide services to address unsafe parenting	Family Voluntary Services (FVS) planned to close its case involving a parent with two children, ages 2 and 3, despite ongoing reports of neglect. FVS was basing its decision on the fact that the family was residing in a supportive housing program as a safety factor. The Ombudsman found this to be unreasonable, as the housing program reported several child safety concerns and repeatedly asked DCFS to provide additional services.	The Ombudsman contacted the Deputy Regional Administrator and brought the child safety concerns to her attention.	DCFS determined that the case would remain open and additional services would be provided to strengthen and preserve the family.
Unsafe plan for in-home placement	CFWS was planning to allow two young children, ages 2 and 3, who had been removed from their parents, to return home prior to the dependency fact-finding hearing. The Ombudsman found this plan to be clearly unreasonable as the mother was still living with the perpetrator of serious physical abuse against the 3-year-old child.	The Ombudsman contacted the Area Administrator (AA) and brought the concerns with the case plan to the AA's attention.	The AA and CFWS supervisor agreed that an in-home placement was not appropriate. DCFS requested, and the court ordered that the children remain in out-of-home placement. The perpetrator later moved out of the home, and the children were returned to the mother after the dependency trial.
Failure to investigate allegation of child neglect	CPS screened out for investigation several reports alleging lack of supervision, inadequate, food, truancy, and hygiene concerns for two non-dependent children, ages ten and fourteen. The Ombudsman was concerned that CPS would screen out a new referral reporting similar allegations.	The Ombudsman contacted the CPS supervisor to ensure that the latest referral would be reviewed and screened for investigation consistent with department policy.	The referral was accepted for investigation and the children were placed into protective custody based on clear evidence of neglect.

Failure to ensure youth's well-being	A 14-year-old legally free youth was signed up to attend a summer camp that he had attended for several years. Two days before he was scheduled to leave, it was discovered that there was not a waiver allowing the youth to travel out-of-state. As there was not enough time to obtain the needed waiver, CFWS informed the youth that he could not attend camp this year. The youth was bitterly disappointed.	The Ombudsman contacted the Area Administrator and Regional Administrator and urged them to allow the youth to attend camp.	The agency changed its position and the youth was permitted to attend the camp.

OMBUDSMAN IN ACTION: PREVENTING FUTURE MISTAKES

Key Issue	Investigative Finding	Ombudsman Action	Outcome
Inadequate CPS investigation	CPS determined that an allegation of neglect by the parents of three non-dependent children, ages 3, 4 and 7 was unfounded, despite the fact that law enforcement removed the children from the home because they had no food available, were sleeping with inadequate bedding, and the conditions of the home were unsafe. The Ombudsman found that CPS failed to conduct an adequate investigation. Specifically, the social worker failed (or failed to document) to interview the subject children, and made no collateral calls such as to schools or medical providers.	The Ombudsman contacted the Area Administrator and requested a review of the investigation. The Ombudsman expressed concern that the unfounded finding may lead to the children's return to their parents' care without adequately addressing parental deficiencies and safety concerns.	The Deputy Regional Administrator reviewed the investigation and agreed with the Ombudsman's concerns. Although the investigation could not be re-done nor the finding changed, it could be used as a training tool to prevent similar errors in future investigations. The children remain in out-of-home placement while the parents engage in services.

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."

COMMUNICATION OF ADVERSE FINDINGS TO DSHS

As set forth in the November 2009 interagency agreement entered into between OFCO and DSHS[36], 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.

[36] 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 2011-2012

Issue	Number of Adverse Findings	
	2011	2012
Child Safety	**12**	**14**
Failure by CFWS to ensure/monitor dependent child's safety		
• findings regarding health and safety visits	3	2
• failure to inform guardian ad litem of CPS referral on dependent child	1	-
• unsafe placement of dependent child	1	1
• failure to provide safe parent-child visitation plan	-	1
• inappropriate plan for transport of dependent child	-	1
• failure to provide foster parent with information about child's needs	-	1
Failure by CPS/FVS[37] to ensure/monitor non-dependent child's safety	1	3
Inadequate CPS investigation/case management	3	2
Failure to screen in CPS referral for investigation/other screening errors	2	-
Failure to staff case with Child Protection Team prior to return home	-	1
Inappropriate CPS or DLR/CPS finding (unfounded)	1	2
Family Separation and Reunification	**6**	**6**
Failure to reunify family	1	-
Failure to provide appropriate contact between parent and child	1	2
Failure to provide sibling visits	1	1
Failure to provide contact with relative/fictive kin		2
Unreasonable removal of non-dependent child from home	1	-
Failure to place child with relative	1	1
Failure to place child with non-custodial parent	1	-

[37] Family Voluntary Services.

Dependent Child Health and Well-Being	**5**	**2**
Placement issues (incl. placement delays, inadequacies, unavailability)		
• unnecessary/multiple moves	2	-
• inadequate transition plan	1	-
• unreasonable plan to move child based on non-safety related licensing issues	1	-
• unreasonable threat to move child from long-term relative care	-	1
• inadequate foster home	-	1
Failure to provide CHET screen in a timely manner	1	-

Dependent Child Permanency	**6**	**1**
Inappropriate permanency plan for dependent child	-	1
Delay in permanency	5	-
Failure to obtain Regional Administrator approval to move child from long-term foster home	1	-

Parents' Rights	**14**	**8**
Failures of notification, public disclosure or breach of confidentiality	4	1
Delay in completing/closing CPS investigation	6	7
Unreasonable finding of CPS investigation	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	**7**	**2**
Violation of foster parent rights • failures of notification	5	2
Unreasonable licensing delays/other licensing errors	2	-

Children's Legal Issues	**2**	**0**
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	**8**	**6**
Inadequate adoption home study	1	1
Failure to follow CPS child interview protocol	1	-
Failure to conduct supervisory reviews	-	2
Inaccurate, incomplete or delayed documentation	1	3
Other poor practice	5	-

Relative Caregiver Issues	**2**	**1**
Failure to notify caregiver		
• of CPS finding	-	-
• of court hearing	2	-
• of move of dependent child	-	1

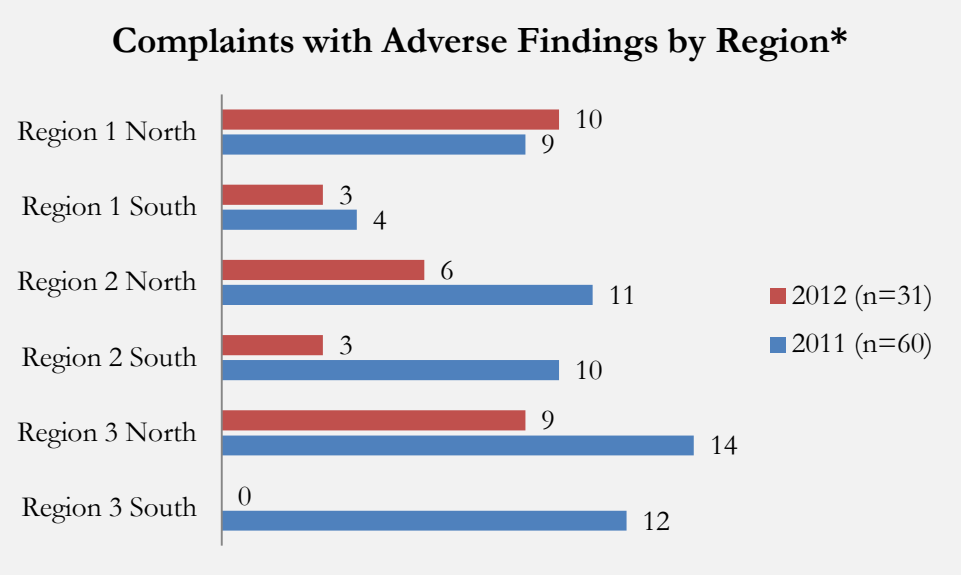
FamLink Issues	**1**	**0**
Failure to expunge old CPS referrals per RCW 26.44.031	1	-

Other Findings	**2**	**1**
Lack of coordination between DSHS divisions resulting in harm to child/family	1	-
Inadequate child fatality review	1	-
Delay in completing DLR/CPS investigation (licensed daycare)	-	1
TOTAL NUMBER OF FINDINGS	**65**	**41**
TOTAL NUMBER OF CLOSED COMPLAINTS WITH ONE OR MORE FINDING	**60**	**31**

The number of adverse findings against the agency **decreased in 2012** (a total of **41 findings**) from 2011 (**65 findings**). This decline in the overall number of adverse findings may be due initiatives to improve the child welfare system and/or decreased staffing levels at OFCO during the reporting year. With fewer staff, OFCO focused our time and resources on child safety issues and taking action to correct errors where we could have an immediate impact. Indeed, the above table shows there were **more findings this year related to child safety concerns** (fourteen findings compared to twelve findings in 2011). Child safety was again the most common category of adverse findings (accounting for **34 percent** of the adverse findings). This represents a **significant increase over last year**, when child safety accounted for nineteen percent of the findings. The next largest category of adverse findings involved **violations of parents' rights** (accounting for **20 percent** of the total findings). For example, OFCO has found that Child Protective Services routinely fails to complete investigations of child abuse or neglect within 45 days as required by policy or within 90 days as required by state law. The timely completion of investigations ensures due process for subjects of the investigation (often parents) who may be anxious to resolve allegations of maltreatment. This was consistent with the percentage of findings in this category in 2011 (21.5 percent).

ADVERSE FINDINGS BY DSHS REGION

This year, the **number of complaints with adverse findings in each of the three larger DSHS Regions was relatively even**. **Region 1** North and South had **13 findings**; **Region 2** had **9**; and **Region 3** had **9**. By contrast, the number of adverse findings compared to last year varied considerably. Overall, the number of findings in Region 1 (13) was the same as last year. Findings in Region 2 and 3 were considerably lower than last year. The most significant decreases were in Region 2 South (King County) – down to 3 from 10 in 2011 – and Region 3 South (Southwest Washington), which had no adverse findings in 2012, down from 12 in 2011.



Source: Office of the Family and Children's Ombudsman, October 2012

***Note**: The total number of adverse findings for all complaints with findings was 41 in 2012 and 65 in 2011.

AGENCY RESPONSES TO ADVERSE FINDINGS

Pursuant to the Inter-Agency Agreement between OFCO and the Department of Social and Health Services,[38] 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; three 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 one of these three 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 provide the caregivers of a six-year-old dependent child in out-of-home care with information regarding the child's behavioral problems which required close supervision. These behaviors were the subject of a department staffing held six months prior to this placement following behavior problems reported by previous foster parents of the two children.

OFCO found no documentation in FamLink indicating that information about the child's past behaviors had been shared with the child's subsequent caregivers. OFCO also confirmed that full information had not been included in the Child Information/Placement Referral form. This is a violation of agency policy[39], which requires that "Caregivers of children in out-of-home placement must be provided all information about the child(ren) being placed in their care." OFCO requested that this information be shared with the current caregiver and as a result, the social worker provided that information in writing.

CA RESPONSE

"I would like to thank your office for taking the time to review the documentation [in this case]. We will not be submitting a statement to either augment or counter your office's findings. Suffice it to say that the basis for the findings has and will be used for future training and guidance with staff. Yesterday and today I have followed up with the staff concerned and clarified our responsibilities."

CA DISAGREEMENT, OFCO MODIFICATION OF AN ADVERSE FINDING

OFCO'S ORIGINAL FINDING

DCFS/CFWS refused to allow contact between a seven-year-old legally free child and several biological relatives who wanted to maintain a relationship with her. This was not a violation of law or policy, as the agency has discretion to allow visits or contact between legally free children and biological relatives as the agency determines is appropriate. However, OFCO found this decision to

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

[39] Children's Administration Practices and Procedures Guide, §4413, Placement Services

be clearly unreasonable under the circumstances. OFCO considered the following factors in making this finding:

- The child was previously placed with her maternal grandfather and maternal uncle. She was moved from that placement due to the relatives' inability to meet her exceptional medical needs, but there was a strong bond between the child and these relatives. After being moved, the child on at least three occasions told her caseworker that she missed her grandfather and uncle greatly and wanted to see or call them. Her requests were denied.
- The paternal grandmother regularly requested contact or visits, and her requests were not granted. OFCO found no reasons why contact should not be allowed with this relative who was an active part of the child's life prior to her being placed in foster care.
- An aunt who lives out-of-state, and wanted to adopt the child came to Washington to attend a court hearing addressing the child's placement. The aunt requested a visit with the child, and made travel arrangements to allow time for a visit. This request was also refused. It is unclear why a visit from an out-of-state relative who expressed deep care for this child and would like to maintain a relationship with her, would be not in the child's best interests.

DCFS stated that it based its decision on a recommendation from the child's therapist, as well as the recommendation of the child's CASA. OFCO reviewed the letter from the child's therapist, recommending against the child having contact with her biological parents or relatives. The letter did not provide evidence that contact with her relatives would be harmful to the child.

While the child appears to be doing well in her foster home, she is still not having any contact with any of her biological relatives.

OFCO contacted the Deputy Regional Administrator to discuss this case, and general concerns about several other cases reviewed by OFCO in which failure to place or allow contact with a relative has been an issue, as well as over-reliance on the professional opinions of therapists.

CA REQUEST FOR MODIFICATION OF FINDING

CA's six page response provided detailed information explaining its recommendations to the court regarding both placement and visitation with the child's relatives. The following summary focuses on why the department recommended against visits with the relatives.

In regards to contact with the maternal grandfather and maternal uncle:

- *During an initial placement of the child with these relatives in 2010, they allowed unsupervised contact with the biological mother and maternal grandmother, including overnight visits. Initially the grandfather and uncle denied allowing the mother and maternal grandmother this contact, but later admitted doing so. The child was removed from their home as a result.*
- *The Department did not hear from the maternal grandfather or the maternal uncle for nine months after the child was removed from their home. The child did not request contact with her grandfather or uncle after this removal.*
- *At a court hearing to address a motion to return the child to these relatives' care in May 2011, the department (as well as the GAL) recommended against placing the child back with the relatives based on the grandfather's failure to disclose the full extent of his criminal history and his allowing unapproved contact between the child and her mother and grandmother. The biological father also filed a motion voicing concerns about placing the child with these relatives.*

- *After the child's primary plan was changed from return home to adoption in August 2011, the Department held several Family Team Decision Making Meetings that included the maternal grandfather and uncle, addressing the concerns about the child's prior placement with them. A decision was made to place the child back with the grandfather at that point.*
- *While in the grandfather's care, the child lost weight and medical providers expressed concern about the grandfather's ability to manage her significant medical condition (cystic fibrosis). In addition, the child began to exhibit concerning behaviors. None of these behaviors were present in her foster home before she was placed with the relatives; she is not exhibiting these behaviors in her current placement. The child also reported sharing a bed with her uncle. For these reasons, the Department removed the child from this placement.*
- *In the seven months since the child was moved from the maternal grandfather and uncle's home, neither has made contact with the Department requesting visits or inquiring about the child.*
- *The child's current therapist has seen her on a consistent basis since she was placed in foster care. Based on her knowledge of the child's specific medical and emotional issues and her knowledge of the relative's behaviors and interactions with the child, the therapist reported to the court that it would not be in the child's best interest to have in-person contact with these relatives. The relatives could start with pictures and letters and build from there based on the child's response. She reported the child is grieving the loss of her mother and father and trying to attach to her adoptive home. The therapist did not rule out future contact. She did not recommend contact with these relatives during this period of adjustment and attachment work with her primary caregivers.*
- *The Department acknowledges that the child requested contact with the maternal grandfather and uncle. However neither the child's therapist, GAL, social worker or the court believes it was in her best interest, at this time, due to the trauma and chaos the child has experienced. Therapy sessions are focused on grieving the loss of her mother and father along with attaching to her adoptive home.*
- *The court ruled that visits with relatives would not occur at this time. The court ordered that relatives' visits with the child would only happen if approved by the GAL, Department, and the child's therapist.*

In regards to contact with paternal grandmother:

- *During the child's dependency, the paternal grandmother has only visited the child on two occasions. These two visits were approved by the Department as she was being considered as a possible placement option for the child. The grandmother was referred for a home study, but the home study did not go forward based on concerns about her CPS and criminal history and the criminal history of her paramour.*
- *The child's mother reported to the Department that the child has had little contact with her paternal grandmother prior to the Department's involvement. The paternal grandmother has had no contact with the child since August 2010. The child has made no mention of the paternal grandmother during the case.*
- *In January 2012 when the grandmother again requested to be considered for placement of the child, the social worker discussed with the grandmother the reasons why she would not be considered for placement. The grandmother did not ask about visiting the child during these conversations.*
- *In April 2012 the grandmother requested a visit with the child, and the social worker encouraged her to write letters to initiate contact with the child. To date, the Department has not received any letters.*
- *The court ruled against relative visitation at this time, but could be considered in future if approved by the child's GAL, therapist, and the Department.*

In regards to contact with paternal great aunt:

- *Three months ago, the father requested that an out-of-state relative be considered for placement. This was the first mention in a two-year-old case of any out-of-state relatives. Shortly thereafter, the grandmother made a similar request that this paternal great aunt be considered. Neither the father nor the grandmother provided the name of this relative, and they acknowledged that the child did have an existing relationship with the relative.*

- *At the Ombudsman's request, the Department obtained contact information for the aunt and contacted her. The great aunt explained that she has only met the child two times: once when she was born, and when the child was three at a family funeral in California. She has not had contact with the child since that time.*
- *When the social worker contacted the child's GAL to update her about these relatives' interest in placement of the child, the GAL expressed concern about the child moving to because it would be her 8th placement and the child was making progress in her current placement.*
- *The social worker asked the child's therapist to provide a letter outlining her recommendations for contact with relatives and a possible change in placement. The therapist did so, stating her reasons for recommending against relative placement.*
- *Prior to the next court hearing, the great aunt informed the social worker that she would be attending the hearing, and asked if it would be possible for her to visit with the child. The aunt was told that the department would defer this decision to the court, as the child's therapist and GAL did not agree that visitation should occur with relatives at this time.*
- *Prior to the court hearing, the social worker asked the therapist for her specific recommendations on relative visits including with the aunt. The therapist stated that due to the aunt's minimal involvement in the child's life to this point, the fact that she does not live in the area, and that the child is working on securing her attachment with her current caregivers, visits would not be in her best interest. If visits were to occur in the future, they would need to be introduced slowly and should start with letter correspondence.*
- *The court ordered against visitation or placement with the relatives based on reports from the GAL and therapist. The Department was ready to provide a visit, if the Commissioner ruled in favor of one. Future visits and communication were not ruled out.*
- *After the court hearing, the social worker spoke with the child's foster parents about possibly exchanging pictures and letters with the relatives; they were open to the idea and the social worker agreed to provide the contact information.*

Based on the above information, the Department respectfully requests OFCO reconsider this adverse finding.

OFCO'S MODIFIED FINDING

Based on the information you provided **OFCO agrees to the following modification of our finding**:

DCFS' decision not to allow visits with relatives was not clearly unreasonable.
As noted in OFCO's original Notice of Adverse Findings, the department's decision not to allow visits between this dependent child and relatives is not a violation of law or policy, as the agency has discretion to allow such contact. After reviewing the department's response, OFCO modifies its original finding and acknowledges that this decision was not clearly unreasonable under the circumstances.

However, **OFCO is troubled by the department's opposition to contact or visits between the child and her relatives** for the following reasons:

- The maternal grandfather had a typical grandfather/granddaughter relationship and had previously cared for her in 2008 and in 2010;
- The maternal uncle similarly had a pre-existing relationship with the child and had served as her caregiver;

- The child requested visits with her grandfather and uncle following removal from their home;
- Although ruled out as a placement option, the paternal grandmother was an active part of the child's life prior to her entry into foster care and expressed a desire to have contact with the child; and
- While the out-of-state paternal great aunt had only met the child on two prior occasions she demonstrated her commitment to the child by flying to Washington State to attend a court hearing and in hope of visiting the child.

Of particular concern is the department's reliance on speculation that contact with biological parents or extended family would be detrimental to the child's sense of permanency and belonging with her adoptive family. Just as likely perhaps, is that contact with these relatives could: reassure this child that she is loved by both her adoptive and biological families; generate a stronger sense of identity and self-esteem in this child; and increase the stability of her adoptive placement.

While OFCO recognizes the department's concern regarding some of the relatives' ability to respect appropriate boundaries during visits, this issue could possibly have been addressed through adequate preparation and supervision of contact with the child. Rather than categorically deny all visits or contact between a dependent child and relatives, OFCO believes that each relative should be considered individually in order to determine whether contact or visits would be beneficial to the child.

Thank you for your thoughtful response to our Notice of Adverse Finding and engaging in this dialogue to improve practice and achieve better outcomes for children and families.

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

OFCO FINDING

OFCO received a complaint alleging that DCFS/CFWS planned to move a 16-year-old legally free youth from his relative placement if the relatives did not move forward with adopting the youth. OFCO found that in December, 2011, the youth's case had been transferred to the adoption unit, and the assigned adoption social worker had called the relatives to inform them of this case transfer. Case notes indicated that the adoption worker was actively seeking an adoptive placement for the youth. OFCO found this to be a clearly unreasonable case plan, for the following reasons:

- The youth had been living with his grandparents since September, 2007, and although he continued to exhibit behavior problems, had generally made good progress in his grandparents' care;
- The youth had expressed his desire to remain with his grandparents, several times to various people, including his attorney;
- The grandparents had consistently expressed their desire to care for their grandson until he reached adulthood, although not in the form of an adoption or third party custody;
- DCFS had been locked in a conflict with the grandparents over their resistance to adopting the youth, which DCFS believed was the most appropriate permanency plan for him. In August, 2010, the court ordered that the youth not be removed from the grandparents' home without further court order, that concurrent permanency planning for either adoption,

long term foster care or guardianship was appropriate for this youth, and that these options be explored with the grandparents.

OFCO acknowledges that this has been a complex case, in part because the level of hostility on the part of the grandparents toward the original DCFS office made forward progress on achieving a permanency plan for the youth difficult. OFCO contacted the Area Administrator (AA) to request that DCFS consider transferring the case to the office that had been providing courtesy supervision services for the relative placement. The AA agreed, and contacted her counterpart in the other region, who agreed to accept the case. The AA also requested a change of venue for the legal case, which has since been accomplished. It is OFCO's hope that an appropriate permanency plan for this youth will be more quickly and successfully achieved with the transfer of this case to the region in which the youth and relatives reside.

CA REQUEST FOR MODIFICATION OF FINDING

The following is a brief summary of DCFS's three-page letter requesting modification of the adverse findings:

We respectfully disagree with your findings based on several points:

1. The youth deserves permanency;
2. The grandparents have not put the youth and his siblings' needs above their own;
3. The grandparents have not provided permanency for the youth's two formerly-dependent siblings; and
4. The grandparents contributed to additional trauma for [one of the siblings, who was placed in their home along with the youth] when they abruptly requested his removal as they were unable to meet the child's special needs.

To understand why the social workers continued to make active efforts to locate a different permanent placement requires that the family history be thoroughly considered and explained.

DCFS's letter provided additional factual details for each of the three points.

OFCO'S RESPONSE DENYING MODIFICATION

OFCO does not dispute that the youth deserves permanency. In this case, his grandparents' notion of an acceptable permanency plan differs with the agency's policies regarding preferred permanency plans, i.e. in most cases, adoption. The grandparents repeatedly expressed their commitment to long term foster care, and the court in fact ordered that this option be explored as part of concurrent planning, in its court order of August 2010.

The DCFS office however, was not willing to consider long term foster care as a permanent plan for this now 17-year-old youth, as this option was never offered to the grandparents and the case was transferred to the adoption unit. OFCO recognizes the agency's concern regarding the grandparents' inability to maintain the youth's younger sibling in their home. On the other hand, the grandparents have demonstrated their long-term commitment to two of their four grandchildren. This youth has been in their care for almost five years, and they have raised their oldest grandchild, the boys' older sister, now a young adult in college, since infancy.

For these reasons, OFCO determined that the department's failure to pursue a permanent plan of long term foster care in his grandparents' care was unreasonable under the circumstances.

IV. IMPROVING THE SYSTEM

PART ONE: WORKING TO MAKE A DIFFERENCE

- Severe Abuse of Adopted Children: Recommendations to Strengthen Adoptions and Safeguard Children
- Systemic Findings and Recommendations
  - Barriers to Placement with Out-of-State Relatives Delays Permanency
  - Delays in Completing CPS Investigations Leave Children at Risk of Harm
  - Life-Long Impact of a Founded Finding of Child Abuse or Neglect

PART TWO: OFCO CRITICAL INCIDENT CASE REVIEWS

- Summary of Findings
- Child Fatality Reviews
  - 2011 Fatality Data
- Near Fatality Reviews
- Recurrent Maltreatment
  - OFCO Finding in Recurrent Maltreatment Case
  - Summary of Data

PART THREE: 2012 LEGISLATIVE UPDATE

"The Severe Abuse of Adopted Children Committee Report is a call to arms. This is the launch point."
-Mary Meinig, KING5 News, October 22, 2012

PART ONE: WORKING TO MAKE A DIFFERENCE

RECOMMENDATIONS TO STRENGTHEN ADOPTIONS AND SAFEGUARD CHILDREN

The vast majority of adoptive parents provide loving homes to children in need and play an essential role in our child welfare system. These individuals deserve our appreciation and should be commended for their dedication and commitment to their children.

In response to OFCO's 2011 Annual Report discussing severe abuse of adopted children, the governor directed OFCO and CA to establish a committee to examine this issue in greater detail and make recommendations to improve the adoption process. The committee's recommendations focus on: State Oversight of Child Placing Agencies; Assessing Prospective Adoptive Families; and Training and Post Adoption Support and Services. (The Severe Abuse of Adopted Children Report is available at: http://www.governor.wa.gov/ofco/)

This section provides background information on the cases of abuse which led to this report, the activities of the committee and a summary of the report's recommendations. Two of these recommendations, and possible strategies for implementation are discussed in more detail, they are: Tracking Adoption Disruption and Dissolution, and Strengthening Qualifications and raining Requirements for Individuals Conducting Adoption Home Studies and Post Placement Reports.

BACKGROUND

The Office of the Family and Children's Ombudsman (OFCO) 2011 Annual Report[40] documented an alarming cluster of cases of severe child abuse and neglect occurring in adoptive or pre-adoptive placements. Eleven of the fifteen cases described in the *2011 Annual Report*, occurred in 2011. These cases include children who were adopted: from the Washington state foster care system; from the foster care systems of other states; from foreign countries; and through private agencies or through private adoption facilitators. What is particularly disturbing is that in these cases, the child abuse and neglect occurred in homes that had been scrutinized and approved by public or private child welfare agencies as appropriate adoptive homes for the child, and/or finalized by the court as an adoption.

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

- Locking the child in a room;
- Withholding food from the child;
- Disparaging remarks about the child and discrediting the child as being untruthful;
- Exaggerating or misstating the child's negative behaviors;

[40] Available at: http://www.governor.wa.gov/ofco/reports/default.asp

- Physical and emotional abuse;
- Forcing the child to remain outside the home;
- Denying the child access to toilet facilities; and
- Isolating the child from the community, such as removing the child from public school.

Of the seventeen children in this report who were victims of severe abuse, ten were Caucasian, five were African American (four of whom were adopted internationally), one was Native American, and one a Latino child, who was also adopted internationally. All adoptive parents were Caucasian.

In response to these troubling issues concerning the severe child abuse and neglect of adopted children, Governor Gregoire requested that Children's Administration (CA) and OFCO convene a multi-disciplinary workgroup to examine these issues and make recommendations to improve the adoption process and protect children.

This workgroup was co-chaired by Denise Revels Robinson, Assistant Secretary of CA and Mary Meinig, Director of OFCO. Members of the workgroup represent various professions and organizations including: Children's Administration; private child placing agencies who conduct domestic and international adoptions; the Office of the Attorney General; the court; public defense attorneys; the Governor's Office; researchers; and medical professionals. The workgroup conducted a thorough review of the adoption process with formal presentations discussing the following topics:

- Case Reviews of Incidents of Severe Abuse of Adopted Children & Common Elements;
- Legal Framework- International Convention, Federal and State Laws and Regulations Governing Adoptions and Child Placing Agencies;
- International Adoption Process;
- Domestic Adoption Process; Foster Care Adoption Process;
- Adoption Home Studies and Post Placement Reports; and
- Medical Perspective on Child Maltreatment including Starvation; and a Summary of Research on Adoption Attachment and Abuse.

Additionally, co-chairs Revels Robinson and Meinig met with representatives from private adoption agencies throughout the state. The final report and recommendations were submitted to the Governor in September 2012.

REPORT RECOMMENDATIONS

A review of current Washington State laws and agency regulations governing adoptions revealed a lack of depth and detail in many areas of the adoption process. For example, sections of the WAC regulating private adoption agencies address minimum requirements for adoption home studies and post-placement reports in a cursory manner, if at all. By comparison, federal laws and regulations implementing requirements for international adoptions under the Hague Convention extensively address each phase of the adoption process. Other states, such as Oregon have enacted regulations aligned with The Hague Convention standards. Many of the recommendations made in this report mirror requirements found either in federal laws or in regulations from other states.

The report recommendations are grouped under the following categories: State Oversight of Child Placing Agencies; Assessing Prospective Adoptive Families; and Training and Post Adoption Support Services. Implementation of most recommendations involves amending state law, administrative regulations, or agency policies.

State Oversight of Child Placing Agencies

- Strengthen State Oversight of Child Placing Agencies Providing Adoption Services by Enacting Administrative Rules Consistent with The Hague Convention and Federal Laws and Regulations

- The Department Should Develop and Distribute a List of Key Concerns or "Red Flags" regarding Troubled Adoptions

- The Department Should Establish a Procedure to Track Adoption Disruption and Dissolution

Assessing Prospective Adoptive Families

- Strengthen Qualifications for Individuals Conducting Adoption Home Studies and Post Placement Reports

- Enhance Minimum Requirements for Adoption Home Studies

- Establish Procedures to Ensure that all Adoption Home Studies are Filed or Recorded as Currently Required by State Law

- CA Should Establish an Internal Committee to make Adoption Decisions for Dependent Children *CA has already started working on implementing this recommendation.*[41]

- Enhance Minimum Requirements for Post-Placement Reports

Training and Post Adoption Support Services

- Improve Training and Preparation for Prospective Adoptive Parents

- Create Minimum Training Requirements for Child Placing Agency Staff

- Provide Training to Professionals Who are Directly or Indirectly Involved with the Adoption Process

- Enhance Support Services for Adoptive Families

Many of these recommendations can be implemented by the department through changes to administrative rules or agency policies. Other recommendations may require legislative action and changes to our state laws. The Ombudsman believes that the two recommendations and possible steps towards implementation which are discussed below merit particular attention.

[41] Reported to OFCO by CA Assistant Secretary Revels Robinson, email received January 2, 2013

ESTABLISH A PROCEDURE TO TRACK ADOPTION DISRUPTION AND DISSOLUTION

Adoption disruption describes an adoption process that ends after the child is placed in an adoptive home but before the adoption is legally finalized. Adoption dissolution occurs when an adoptive placement ends after the adoption is legally finalized, resulting in the child's return to (or entry into) foster care or placement with new adoptive parents.[42]

Currently, there is no formal procedure to track adoption disruptions and dissolutions. As a result, we do not know: the extent of this phenomenon; whether certain types of adoptions are more likely to disrupt or dissolve; and how best to support adoptive families and safeguard children.

Possible Changes to State laws, Regulations and/or Agency Policies:

- **Require Child placing agencies to report adoption disruptions and dissolutions to the Department.** Adoption agencies could be required to submit a written report within 14 days after a disruption or dissolution is reported to the adoption agency if the agency was involved in the adoption home study of the family, the placement of the child, or the supervision of the adoptive placement. The agency's report should also include a description of: services provided in an attempt to preserve the placement; and the agency's efforts to arrange for an alternative placement, including foster care.[43]

- **Require CA to track adoption disruptions and dissolutions through its case management information system (FamLink).** CA should document in FamLink whenever: a child's pre-adoptive placement disrupts and the child comes back into foster care; when an adopted child is placed in foster care due to allegations of child abuse or neglect; or when an adopted child's adoption dissolves through the adoptive parent's death or termination of parental rights.

STRENGTHEN QUALIFICATIONS AND TRAINING REQUIREMENTS FOR INDIVIDUALS CONDUCTING ADOPTION HOME STUDIES AND POST-PLACEMENT REPORTS

Qualifications and Training- Current law provides that a person with a master's degree in social work or a related field and one year of experience in social work, or a bachelor's degree and two years of experience in social work, or a person approved by the court, is qualified to conduct an adoption home study and post-placement report. There are no requirements for either the supervision of individuals conducting adoption home studies or training requirements.

Possible Changes to State Laws, Regulations and/or Agency Policies

- **Require the department to certify individuals conducting home studies and post-placement reports.** Some states[44] require that individuals conducting home study or post-placement reports must be licensed and/or certified by the Department. Licensing and

[42] Adoption Disruption and Dissolution, Child Welfare Information Gateway, (June, 2012), http://www.childwelfare.gov/pubs/s_disrup.pdf. A child's return to foster care does not necessarily result in adoption dissolution.

[43] See Oregon Administrative Rules (OAR) 413-215-0411

[44] For example, Ohio, OCR 3107.014 and New Mexico, NMSA 32A-5-13

certification requirements provide a heightened level of oversight. Qualifications for certification include:[45]

- MSW degree from an accredited school of social work and be licensed by the board of Social Work, or Masters degree in sociology, psychology, guidance and counseling or counseling from an accredited school or be licensed at the Licensed Professional Clinical Counselor level by the counseling and therapy board: and
- Have two years paid, full time experience in family evaluation and child development and behavior

State law should also provide that the department may assess a reasonable fee to the person or agency certified.

- **Require the department to establish minimum training requirements for individuals conducting home studies and post-placement reports.**
  Several states have specific training requirements set forth in state regulations. These rules require a minimum number of hours and identify a variety of training topics such as: child development; effects of international adoptions; race, culture and identity; placement strategies; and issues of acculturation and assimilation. In one state, the training curricula are organized into two tiers. Tier I is foundational information needed within the first six months of practice, and Tier II is advanced adoption training, provided after one to three years of adoption practice. Each tier includes 36 hours of training.[46]

Setting both minimum qualifications and training requirements will help address concerns with the education, training and qualification of adoption agency employees and other individuals conducting home studies, post-placement reports and providing adoption services.

[45] New Mexico: NMSA 32A-5-13 and NMAC 8.26.3.17
[46] Ohio, ORC 3107.015

SYSTEMIC FINDINGS AND RECOMMENDATIONS

BARRIERS TO PLACEMENT WITH OUT-OF-STATE RELATIVES DELAYS PERMANENCY

Relatives are a vital resource for children who have been removed from the care of their parents. Research shows that:[47]

- ✓ Relative placements are as safe as or safer than non-relative foster care placements. Dependent children living with relatives experience abuse or neglect at lower rates than children with unrelated foster families.
- ✓ Relative placements provide greater stability. Children placed with relatives generally have fewer moves while in out-of-home care.
- ✓ Siblings are less likely to be separated when placed with relatives. This helps to reduce the trauma and separation that accompany children's removals from their parents by preserving important connections to their siblings. Sibling bonds, just like parent-child bonds, contribute significantly to a child's developing sense of attachment and identity. Because relatives are more likely to take in larger sibling groups than non-relative caregivers, siblings placed in relative care are more likely to achieve permanency together. When siblings cannot be placed together permanently, relatives are more likely to maintain siblings' relationships with one another.
- ✓ Relative placements help children maintain community connections. Children placed with relatives are more likely to remain within their own neighborhoods and continue attending their original schools.

In Washington State, approximately 35 percent of children under state supervision are placed with relatives, and ten percent of these relative caregivers are licensed foster parents. (Nationally, 26 percent of foster children are placed with relatives.)[48] According to DSHS, as of June 30, 2011, there were over 3,100 children placed in relative care.[49]

BACKGROUND

Laws & Policies Governing Placement with Relatives

> ***"Children who cannot be with their parents, guardians, or legal custodians are best cared for, whenever possible and appropriate by family members with whom they have a relationship. This is particularly important when a child cannot be in the care of a parent, guardian, or legal custodian as a result of a court intervention."***
>
> *Washington State, Chapter 17, Laws of 1999*

As soon as a child is placed in state care, state laws mandate that the priority placement for a child, pending a court hearing, is with a willing and available relative. The department must make efforts to place the child with a relative or other suitable person requested by the parent on the next business

[47] Time for Reform- Support Relatives in Providing Foster Care and Permanent Families for Children, Pew Charitable Trust, (2007) at: http://www.pewtrusts.org/uploadedFiles/wwwpewtrustsorg/Reports/Foster_care_reform/SupportingRelatives.pdf

[48] *Foster Care Statistics 2010,Child Welfare Information Gateway.* Available online at http://www.childwelfare.gov/pubs/factsheets/foster.cfm)

[49] Children's Administration 2011 Year in Review

day after the child is taken into custody.[50] The statutory preferences for relative placement, and the respect for family autonomy, continue throughout the dependency process and are designed to facilitate a child's early placement with a relative. Once dependency is established, "Placement of the child with a relative . . . shall be given preference by the court".[51] State law also provides that as long as the relative appears "suitable and competent to provide care and treatment, the criminal history background check need not be completed before placement, but as soon as possible after placement."[52] Additionally, "[i]n an attempt to minimize the inherent intrusion in the lives of families involved in the foster care system and to maintain parental authority where appropriate, the department, absent good cause, shall follow the wishes of the natural parent regarding the placement of the child with a relative or other suitable person."[53] Consistent with these state laws, Children's Administration has implemented extensive policies governing the social worker's responsibilities to identify, notify and assess for placement, available relatives.[54]

Federal laws also recognize a preference for relative over non-relative placements. The Indian Child Welfare Act of 1978 requires that "a preference shall be given, in the absence of cause to the contrary, to a placement with a member of the Indian child's extended family . . ."[55] Additionally, in order for states to receive Federal payments for foster care and adoption assistance, title IV-E of the Social Security Act requires that states "consider giving preference to an adult relative over a nonrelated caregiver when determining placement for a child, provided that the relative caregiver meets all relevant State child protection standards."[56]

ANALYSIS

Despite the legal preference for relative placement and department policies designed to identify and support placement with available relatives, OFCO continues to receive a high number of complaints alleging that the department failed to place a child with an available relative. In the 2012 reporting year, OFCO found that issues involving family separation and reunification were the most frequently identified issues in complaints (253). Within this category, the failure to reunite families (66) and the failure to place children with relatives (61) accounted for fully half of the addressed issues.

Particularly complex are complaints regarding out-of-state relatives who seek placement, and possible adoption of a dependent child. These complaints are even more challenging when the child is in an established non-relative foster placement and the foster parents also wish to adopt the child. In such cases, there are often a number of competing policies and child welfare principles at play:

- *Stability* - The state's duty (and best practice) to minimize the number of out-of-home placements for a child.
- *Parent-Child Visits* - Visitation is the right of the family and early, consistent, and frequent visitation is crucial for maintaining parent-child relationships and making it possible for parents and children to safely reunify. The department must encourage the maximum parent and child and sibling contact possible.[57] Placing a child with an out-of-state relative in most

[50] RCW 13.34.030
[51] RCW 13.34.130(5)
[52] RCW 13.34.130(9)
[53] RCW 13.34.260(1)
[54] CA Policies and Procedures Guide, Section 4527
[55] Indian Child Welfare Act of 1978, 25 U.S.C. 1901-1963. Section 1915(b)
[56] 42 U.S.C. § 671(a)(19)
[57] RCW 13.34.136(2)(b)(ii)

cases makes parent-child visits logistically impractical if not impossible. As such, out-of-state relatives are not usually considered a viable option until the approved case plan is adoption or guardianship.

- *Relative's Ability to Establish or Maintain a Relationship With the Child* - Once a child enters state care, it can be difficult for a relative to maintain contact with the child. Relatives do not have a legal right to visit, even if agency policy deems it good practice when possible.
- *ICPC*[58] *Home Study Process* - Prior to placing a child with an out-of-state relative, the relative must complete an approved ICPC home study. This process from referral to completion can take several months and delays placement with an otherwise available relative.
- *The Child's Bonding and Attachment to the Caregiver* - The longer a child remains with a non-relative caregiver, the greater the opportunity for the child and caregiver to bond and form attachments, making it potentially more traumatic to disrupt that attachment and move the child to a relative placement.
- *Relative's Ability to Participate in the Child's Case* - Out-of-state relatives are often unable to attend court hearings, various meetings, or case staffings regarding the child. As such, they are less able to advocate for either the child or for full consideration as a placement resource.

The following OFCO complaint summaries illustrate the complex issues and competing policy goals involved when determining whether to place a dependent child in the care of an out-of-state relative.

Approved Relative Denied Placement of Dependent Child Due to Length of Child's Placement with Non-Relatives

In the spring of 2009, CPS filed for dependency on a then two-year-old child and three other siblings (1, 8 and 11 years old) based on allegations of child abuse. The children were placed with relatives; the two older children with a grandparent, and the two younger children with an aunt.

The two-year-old's placement with the aunt however, was short term, as the aunt required additional support and resources in order to care for the two toddlers in addition to her own children. The two year old was moved from the aunt's care and then experienced several short-term foster care placements. In the spring of 2010, this child was placed with non-relative foster parents in what would eventually be a permanent home.

Even though the child was in non-relative foster care, in-state relatives initially remained in regular contact with the child, including facilitating visits with the other three siblings. However, in the fall of 2010, the court suspended contact between this child and his biological family, based on reports of the child's aggressive and defiant behavior and the recommendation of this child's therapist. A few months later, the court deferred any further visits between this child and the relatives until recommended by the child's therapist.

In the summer of 2010, an out-of-state relative contacted the department and expressed interest in being a placement resource for the now three-year-old child. The department requested an ICPC home study of this relative. During the home study process, the DCFS social worker shared with the ICPC social worker the following concerns about moving the child from the current non-relative placement:

[58] The Interstate Compact on the Placement of Children (ICPC) is statutory law in all 52 member states and jurisdictions. The ICPC establishes uniform legal and administrative procedures governing the interstate placement of children. (RCW 26.34).

- The child has had ten placements in his time in foster care, which has impacted his attachment and his fear of abandonment.
- This child struggles with intense nightmares about being taken away from the current foster parents.
- This child does not know the out-of-state relative.
- Moving this child to the relative's care may cause additional trauma as this child has developed a strong bond with the foster parents and his therapist, and thrives on his daily routine.

In early 2011, the relative's ICPC home study was approved. This home study also identified therapeutic treatment programs in the relative's community that could meet the child's therapeutic needs.

In the spring of 2011, the department referred this case to the Foster Care Assessment Program (FCAP) for assistance in identifying the now four-year-old child's needs, appropriate services and case plan recommendations.

The department also held a Family Team Decision Meeting (FTDM) to develop a plan to reintroduce the child to his family in a therapeutic manner. Present at this meeting were professionals related to the case, foster parents, and relatives. The proposed plan included cards and letters from the parents and relatives to be read to the child by his therapist. The plan also provided that at the therapist's discretion, the out-of-state relatives would get to know the child through Skype visits.

The child's therapist, however, continued to recommend that no contact occur between the child and his family. The court rejected the plan proposed at the FTDM and instead ordered that communication between relatives and the child occur as directed by the child's therapist. At a subsequent hearing, the court provided for three visits with the out-of-state relative and the child's therapist to discuss the child's treatment and to introduce the child to this relative. The court also allowed additional visits to take place upon agreement by the therapist, guardian ad litem and DCFS social worker.

The three meetings between the therapist and out-of-state relative and introductory visits with this child occurred in the summer of 2011. The therapist continued to recommend that the child remain in his current foster home with a plan for adoption, arguing that any change in his placement could cause irreparable emotional damage. The FCAP report however, which was completed in the early summer of 2011, supported relative placement and recommended increasing contact and visits between the child and the out-of-state relative. The assessment also concluded that placing this child with the relative would not necessarily require a prolonged transition.

A case staffing was held in the fall of 2011. At this meeting the department concluded that it was in the child's best interest to remain in the current non-relative placement for adoption. In reaching this decision, the department considered in part the length of time this child had been in the caregivers' home (nearly a year and a half) and the potential impact on the child of disrupting this placement. This case plan was presented and approved by the court. The court rejected any adoptive placement other than the current foster parents. A few months later, the child's adoption by the non-relative foster parents was finalized. This child's siblings remain in permanent placements with their relatives. This child and the three siblings have not seen each other or had contact in over two years.

Court Denies Placement of Child with Approved Relative Despite Agency's Recommendation

In the fall of 2010, an infant entered state care at birth due to neglect related to the parents' substance abuse and prior involvement with CPS. The department filed for dependency and placed the child in non-relative foster care. The department considered (and declined) placement with an in-state relative but did not seek potential out-of-state relative placements.

The child's parents failed to remedy their parental deficiencies and in the summer of 2011, the department filed a petition for termination of parental rights.

In the fall of 2011, an out-of-state relative learned of the child's placement in foster care and contacted the department about adopting the child. Two months later, an ICPC home study on this relative was completed and approved. The relative and other family members continued to contact the department and request that this child be placed with the out-of-state relative.

Three months after the ICPC home study was approved, the department held an adoption placement committee staffing and considered potential relative placement versus maintaining the child in the current foster home, in the context of the child's needs. This committee recommended that the child remain in the current placement and be adopted by the foster parents. This decision was based in part on the fact that the now one-year-old child had been in the foster parents' care for over a year and had developed a strong attachment to the foster parents and foster siblings.

In the spring of 2012, and one month after the placement staffing, the court considered a motion to place the child with the relative. The court did not make a ruling on placement, but directed the department to further investigate relative placement, considering both the statutory preference for relative placement as well as the best interests of the child.

Recognizing concerns that perhaps the department had not looked hard enough or early enough for relatives and that this child would benefit from establishing and maintaining family connections, the department developed a plan to facilitate a relationship between this child and the out-of-state relative. This plan included visits with the relative and further assessment of the child. That summer, the relative travelled to Washington State for a series of visits, including overnight visits, arranged by the department. These visits went well and with the assistance of a child mental health specialist, the department developed a transition plan to place the child with the out-of-state relative.

At a court hearing in the fall of 2012, the department recommended placement of the child with the relative for adoption. This case plan was opposed by the child's guardian ad litem who advocated for keeping the child in the current foster care placement for adoption. The court denied the department's motion to place the child with the relative and two months later, the child's adoption by the foster parents was finalized.

An Evolving Assessment of Best Interests of the Child: Remain in Foster Home Since Birth, or Move to Relative Care?

A few days after her birth in the summer of 2010, a child was placed in a non-relative foster home where she remained for the next two years. Early on in this case, the department had contacted various relatives who expressed interest in placement of this child, including an out-of-state relative.

In early 2011, a Family Team Decision-Making Meeting (FTDM) was held. The social worker, parents, relatives and other participants identified a primary plan of family reunification and an alternative plan of relative placement. Notes from this meeting indicated that the out-of-state relatives would be referred for an ICPC home study immediately. However, the department decided not to initiate the ICPC process or pursue placement with this out-of-state relative at that time as it would have eliminated parent-child visits and thus interfered with efforts to reunite the family.

At a review hearing within five months of this FTDM however, the court accepted the department's recommendation to change the permanent plan from reunification to adoption, based on the parents' lack of progress in services.

Throughout this case, the parents' position on the child's placement and case goals often wavered. At times they supported the child's foster care placement, and pursued visits, court ordered services and reunification. At other times they wanted the child placed with the out-of-state relative as a permanent case plan. In the fall of 2011, the parents were willing to relinquish parental rights and consent to adoption with the out-of-state relatives and they requested that the court order placement with these relatives. The department opposed this motion, on the grounds that the now one-year-old child had been in the foster home since birth, received excellent care in this home, and had bonded with the foster parents. The department believed that disrupting this long-term placement would be harmful to the child. The child's court appointed special advocate also opposed any change in the child's placement and the court denied the parents' motion.

The parents continued to contest the child's placement and advocated for relative adoption. Several of the issues in this case, including the foster parents' and relative's requests to intervene, and the parents' request to place the child with the relative, were addressed through contested court hearings. Some of these decisions were accepted for appellate review, underscoring the competing goals recognized in state laws of preference for placement with relatives, respect for parental authority in selecting a suitable caregiver, and the best interests of the child.

In the fall of 2012, two-and-a-half years after the child entered state care, the department re-evaluated the case plan. The department recognized that both the foster home and the out-of-state relative presented excellent placement options for this child. The department concluded that ultimately, placement with the relative for adoption was in this child's best long-term interest. The court appointed special advocate concurred and an agreed order changing the child's placement was entered.

RECOMMENDATION

Improving Decisions Regarding Placement with an Out-of-State Relative

As these cases demonstrate, the decision to place a child with an out-of-state relative can be exceptionally difficult and often involves multiple goals such as: consideration of parental preferences, limiting the number of out-of-home placements, maintaining sibling groups, preference for relative/kinship placements, and consideration of the child's bonding and attachment with a non-relative care provider. When considering an out-of-state relative for placement of a dependent child, the decision making process should:

- Reflect the legal preference for placement with the child's relative;
- Weigh the lifelong benefit to the child of placement with a relative and facilitating connection to his/her extended family of origin.
- Employ objective criteria addressing specific factors related to the child's health and well being;
- Consider the relationship between the relative and child; however, the lack of an established relationship should not be a barrier to placement particularly when the child entered state care as an infant; and
- Assist out-of-state relatives in establishing or maintaining a relationship with the child through phone calls, Skype calls, or visits if the relative is able to travel to Washington State.

From the moment a child enters state care to the final case outcome best practices promote the child's relationship with extended family. For example, state laws and department policies require ongoing efforts to place children with relatives, provide for sibling visits, engage and empower relatives in case planning through Family Team Decision Making meetings, and allow relatives to petition the court for visits with a dependent, legally free child. An overarching theme guiding best practices in our child welfare system should be *family first.*

DELAYS IN COMPLETING CPS INVESTIGATIONS LEAVE CHILDREN AT RISK OF HARM

In 2010, 2011 and now in 2012, through our reviews of cases with three founded reports of child abuse or neglect within one year, OFCO has found that Child Protective Services routinely fails to complete investigations of child abuse or neglect within 45 days as required by policy or within 90 days as required by state law. The timely completion of investigations is crucial to child safety and effective case planning, and ensures due process for subjects of the investigation (often parents) who may be anxious to resolve allegations of maltreatment.

Of the 111 "Three Founded" cases OFCO reviewed in 2012:

- Nearly half (49 percent) of the cases, at least one CPS investigation remained open beyond the 90 day deadline.
- 28 percent of the cases, two or more investigations were not completed on time.
- 15 percent of the cases, all three CPS investigations were open beyond 90 days.

The length of the delay varied; however, in some cases, CPS investigations remained open for several months beyond the 90 days allowed to complete an investigation.

Additionally, in 2012, OFCO made seven adverse findings against the department for failure to close a CPS investigation in a timely manner; and in both 2011 and 2010, OFCO made six such adverse findings.

Untimely completion of CPS investigations is clearly a systemic issue affecting a large number of families. DSHS/CA data shows that 26 percent of all CPS investigations initiated between September 1, 2011 and June 1, 2012 remained open more than 90 days. A full ten percent remained open more than 150 days.[59]

Timelines for Completing CPS Investigations

State Law:

CPS is required to complete an investigation into alleged child abuse or neglect within 90 days from the date the report is received, unless a law enforcement agency or prosecuting attorney has determined that a longer investigation is necessary. At the completion of the investigation, the department is required to make a finding that the report of child abuse or neglect is either founded or unfounded.[60] The department must then notify the subject of the alleged child abuse or neglect of the department's investigative findings. This notice informs the subject that:

- a written response may be submitted to the department;
- the department's records may be considered in subsequent investigations or child protection/custody proceedings;
- a founded report of child abuse or neglect may disqualify a person from working with vulnerable populations; and
- the subject has a right to appeal the department's finding of child abuse or neglect.[61]

[59] DSHS/CA DATA Report, 11/28/2012
[60] RCW 26.44.030(11)(a)
[61] RCW 26.44.100(2)(a)

Agency Policy:
CPS Investigative Assessments must be completed within 45 days of CPS receiving a report of alleged abuse or neglect.[62] The supervisor must review all cases open to CPS to determine if the 45-day requirement has been met.[63] The supervisor may extend the investigation for an additional 45 days, in accordance with state law. FamLink has an extensions/exceptions page where the supervisor can document such an extension and the reason why it is being granted.[64] To address workload issues related to implementation of the Child Safety Framework in 2011, CA temporarily increased the number of days from 45 to 60 for CPS to complete an investigation. This temporary extension was in effect from November 14, 2011 through February 2012.

IMPACT ON CHILDREN AND FAMILIES

Protection of Children. The main purpose of the Investigative Assessment is to determine and 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. The failure to complete an investigation in a timely manner and determine whether or not child abuse or neglect has occurred can leave children at risk of continued maltreatment. As explained below, existing CA policy does not require that the social worker conduct health and safety checks on the child once the initial face-to-face contact or interview occurs. An abused or neglected child can therefore remain in the home, without any further intervention, services, or monitoring, while a decision on the investigation is pending. Additionally, 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, which initiates a review of the case by OFCO.

DELAY IN MULTIPLE CPS INVESTIGATIONS, REGARDING THE SAME FAMILY, LEAVES CHILD AT RISK OF ONGOING PHYSICAL ABUSE

CPS Intake #1
In late November 2011, CPS accepted for investigation a report that a seven-year-old child told her teacher that her mother hit her with a stick. The school nurse observed several dime-sized bruises on the child's bottom. A few days later, the CPS social worker completed an initial face-to-face interview with the child who repeated her disclosure that her mother hit her on the bottom with a stick. The CPS investigator did not document any attempts to interview or engage the child's mother regarding this allegation. However, it appears that the mother moved and withdrew the child from this school following this allegation.

[62] Children's Administration Practices and Procedures Guide, Section 2540.
[63] Children's Administration Practices and Procedures Guide, Section 2610(C). This policy does not specify any reasons for an extension or exception.
[64] 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.

CPS Intake #2
Four months later, and while the first investigation was still pending, CPS received a second report of child abuse in early March 2012. This time, the child told staff at her new school that her mother hit her on the back of her legs with a hanger, leaving bruises. The CPS social worker conducted an initial face-to-face contact with the child a few days later, but the child refused to speak with the social worker, indicating that her mother and brother had instructed her not to talk to anyone. The social worker interviewed the child's mother, who admitted to spanking the child, but denied hitting her with a hanger. Although the mother agreed to allow the social worker to come to her home, the CPS investigator did not document any attempts to do so until two months later.

CPS Intake #3
In late May 2012, and while the first two CPS investigations were still open, CPS received a third referral alleging that the mother hit the child on top of her head with a hanger. The child had recently been enrolled at a third school. The child would not allow the CPS investigator to record the interview or take any pictures. The child confirmed that she had been hit on the head, and that it had happened more than once, but that it "didn't hurt." The child then ended the interview. The CPS investigator did not document attempts to contact the mother regarding this allegation.

CPS Intake #4
In June 2012, CPS received a fourth report that the child disclosed that her mother hit her on the head with her fist and that her head was still hurting. The CPS social worker conducted a timely face-to-face interview with the child. Although the child was again reluctant to discuss the details with the social worker, she confirmed that her mother punched her in the head. Attempts to meet with the mother or engage her in a case staffing were unsuccessful.

In July 2012, nearly eight months after the first CPS referral was accepted for investigation, CPS determined that three of these allegations were "Founded" for physical abuse (Intake #3 was determined to be "Unfounded'), and the CPS investigations were closed. No services were provided to the family and the child was not removed from her mother's care.

Several factors in this case, such as the parent's refusal to cooperate with the investigations, and cultural and language issues, made these investigations more challenging. However, they do not explain why the first two investigations were not completed within 90 days. Had the first two investigations been concluded as "Founded" in a timely manner, CPS may have had more leverage in gaining the mother's cooperation during the subsequent investigations.

Due Process for Parents and Other Subjects of CPS Investigations. 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 CPS record and can prevent them from employment in certain fields.

DELAY IN COMPLETING CPS INVESTIGATION HINDERS REUNIFICATION AND DENIES SUBJECT DUE PROCESS

OFCO received a complaint regarding a CPS investigation into allegations of sexual abuse of a seven-year-old dependent child by the mother's boyfriend. The mother had an open CFWS case as the child was placed in out-of-home care, and the mother was engaging in services to have the child returned to her care. The Ombudsman found that although the majority of investigative activities had occurred within a month of the CPS report being made, CPS did not contact or interview the mother's boyfriend (the alleged perpetrator) until six months later. Law enforcement had interviewed the child and informed CPS that no further law enforcement action would be taken. Meanwhile, CFWS questioned the mother's ability to protect the child based on the unresolved allegation, hindering reunification efforts. The mother's boyfriend was also not being allowed to transport the mother to visits or to attend the visits (which he had previously been attending, due to his existing relationship with the child) for this extended period of time. The boyfriend did not have an opportunity to address the allegations until months later, when CPS interviewed him. The investigation was then closed as "Unfounded".

The failure to complete a CPS investigation in a timely manner can have other negative consequences for children and families, not necessarily related to child safety or a subject's due process. For example:

FAILURE TO CLOSE CPS INVESTIGATION DELAYS CONSIDERATION OF GRANDPARENT FOR PLACEMENT

OFCO received a complaint that CFWS was refusing to consider a grandparent for placement of an eleven-year-old legally free child. The child had been in foster care for six years, and had experienced eleven different placements. The grandparent had requested to be considered for placement of the child, but her request was declined by CFWS. The Ombudsman found that CFWS was not considering her at that time due to an open CPS investigation in which she was involved. Upon further investigation, the Ombudsman discovered that that investigation had been open for over a year, even though the investigative work was complete and the evidence gathered appeared to indicate that the finding would be unfounded. In addition, the grandparent had been incorrectly named as the subject of that investigation, when in fact it was the grandparent's ex-spouse who was the subject. This error had been resolved early on in the investigation, as the grandparent had not been present during the reported incident, and had moved out of the household soon thereafter. However, the CPS report remained open erroneously under the grandparent's name, and since CFWS cannot consider an individual involved in a current CPS investigation for placement of a dependent child, her request to be considered was denied. A month after OFCO began investigating the complaint, CPS finally closed the investigation as "Unfounded" as to the grandparent's former spouse, and the grandparent was referred by CFWS for a home study in order to be considered for placement of the child.

OFCO RECOMMENDATIONS

CA Must Prioritize Completing CPS Investigations Within 90 Days as Mandated by State Law

For the past three years the Ombudsman has identified a chronic pattern of the department's failure to complete CPS investigations in a timely manner. This past year, over a quarter of all CPS investigations remained open more than 90 days. To address this issue, CA leadership has instituted corrective action plans and is actively tracking the status of open CPS investigations.[65] To aid current efforts to comply with state law governing CPS investigations, the department should produce quarterly reports on each DCFS office documenting the number of CPS investigations open beyond 90 days, 120 days and 150 days. This would help identify the scope of the problem, possible causes for delays and potential solutions. It would also document the department's progress in addressing this issue.

CA Policy Should Require Monthly Social Worker Visits with Children Involved in any Investigation Open beyond 45 Days.

When a report of child abuse or neglect is accepted for investigation, the assigned CPS social worker must have face-to-face contact with the alleged child victim(s) within either 24 or 72 hours, depending on whether the investigation is considered "emergent" or "non-emergent."[66] Once the investigative interview has been completed with the alleged child victim, there is no requirement that the social worker have any further contact with the child while the investigation is pending.

Effective April 1, 2012, CA revised agency policies regarding "Social Worker Monthly Visits."[67] Social workers must now conduct monthly in-person visits with all known ***parent(s) or legal guardians*** involved with the case when the CPS investigation remains open beyond 45 days. The policy provides that these visits may occur at a location other than the parent's home.

In OFCO's analysis, this policy modification does not go far enough, as there is no requirement that the social worker meet with and/or observe *the child*. Department policy should require that the social worker conduct monthly health and safety visits with the alleged child victim, in all CPS investigations open beyond 45 days. Policy should also require that these visits occur in the home where the child resides.

[65] Reported to OFCO by CA Assistant Secretary Revels Robinson, email received January 2, 2013

[66] CA Practices & Procedures Manual, Section 2310(B). 3.An emergent response is required for children who are in present or impending danger

[67] CA Practices & Procedures Manual, Section 4420.

LIFE-LONG IMPACT OF A CPS FINDING OF CHILD ABUSE OR NEGLECT

Should Washington State Establish a Procedure to Expunge a Finding of Child Maltreatment?

OFCO frequently receives complaints from individuals seeking to overturn or expunge CPS findings that they abused or neglected a child. In some cases the CPS finding was made many years ago and since then, the individual has significantly changed their life – having overcome issues such as substance abuse or domestic violence, for example, and successfully parented their child with no further involvement with CPS. They are later shocked to learn that the finding of abuse or neglect remains on their record and can prevent them from working or volunteering with children or other vulnerable populations, or from being a placement option for a child in state care. This issue warrants further study and consideration of whether Washington State should establish a procedure allowing a person to clear their record of abuse or neglect.

The following example of a complaint investigated by OFCO illustrates the harmful consequences a long-past and no longer pertinent CPS finding can have on an individual who has undergone enormous changes.

DECADE-OLD FINDING PREVENTS MOTHER FROM PURSUING SOCIAL WORK CAREER

In 2000, a 23-year-old mother was the focus of a CPS investigation into allegations that she was using drugs and neglecting her two-year-old child. The mother and the child's father lost their jobs and all their belongings due to their addiction, and could not provide for their child's basic needs. There were also incidents of domestic violence in the home resulting in a restraining order prohibiting the father from having contact with the mother and the child. In late 2000, CPS determined that the allegation of child neglect was founded, removed the child from the home and filed a dependency. Throughout the dependency, the mother actively engaged in and successfully completed services including: substance abuse treatment, parenting classes, and domestic violence counseling. Her child was returned to her care and in 2001, the dependency case was dismissed.

In 2004, the mother went back to college with the goal of becoming a chemical dependency counselor. She graduated from community college in 2008. In 2011, she graduated from a state university with a BA degree in Social Sciences. While pursuing her studies, the mother worked full time, cared for her child, and had no further contact with CPS.

The mother then planned to enroll in a graduate program and obtain a Masters of Social Work degree. Learning that the CPS finding that she had neglected her child 11 years prior could derail her future career, she wrote to the DCFS Area Administrator requesting that this finding be overturned based on the dramatic changes she had made in her life. The Area Administrator wrote back, explaining to her that at this point, she has no right to appeal the finding, or even have it reviewed, and that the finding cannot be changed.

In another example, OFCO investigated a complaint involving an old CPS finding -- dating back 17 years -- that appeared to be erroneous.

ERRONEOUS FINDING INTERFERES WITH PERMANENCE FOR DEPENDENT CHILDREN

A relative caregiver who had been caring for two dependent grandchildren, ages 12 and 4, for the last year and a half was undergoing a home study for a foster care license. The grandchildren needed a permanent placement and a relative guardianship had been decided upon as the most appropriate permanency plan for these children. The children had been thriving in the grandparent's care, and the home study had been all but approved until the licensor discovered an old founded CPS finding on the grandparent's record, from 17 years ago. The grandparent was shocked as she was unaware of this finding (the finding was made prior to the change in law and policy requiring CPS to inform subjects of CPS investigations in writing of the investigative finding). OFCO was contacted and an investigation was initiated. OFCO reviewed the old CPS records and found that not only were the records very limited, but what was available appeared to have a number of inconsistencies that brought into serious question the accuracy of this founded finding against the grandparent.

OFCO contacted a high-level agency administrator about these concerns, who confirmed that even if there was a way for the grandparent to appeal the finding at this point (which there is not), there was insufficient information in the existing records to determine the accuracy or validity of the finding. Furthermore, there is no way to amend the record in FamLink, the agency's electronic information system. OFCO's findings regarding this complaint ultimately allowed the foster care licensing process to go forward for the grandparent. However, the agency decided that the only possible way to avoid delay or denial of background check clearance for this grandparent in the future was for a new record to be entered under the grandparent's name, explaining the situation.

BACKGROUND

CPS Duty to Investigate and Determine if an Allegation of Child Maltreatment is "Founded". CPS is required to investigate allegations of child abuse and neglect and determine whether the allegation is founded or unfounded.[68] "Founded" means that, based on available information, it is more likely than not that child abuse or neglect did occur.[69] Once CPS completes an investigation, the department must notify the subject of the report of the department's investigative finding.[70]

If a court in a civil or criminal proceeding, considers the same facts or circumstances as investigated by CPS, and makes a judicial finding by a preponderance of the evidence or higher that the subject of the investigation has abused or neglected the child, then CPS is required to adopt the court's finding in its investigation.[71] This situation frequently occurs when the court hearing a dependency proceeding finds that a child has been abused or neglected.

Right to Notice of CPS Finding and to Appeal. A person who is named as an alleged subject in a CPS founded report of child abuse or neglect may challenge the finding and request that the department review its decision.[72] The request for review must be made in writing and within 30 days

[68] RCW 26.44.030(11)(a)
[69] RCW 26.44.020(9)
[70] RCW 26.44.100(2)
[71] RCW 26.44.030(11)(b)
[72] RCW 26.44.125

of receiving notice of the finding.[73] If the department upholds the original finding upon review, the individual may then request an adjudicative hearing before an administrative law judge to contest the finding. The focus of the review and adjudicative hearing is on whether or not a preponderance of the evidence in the hearing record supports a determination that the individual committed an act of abuse or neglect of a child.[74] ***The decision on review does not consider factors such as rehabilitation or remedial steps taken to address issues related to child abuse or neglect.***

An administrative review is also limited to the department's determination that the allegation of abuse or neglect was founded, when there is not a concurrent court finding of child abuse or neglect. A court's finding that child abuse or neglect occurred cannot be challenged through the administrative hearing process. Therefore, if the department's founded finding of child abuse or neglect is associated with a court finding of child abuse or neglect, the department founded finding may not be challenged through an administrative hearing process. Concerns regarding a court's decision are addressed instead through appellate review or other judicial proceedings. If a person fails to seek review in a timely manner or exhausts all administrative and judicial remedies, the finding of abuse or neglect becomes final, and under our current laws, can never be expunged.

ANALYSIS

Administrative Reviews. CA policy provides that in rare circumstances, Children's Administration may grant an administrative review to a person with a CPS finding of child abuse or neglect or other disqualifying crime or negative action (e.g., foster care license revoked) and approve or deny unsupervised contact with children or other vulnerable populations. In the past, the Administrative Review process has been slow and difficult to access. However, Children's Administration has recently modified this process in order to be more responsive to requests for review. For example, while many criminal convictions require review by the Area Administrator, a supervisor may now review most minor offenses (e.g., hunting or fishing violation, non-violent property crimes, etc.) and approve or deny the request. Children's Administration continues to review this process and implement improvements.

Vacating Criminal Convictions. Criminal convictions can also prevent a person from working or volunteering with children in an unsupervised setting. However, Washington State law allows that some misdemeanor, gross misdemeanor and felony convictions can later be vacated, or cleared from a person's record. Once a conviction is vacated, it cannot be considered for the purposes of licensing, contracting, certification, or authorization for unsupervised access to children or vulnerable populations.[75] There is no similar procedure by which a person can have a finding of child abuse or neglect vacated.

Approaches by Other States. Many states have provisions in their state laws for vacating certain child abuse and neglect reports. These statutes vary as to standards and procedures. For example, in Vermont, seven years after a person has been placed on the registry for a finding of child abuse or neglect, a person may file a request to expunge their record. The person must prove that a reasonable person would believe that he or she no longer presents a risk to the safety or well-being of children.[76] Wisconsin has a "Rehabilitation Review" process allowing a person to clear his or her records for employment and licensing purposes. The application is considered by a Rehabilitation

[73] RCW 26.44.125(2)
[74] WAC 388-15-129
[75] RCW 9.94A.640, RCW 9.96.060 and WAC 388-06-0210
[76] Vermont Ann. Stat. Tit. 33, §§ 4916c; 4916d

Review Panel, which determines whether there is sufficient evidence of rehabilitation.[77] Other states automatically expunge records after a certain period of time. For example, Indiana state law provides that the department shall expunge the substantiated report no later than the date on which any child that is named in the report as a victim of child abuse or neglect becomes age 24[78].

OFCO RECOMMENDATION

The legislature should establish a workgroup made up of representatives from Children's Administration, the Office of Public Defense, Parents Advisory Council, Office of the Attorney General, Administrative Office of the Court, and other stakeholders to examine this issue in greater detail and propose a specific standard and procedure for vacating findings of child maltreatment. Questions to be addressed include:

- Whether only findings of child neglect, and not abuse, should be eligible to be vacated?
- Should the procedure to vacate a finding be conducted by the department, or through the court system?
- What factors should be considered when deciding whether to vacate a finding of child maltreatment?
- Should a person be required to wait a specific period of time before seeking to vacate a finding of child abuse or neglect? and
- What safeguards must be included to protect vulnerable populations?

[77] See, Wisconsin Caregiver Program Manual, Chapter 5. http://www.dhs.wisconsin.gov/caregiver/pdffiles/Chap5-RehabReview.pdf
[78] Indiana Ann. Code §§ 31-33-26-14; 31-33-26-15

PART TWO: OFCO CRITICAL INCIDENT CASE REVIEWS

BACKGROUND

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

- **Child Fatalities[79]-** 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; or when the fatality occurred in a CA or Department of Early Learning (DEL) licensed, certified, or state operated facility.

- **Child Near Fatalities[80]-** 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.[81]

- **Recurrent Maltreatment[82]-** When families or children experience recurrent maltreatment-three founded reports of alleged abuse or neglect within the last twelve-month period.

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

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

- 60 reviews of child fatalities both involving child abuse or neglect and cases unrelated to child maltreatment;
- 16 reviews of child near fatalities;
- 111 reviews of cases of recurrent maltreatment; and
- Over 200 reviews of other critical incidents. [83]

[79] RCW 74.13.640(1)(b) requires the department to 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 maltreatment.

[80]RCW 74.13.640(2) requires the department to 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 Ombudsman's request.

[81] RCW 74.13.500.

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

OFCO'S REPORTING PERIOD FOR VARIOUS CRITICAL INCIDENTS

CHILD FATALITIES: This section discusses 60 reviews of child fatalities both involving child abuse or neglect and cases unrelated to child maltreatment, occurring between January 1, 2011 and December 31, 2011. 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 2011 calendar year.

CHILD NEAR FATALITIES: In 2012, OFCO reviewed 16 near fatalities occurring between January 1, 2012 and December 31, 2012.

RECURRENT CHILD MALTREATMENT: For the period September 1, 2011 through August 31, 2012, OFCO reviewed 111 cases of recurrent maltreatment.

OFCO'S ADMINISTRATIVE REVIEW PROCESS

OFCO has developed a database of child fatalities and near fatalities 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.

In addition to OFCO's independent reviews, the Ombudsman participates in:

- **External Child Fatality and Critical Incident Case Reviews**:
  CA and local county child death and critical incident reviews across the state. These reviews provide the Ombudsman with a unique perspective on how reviews are conducted as well as on common factors in child fatalities and critical incidents.[84] 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.

- **Internal Children's Administration Critical Incident Staffings**:
  Beginning in January 2010, under the direction of the current Assistant Secretary, Denise Revels Robinson, CA established a protocol for convening immediate case staffings regarding child fatalities 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.

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[83] In a recent one-month period (November 2012), the Ombudsman received 21 notifications of "other" critical incidents. We estimate receiving over 200 such notifications annually.

[84] 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

- In 2011, OFCO reviewed 60 child fatality cases, both involving child abuse or neglect and cases unrelated to child maltreatment. This represents a 21 percent decrease from 2010, and the lowest number since 2004.
- It is concerning however that while the number of child fatality cases has decreased, there has been a steady increase in the number of child fatalities *directly attributed* to physical abuse or neglect, from eight fatalities in 2009, to 17 in 2010, to 23 in 2011.
- Child abuse or neglect factors were present and *may have contributed to* the child's death in an additional 22 percent of fatalities.

NEAR FATALITY REVIEWS

- OFCO reviewed 16 near-fatality cases in 2012, an increase from those reviewed in 2011.

RECURRENT MALTREATMENT REVIEWS

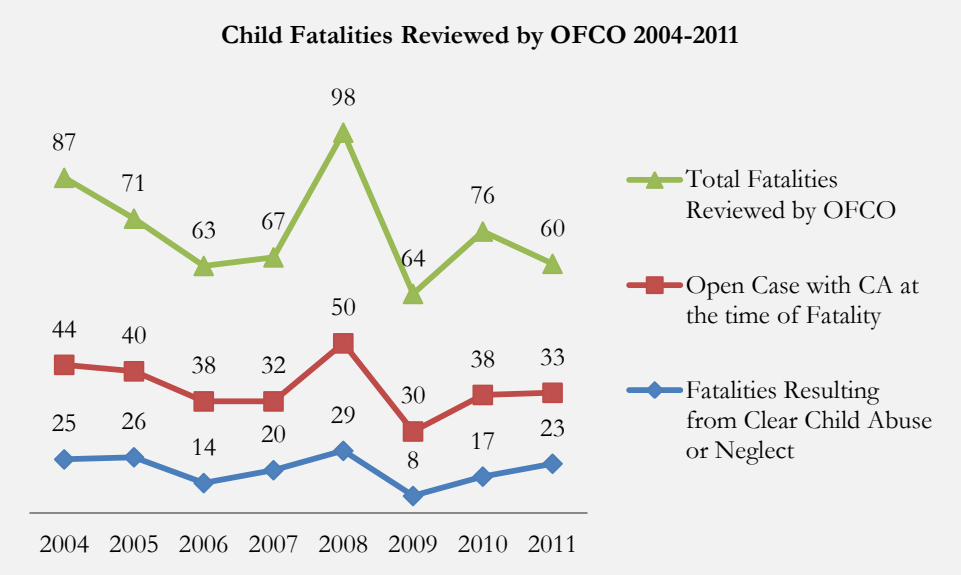
- OFCO received 111 notifications of recurrent maltreatment in its 2012 reporting period, a 15.6 percent increase over the same period last year.
- Neglect continues to constitute the largest number of the founded reports (74 percent) and is more likely to recur than physical or sexual abuse.
- Caregiver substance abuse remains the most prevalent risk factor in these cases (60 percent of cases in 2012, an increase over the 55 percent of cases last year).

CHILD FATALITY REVIEWS

FATALITIES REVIEWED BY OFCO

The Ombudsman reviews all fatalities both involving child abuse or neglect and cases unrelated to child maltreatment, of children whose family had an open case with DSHS CA at the time of death or within one year prior.[85] Since 2004, the number of fatalities reviewed by OFCO has fluctuated between 60 and 98 per year. In the 2011 calendar year, OFCO reviewed **60 fatalities, 21 percent fewer** than the previous year, and **the lowest number since 2004**, when OFCO began collecting this data. It should be noted that a new state law[86] went into effect on July 23, 2011, modifying which fatalities DSHS must review to those deaths that "are suspected to be caused by child abuse or neglect." This law further requires DSHS to consult with OFCO to determine if a fatality review should be conducted in any case in which it cannot be determined whether the child's death is the result of suspected maltreatment.[87] OFCO typically reviews approximately 11 percent of the overall number of child deaths in Washington State.[88] Since 2009, in fatalities reviewed by OFCO, the number of child fatalities **directly attributed to physical abuse or neglect has increased, from 8 fatalities in 2009, to 17 in 2010, to 23 in 2011**.

Fifty-five percent of child fatalities were related to an **open DCFS case at the time of the child's death**, and **40 percent** of the cases were closed at the time of death but **open with DCFS within the previous year**. An additional three fatalities (five percent) occurred in a day care facility licensed by the Department of Early Learning (DEL).[89]



Source: Office of the Family and Children's Ombudsman, November, 2012, based on analysis of DSHS CA data

[85] 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.
[86] RCW 74.13.640
[87] This law also states that DSHS may review any near fatality at its discretion or at the request of the Ombudsman.
[88] 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
[89] DEL is a separate agency from DCFS. However, DLR-CPS investigates allegations of child abuse or neglect occurring at a daycare facility.

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** (rather than was the cause of) 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. OFCO found that in 2011, physical abuse caused the child's death in five cases (eight percent) and neglect clearly contributed to the child's death in eighteen cases (thirty percent). OFCO also found that in an additional 13 cases (22 percent), child abuse or neglect factors were present and may have contributed to the child's death.

CHILD FATALITY DEMOGRAPHICS AND DISPROPORTIONALITY

Consistent with data for all child deaths in Washington State, the majority of fatalities that OFCO reviewed in 2011 (70 percent) were of children under the age of two. Again consistent with statewide data, 42 percent of fatalities were females and 58 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 Native American children make up two percent of the children in Washington State, they represent 17 percent of the child fatalities reviewed by OFCO. Similarly, African American children make up 4.5 percent of the state's child population yet represent 12 percent of the reviewed fatalities.

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.[90]

RACE/ETHNICITY OF 2011 CHILD FATALITIES REVIEWED BY OFCO

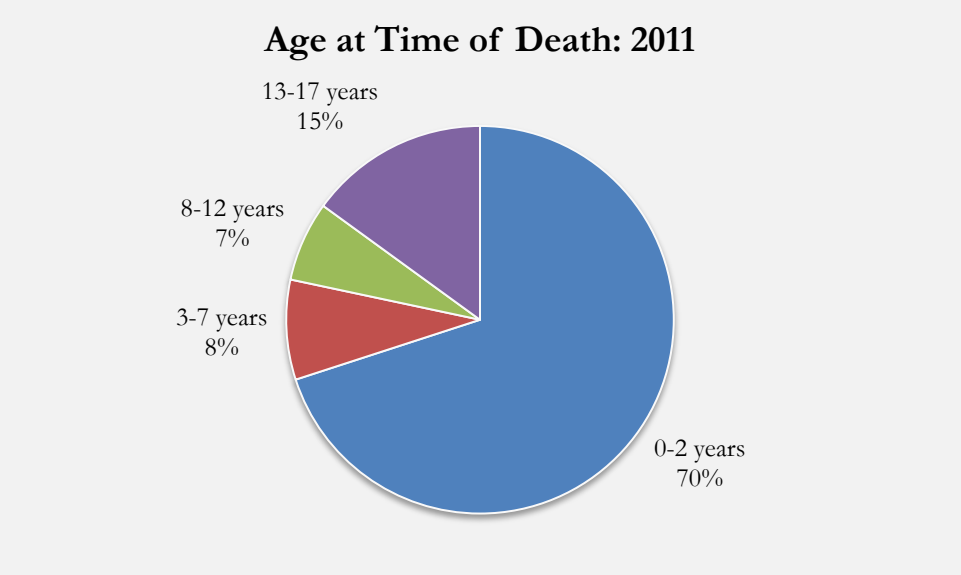
	2011 Fatalities	Children in DCFS placement	WA child population
African American	12%	10%	4.5%
American Indian or Alaska Native	17%	12%	2%
Asian/Pacific Islander	7%	1%	6.8%
Caucasian	77%	58%	80.6%
Multi-Racial	13%	12%	6%
Caucasian and American Indian or Alaska Native	*7%*		
Caucasian and African American	*3%*		
Caucasian and African American and Other	*2%*		
Unknown or Other Race	0%	3%	0%
Hispanic	10%	16%	15.5%
Caucasian, Not Hispanic	68%		72.5%

Source: Office of the Family and Children's Ombudsman, November 2012, 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

[90] 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

CHILD'S 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, October, 2012, based on analysis of DSHS CA data

INFANT SAFE SLEEP ENVIRONMENTS: PUBLIC EDUCATION EFFORTS

In 2011, OFCO documented an **unsafe sleep environment** in **59 percent** of infant deaths it reviewed. This account for **one third of all the child fatalities** reviewed. Unsafe sleep environments therefore continue to be a major contributor to infant fatalities.

OFCO continues to participate in the Infant Safe Sleep Coalition facilitated by Representative Mary Helen Roberts, to promote public education about safe sleep environments for infants. This ad hoc committee includes a broad range of stakeholders in infant well-being, such as representatives from the public health and early learning community, Northwest Infant Survival and SIDS Alliance (NISSA), Sudden Unexpected Infant Death (SUID) Foundation, Safe Kids program of Mary Bridge Children's Hospital, Native American Women's Dialogue on Infant Mortality (NAWDIM), Equal Start Coalition (a Seattle group examining racial disparities in urban infant deaths), the National Center on Child Death Reviews, Parent Trust, and the Children's Administration. The member organizations of this group are individually and collaboratively working on efforts such as:

- Supporting the Cops and Cribs Program, that was designed to train law enforcement officers on domestic calls to identify unsafe sleep environments and provide cribs as needed. Five law enforcement agencies in Washington have thus far committed to participating in this program, as well as a Child Advocacy Center.
- Conducting classes on safe infant sleep (as well as providing cribs as needed) at Child Advocacy Centers.
- Reaching out to pediatricians and hospital staff while continuing efforts to educate parents and the public with a consistent message about safe sleep.

NEAR FATALITY REVIEWS

OFCO reviewed 16 near-fatality cases in 2012. State law provides[91] that the department may conduct a review of any near fatality at its discretion, or at the request of the Ombudsman. Since the passage of this law in 2011, CA has conducted five executive reviews of near fatalities. OFCO investigates the department's actions and the circumstances of each near fatality to assure that appropriate cases receive an executive review. Examples of these reviews are provided below.

EXECUTIVE CHILD NEAR-FATALITY REVIEWS

Child near fatalities offer a learning opportunity for child welfare and other professionals to understand how interventions with families in the context of the child welfare system can be more effective in preventing child maltreatment. The Children's Administration describes the limited purpose and scope of a Child Near-Fatality Review (CNFR) as follows:[92]

> *A Child Near-Fatality Review is not intended to be a fact finding or forensic inquiry or to replace or supersede investigations by courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's injury. Nor is it the function or purpose of a Child Near-Fatality Review to recommend personnel action against DSHS employees or other individuals. Given its limited purpose, a Child Near-Fatality Review should not be construed to be a final or comprehensive review of all the circumstances surrounding the injury of a child. The CNFR committee's review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers. The committee has no subpoena power or authority to compel attendance and generally only hears from DSHS employees and service providers. It does not hear the points of view of the child's parents and relatives, or of other individuals associated with the injured child's life or death.*

Executive Near-Fatality Review Committees typically include CA staff, the Family and Children's Ombudsman, and community professionals selected from diverse disciplines with expertise relevant to the case, such as law enforcement, chemical dependency, domestic violence, mental health, child health, or social work. Committee members have no previous involvement with the case.

The following cases exemplify the near-fatality review process and the types of findings and recommendations that have been made since these reviews were initiated.

DECISION TO SCREEN OUT CPS INTAKE FOR INVESTIGATION PRESENTS MISSED OPPORTUNITY TO ASSESS CHILD SAFETY

A 14-month old child was found unconscious and not breathing by law enforcement when called to the family's home on an unrelated matter. The child suffered serious brain damage. Years prior to this near-fatality incident, the Children's Administration had provided services to the child's mother with regard to three older children. Prior to the subject child's birth, CA received three reports of suspected neglect, involving domestic violence between the parents and substance abuse by the mother. At the time of the subject child's birth, the mother was enrolled in an in-patient drug treatment program and she agreed to a voluntary service plan and her case with CA was closed

[91] RCW 74.13.640(2)

[92] Statement provided by CA in the Executive Summary of each Near-Fatality Review report.

shortly thereafter. A CPS intake when the child was six months old alleged that the child was transported by her mother without the use of child safety restraints. The intake was screened in for alternative intervention and a letter was sent to the mother informing her of free car seat resources and the case was closed. A month prior to the near-fatality incident, CPS received a second intake from a drug court case manager who reported that the mother had tested positive for methamphetamines and missed a court date. The whereabouts of the mother and child were unknown at the time, and the intake was not screened in for investigation.

The Child Near-Fatality Review committee's discussion focused on the CPS intake process and the challenges presented when clients are engaged with multiple systems, such as CPS, law enforcement, or the courts. The committee formulated several findings, most notably, that the decision to screen out the intake reported by the drug court case manager a month before the critical incident was a missed opportunity to assess the safety of the child. The mother's history of chronic neglect, mental illness, criminal activity, substance abuse and termination of parental rights were "significant indicators perhaps not fully considered at the time of the intake screening decision."[93]

Stemming from its findings, the committee made three recommendations: 1) CA should explore establishing a formal and systematic information exchange with Washington State Department of Corrections; 2) CA's interagency agreements with local law enforcement agencies should address utilizing technology for information sharing between agencies and when to notify local law enforcement if CA receives an intake alleging a child's whereabouts is unknown and there are concerns or risk of abuse or neglect; and 3) CA's intake supervisors should receive a "lessons learned" reminder of the importance of a comprehensive review of a parent's history of involvement with CA when making intake screening decisions.

INFANT STARVES DESPITE REGULAR MEDICAL CARE AND IN-HOME SERVICES

A two-month-old infant was admitted to the hospital for severe failure to thrive from nutritional deprivation and a severe skin infection. At the time of the incident, the infant was in the care of her mother and the family was receiving Family Voluntary Services (FVS) from the Children's Administration. CA had provided services to the mother as an adolescent, for a period of 6-7 years. CA had no further contact with her until approximately five years later, about a month prior to the birth of the subject child, when CPS received two reports alleging neglect of the mother's first child. These intakes were screened in for investigation, and the mother voluntarily agreed to participate in services to assist her in maintaining a clean and safe home, and improving her parenting skills. Additional service goals included encouraging the mother's full participation in mental health services and helping her learn to identify safe individuals to be around her children. Services included home visits by a public health nurse, therapeutic child care, and in-home counseling and support. The subject child was born within the first month of these services being provided.

From the time of the child's birth to the near-fatality incident two months later, 11 home visits were conducted by either the FVS social worker or the contracted service provider. While some concerns were noted about the mother's progress toward the service goals, there were no concerns about the infant's growth. Her weight was checked by her primary care physician or the public health nurse five times in the 5-6 weeks following her birth. Two weeks later, the infant was admitted to the hospital and diagnosed with severe failure to thrive from nutritional deprivation; the infant had

[93] CA Child Near-Fatality Review report, August 30, 2012.

experienced a 23 percent weight loss in two weeks, which could not be attributed to any disease or medical condition.

The CNFR committee's discussion focused on the role in case planning and service delivery by the three CA-contracted providers and the flow of information between CA and these providers. The committee further examined best practices in obtaining information from collateral sources such as mental health providers and primary care physicians, noting that comprehensive safety assessments are not possible if valuable information is not obtained from collateral contacts or collaterals do not raise concerns in a timely fashion. Finally, the Committee considered planning tools used by CA social workers in assessing safety threats and creating safety plans, as well as in service planning.

The committee made seven findings relating to service delivery in this case. Recommendations included the state-wide adoption of practice changes already implemented by the involved CA office following this incident: requiring CA social workers to visually examine all infants under the age of one year (unclothed) during home visits, and revising the contract requirements for in-home service providers to include weekly observation of any child living in the home of the family receiving the contracted service.

Based on the Ombudsman's experience in participating in these and other Child Near-Fatality Reviews, the process is working as intended – to improve social work practice and service delivery in the child welfare system, and ultimately to reduce child maltreatment in general. Like Executive Child Fatality Reviews, Near-Fatality Reviews bring together a diverse group of experts who lend a critical eye to the work done by the Children's Administration and contracted service providers. The four CNFRs conducted in 2012 demonstrate an in-depth examination of practice issues and have resulted in thoughtful findings and specific recommendations.

OFCO will continue to examine the findings and recommendations made in both fatality and near-fatality reviews to identify patterns and common themes. A stand-alone report regarding the implementation of the recommendations that come out of these reviews will be published in 2013.

SYSTEMIC INVESTIGATION: RECURRENT MALTREATMENT

BACKGROUND

Beginning in 2008, DSHS/CA is required to notify OFCO of families or children who experience three or more founded[94] reports[95] of alleged abuse or neglect within the last twelve month period.[96] 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.[97]

DISCUSSION

For the period of September 1, 2011 through August 31, 2012, OFCO received a total of 111 notifications, a 15.6 percent increase from the same period ending in August 2011. 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 2012, out of 111 cases of recurrent maltreatment, OFCO had 19 complaints or inquiries relating to the child or family, and five notifications of a fatality, near fatality, or other critical incident.

CASE EXAMPLE: OFCO INVOLVED IN RECURRENT MALTREATMENT CASE THROUGH MULTIPLE AVENUES

OFCO received notification of a case with three founded reports relating to a mother's neglect of her nine-year-old son who has both a developmental disability as well as an acute medical condition. The founded reports alleged: 1) that the mother was arrested for Driving Under the Influence with her son in the vehicle; 2) that the mother had failed to bring the child for medical treatments for his acute condition, thus diminishing the likelihood of a cure; and 3) that the mother left the child in the care of his elderly grandmother during a course of treatment and grandmother had been unable to meet the child's basic needs for food and bathing and had not accepted offered assistance.

At this point, DCFS/CPS had closed the family's case without providing any ongoing services. OFCO monitored the case for new referrals and, subsequently, DCFS received another referral alleging that mother may have been drinking and driving with the child. In the course of monitoring the investigation into this allegation, OFCO contacted the assigned social worker to inquire as to why there had been no documented activity on the case in the two months since the child and mother were seen by after-hours workers for the initial face-to-face interview. The CPS supervisor directed the social worker to complete a 30 day Health & Safety Visit with the family immediately. When the mother brought the child into the DCFS office, the child appeared well-cared for and the mother presented as clean and sober.

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[94] "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).
[95] In this context, "report" means a "referral" to Child Protective Services, which DSHS/CA now calls an "intake."
[96] RCW 26.44.030(13).
[97] "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.*

A month and a half later, DCFS received another referral alleging that it may not be safe for the child to be discharged from the hospital to his mother's care. These concerns arose from the mother not returning to the hospital overnight when she said she would be right back; a loud fight between the mother and her boyfriend which resulted in the police responding and the mother being kicked out of hospital housing; and observations by the police and hospital staff that indicated mother may have been intoxicated. DCFS filed for dependency and placed the child in a medically trained foster home so he could continue to receive treatment.

OFCO received a complaint alleging that DCFS was planning to move this child from the medically trained foster home due to a dispute over the reimbursement level for the child's cost of care. **OFCO found that this was true but that the decision to move the child was not clearly unreasonable or contrary to the child's best interests.**

OFCO then received a second complaint regarding this family, alleging that DCFS/CFWS was failing to allow reasonable contact between the parent and the child's medical providers. OFCO found that the agency was placing increasingly stringent restrictions on contact and had told the parent that she could not communicate directly with the child's medical providers, instead directing the hospital to communicate the information to the worker who would pass it on to the mother. **OFCO believed this was a violation of the parent's right to communicate directly regarding the child's health care,** and requested that the department establish whether the medical providers were amenable to direct contact from the mother. Everyone was able to agree to a plan for the mother to contact the doctor once a day.
This second complaint to OFCO also alleged that DCFS was unreasonably failing to place the child with his grandparent and/or return the child to his mother's care despite the mother's completion of services. These concerns were resolved by the court ordering that the child be returned to the mother's care. DCFS continues to oversee the in-home dependency and no further referrals have been received.

OFCO FINDING IN RECURRENT MALTREATMENT CASE

OFCO FINDING:

On October 3, 2011, the Office of the Family and Children's Ombudsman (OFCO) received notification of an investigative assessment that was completed which constituted the **third or subsequent founded report** received by the department within the last twelve months.[98] OFCO reviews each of these cases as part of an ongoing systemic investigation into recurrent maltreatment.

Upon review of this case, OFCO had concerns regarding a determination that an allegation of physical abuse was *unfounded* by Child Protective Services (CPS) in May 2011. OFCO requested that the Area Administrator (AA) review this investigation and the subsequent founded investigations which occurred in July 2011.

OFCO has concluded that the determination of unfounded for the May referral was clearly unreasonable based on the evidence documented in the file. Specifically, in response to OFCO's query to the AA, the CPS supervisor explained: *"The decision was made based on [the injury being] transient marks and inconsistency in [the] child's statements."* However, the facts documented in the course of the investigation do not support the conclusions that 1) the injuries sustained by the child were transient; 2) that the child's statements were inconsistent; and thus, 3) that the investigation should have been unfounded for physical abuse under the WAC definition.

The relevant facts are as follows:

- On Monday, DCFS/CPS received an intake from the seven-year-old child's school alleging that the child arrived at school with an injury on her shoulder. Child stated that her mom hit her with the cat box litter scoop. The child has a six inch long abrasion on her shoulder that is about two inches wide. The referent stated the injury looks like scratch marks that are inflamed. This intake screened in for investigation with a 72-hour response time.
- On Tuesday, the CPS social worker conducted an initial face-to-face interview with the child at her school. The interview and social worker's observations of the child's injury are summarized as follows: *Child told me she got scratched on the shoulder by her mom. Her mom hit her with a kitty litter scoop. She said it hurt a lot. It happened on Sunday. Child showed me her injury which appeared to be consistent with her statement. The mark was about three inches long and one inch wide with multiple linear abrasions. The skin had been broken and was lightly scabbed over. The injury is on the back of her left shoulder. Child told me that she gets spankings with a spanking board. She said she is afraid of her mom and dad.*

After this interview, the social worker went to the Police Department and informed them a crime may have occurred. The social worker and a police officer returned to the school and photographed the child's injury. The child told the officer that "her mom had hit her with the kitty litter scoop."

Thereafter, there are no case notes documenting any further contact between CPS and the child.

Based on these notes, the child consistently disclosed being hit with a kitty litter scoop by her mother resulting in an injury to her shoulder which was clearly visible to the CPS social worker and law enforcement officer two days after the incident was alleged to have occurred.

In approving the investigation for closure as unfounded, the supervisor wrote, *"Allegations are not founded for physical abuse; these appear to have been very transient marks, though inflicted, per the child's statement."*

Under WAC 388-15-09(1) "Physical abuse means the nonaccidental infliction of physical injury or physical mistreatment on a child. Physical abuse includes, but is not limited to, such actions as…

[98] RCW 26.44.030(13).

(f) Doing any other act that is likely to cause and which does cause bodily harm *greater than transient pain or minor temporary marks*…." (emphasis added). **OFCO disagrees that a mark that was described two days after it was inflicted as "three inches long and one inch wide with multiple linear abrasions. The skin had been broken and was lightly scabbed over" qualifies as "minor temporary marks."**

As for the explanation that the unfounded decision was based in part on the child's inconsistent statements, it is unclear what this is based on given the documented consistency in the child's statements to her teacher, during the CPS interview, and to law enforcement. To the contrary, the supervisor wrote in case notes that the "child…was consistent in stating she had been struck by her caretaker"

Thus, because the evidence shows that, more likely than not, physical abuse as defined by WAC 388-15-09(1)(f) did occur, OFCO finds that CPS' determination of this intake as unfounded for physical abuse is clearly unreasonable.

CA RESPONSE:

Thank you for your feedback. We agree with your assessment. You have provided good information that **will help us improve our work with children and families**.

I will be sharing your letter with the assigned social worker and social work supervisor, plus have requested training for the unit by the regional CPS Coordinator on transient marks and elements of a comprehensive CPS investigation.

In further review, CA agrees with OFCO's finding that the documented marks on the youth in question were not transient. Documentation could have been more extensive and clearer in accurately depicting the injury. Additionally, consultation with CA's medical consultant would have been important in assessing the injury or asking the parent to take the child to their primary care physician for treatment and documentation of the injury.

We also agree that the statements made by the child were consistent as the child reported the same story of acquiring the injury to her teacher, the CPS investigator, and to law enforcement. The child did add detail of variations to her story with successive interviews; however ultimately her message remained consistent.

We understand OFCO's rationale behind a founded finding for physical abuse. However we are not certain that the department would have ultimately prevailed in maintaining the finding as the client moved through the CAPTA review and appeal process.

SUMMARY OF DATA FOR RECURRENT MALTREATMENT CASES:

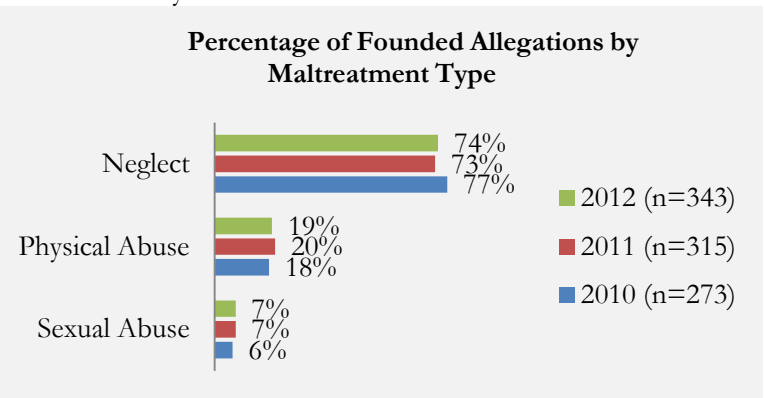
OFCO's data for this group of cases with three or more founded reports within one year remains fairly consistent year-to-year and with state and nation-wide child welfare data, in that:

- Reports of neglect constituted 74 percent of the founded reports, physical abuse 19 percent, and sexual abuse seven percent.[99]
- Neglect is more likely to recur than physical or sexual abuse.[100]
- Caregiver substance abuse is the most prevalent risk factor (affecting 60 percent of the families) in these recurrent cases.
- A significant percentage of families have had a previous dependency for either a parent (eight percent) or a child (38 percent).

2012 data includes notifications received by OFCO within its reporting year, which commences September 1st and ends August 31st. Data from 2011 and 2010 is provided for comparison.

TYPE OF CHILD MALTREATMENT

The graph below summarizes the type of maltreatment substantiated in the first, second, and third founded reports.[101] Consistent with previous years, physical neglect is, by far, the most common type of maltreatment experienced by children in these recurrent cases, comprising nearly 74 percent of all founded reports reviewed by OFCO.



Source: Office of the Family and Children's Ombudsman, November 2012, based on analysis of DSHS/CA data

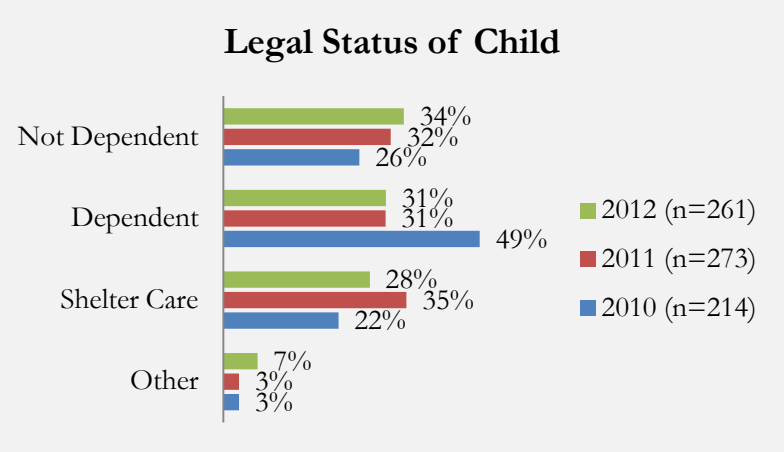
[99] In the federal government report, Child Maltreatment 2007, nationwide statistics showed: "During FFY 2007, 59.0 percent of victims experienced neglect, 10.8 percent were physically abused, 7.6 percent were sexually abused, 4.2 percent were psychologically maltreated, less than one percent were medically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

[100] 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.").

[101] 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."

LEGAL STATUS OF CHILDREN AT TIME OF NOTIFICATION

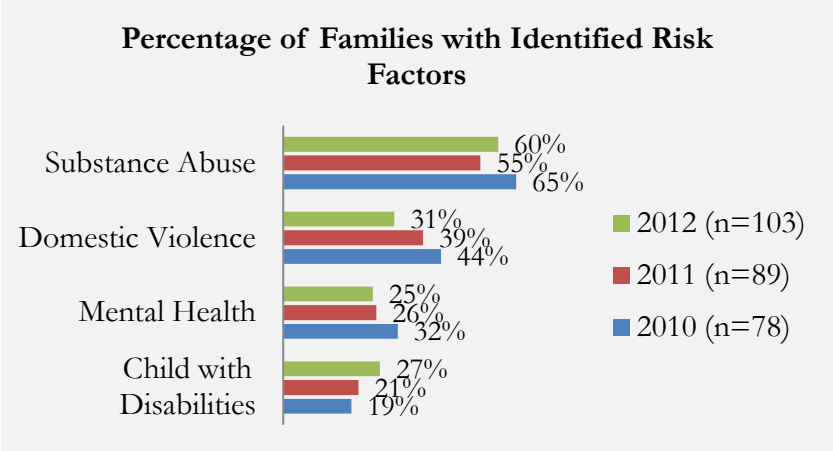
For a large majority (59 percent) of the cases reviewed, DSHS/CA had already taken affirmative legal action – either through an in-home or out-of-home dependency – to ensure the safety of the children.[102] Thirty-four percent of children identified were not dependent or in shelter care at the time OFCO 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 2012, based on analysis of DSHS/CA data

PRESENTING RISK FACTORS[103]

Substance abuse was identified as a risk factor in more than half (60 percent) of the families, representing an increase of five percent since 2011. These cases often involve parental abuse of alcohol or prescription medications. Thirty-one percent of families experienced domestic violence and twenty-five percent experienced mental health issues. Both of these risk factors decreased slightly compared to 2011. The percentage of families with at least one child with a disability (27 percent) increased when compared to previous years.

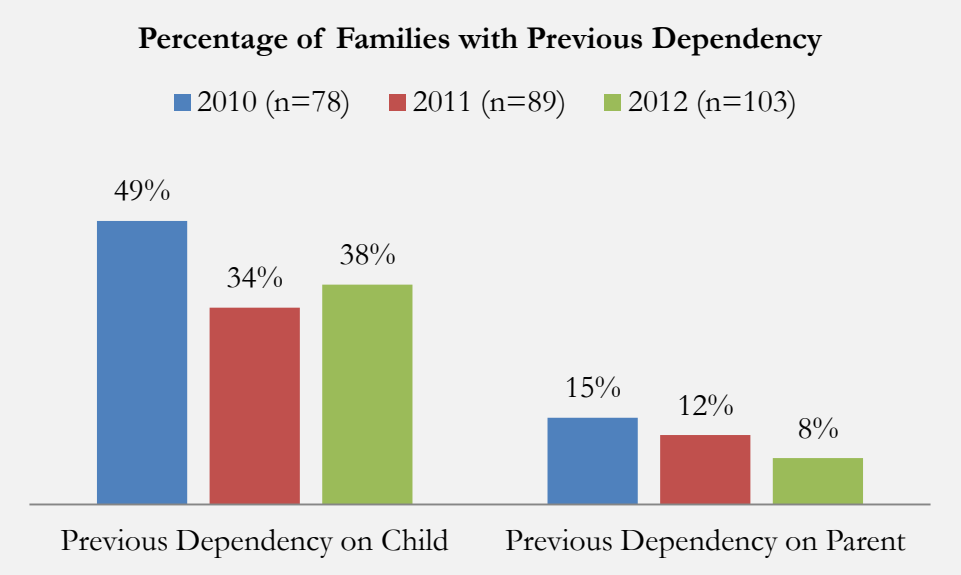


Source: Office of the Family and Children's Ombudsman, November 2012, based on analysis of DSHS/CA data

[102] 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.
[103] 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

Consistent with 2011, 46 percent of families involved in these recurrent maltreatment cases experience a prior dependency. The number of families with a previous dependency for at least one child increased slightly since 2011, but remained significantly lower than 2010, when almost half the families had a previous dependency on a child. The number of families with at least one parent who was dependent as a child slightly decreased steadily over the last three years, from 15 percent in 2010 to 12 percent in 2011, and just 8 percent in 2012.[104]

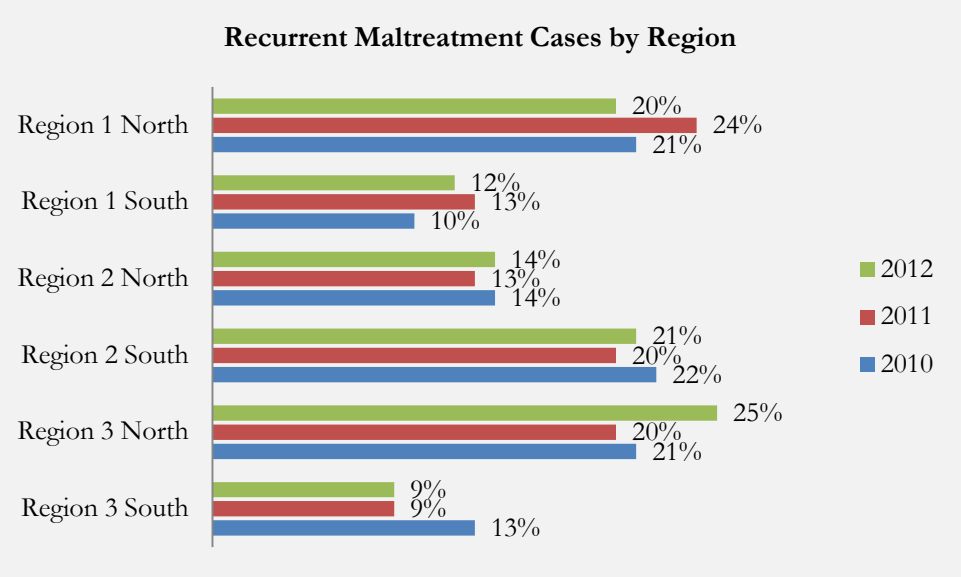


Source: Office of the Family and Children's Ombudsman, November 2012, based on analysis of DSHS/CA data

These cases involve a wide range of circumstances: parents who were in foster care as children; 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 as a result of a dependency action; and adopted children, now the victims of abuse or neglect in their adoptive homes. In 2012, three of the recurrent maltreatment cases involved abuse or neglect of dependent children by licensed foster parents or group home staff. Two involved abuse or neglect which occurred in licensed daycare facilities.

[104] This decrease may be attributable to changes in the way information is available in CA's current case information database, FamLink, versus the previous CAMIS system.

RECURRENT MALTREATMENT CASES BY DCFS REGION



Source: Office of the Family and Children's Ombudsman, November 2012, based on analysis of DSHS/CA data

PART THREE: 2012 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 2012 legislative session, the Ombudsman reviewed, analyzed, and commented on several pieces of proposed legislation regarding Title IV-E waiver and reinvesting in child welfare services, and a flexible approach to Child Protective Services and responding to the needs of families, and extending foster care services to age 21. OFCO provided written or verbal testimony on the following legislation:[105]

ENACTED LEGISLATION

TITLE IV-E WAIVER AND REINVESTMENT

(Chapter204, Laws of 2012, Effective June 7, 2012)

This legislation facilitates the reinvestment of savings resulting from reductions in foster care into child welfare programs to strengthen and preserve families and improve outcomes for children. Federal funding for child welfare focuses primarily on out-of-home placement rather than alternative services to support families and protect children.

Under Title IV-E of the Social Security Act, federal funds are available for monthly maintenance payments for the daily care and supervision of eligible children in out-of-home care. States are required to match federal funds. A state's IV-E claims can increase as the number of children in foster care increases. However, the opposite also occurs: when a State succeeds in reducing foster care caseloads by reuniting families or establishing a permanent home for a child, the State typically loses federal foster care dollars. By reestablishing Title IV-E waivers, States may now apply to use federal foster care dollars for services to prevent entry into foster care or to ensure that family reunification is safe and permanent.

This legislation provides that savings from reductions in foster care may be used to (1) safely reduce entries and prevent re-entry; (2) safely increase reunifications; (3) achieve permanency for children unable to reunify; and (4) improve outcomes for youth who age out of care. The director Ombudsman serves on the Title IV-E Advisory Committee. The advisory committee is co-chaired by Representative Ruth Kagi and Denise Revels Robinson, the Assistant Secretary of the DSHS Children's Administration.

The majority of complaints investigated by OFCO involve the separation and reunification of families and the safety of children living at home or in substitute care. This legislation directs funds to provide necessary services to improve outcomes for children and families.

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

A FLEXIBLE APPROACH TO CHILD PROTECTIVE SERVICES- "FAMILY ASSESSMENT RESPONSE"

(Chapter259, Laws of 2012, Effective June 7, 2012)

This legislation provides greater flexibility to our state child welfare system to engage families and effectively address concerns regarding child maltreatment. Specifically, in two pilot sites, the department will implement a procedure to respond to accepted CPS referrals either by conducting a traditional CPS investigation, or by conducting a "family assessment" and offering services. Strengths of this legislation include:

- A family assessment still includes a comprehensive evaluation of child safety and risk of subsequent maltreatment.
- Parents have a right to refuse a family assessment and opt instead for a CPS investigation if they choose.
- Based on new information CPS may change its response from a family assessment to an investigation.
- A family assessment does not result in a determination that allegations of abuse or neglect are either "founded" or "unfounded."
- A family assessment provides an avenue to engage the family and provide appropriate voluntary services to prevent future maltreatment.
- The family assessment response process will undergo a rigorous independent progress report addressing child safety measures.

OFCO's testimony stressed that implementation strategies should ensure that:

- The case selection process for a family assessment is consistent in both sites.
- Law enforcement, along with other stakeholders are involved in the planning, site selection and implementation process.
- The department monitors cases referred for a family assessment to identify and address any unintended consequences that might increase the risk of child maltreatment.

OFCO is developing an internal work plan to monitor the Family Assessment Response (FAR), its impact on the child welfare system, and on the type of complaints received by the Ombudsman. OFCO is particularly interested in:

- ***The availability of services to assist families;***
- ***Subsequent CPS referrals on families engaging in FAR;***
- ***Initial CPS screening decisions; and***
- ***Child safety.***

PROVIDING FOR EXTENDED FOSTER CARE

(Chapter 52, Laws of 2012, Effective June 7, 2012)

This legislation provides basic care and stability necessary for a foster youth to pursue postsecondary education until he or she turns 21 years of age. This program will prepare these youth for early adulthood and improve their chances for success.

To ensure that eligible foster youth have an opportunity to take advantage of extended foster care, the dismissal of a dependency is postponed for six months after the youth turns 18.

OFCO's testimony expressed concerns about the plight of the approximately 400-500 foster youth who turn 18 years old and "age out" of our foster care system each year. Many of these youth lack basic services to successfully transition into adulthood.

Studies of youth who leave foster care without a safe, permanent family reveal negative life outcomes.[106] For example:

- Twenty-five percent of youth who aged out of foster care did not have a high school diploma or GED.
- Less than two percent finished college compared with 23 percent of youth in the general population.
- Over half of youth who aged out of foster care experienced one or more episodes of homelessness, and nearly 30 percent were incarcerated at some point.
- Youth who aged out of foster care were less likely to be employed or to have health insurance than were their peers who had not been in foster care.

These negative experiences compromise these young adults' abilities to lead independent, fulfilling and productive lives and create substantial costs for government.

[106] *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

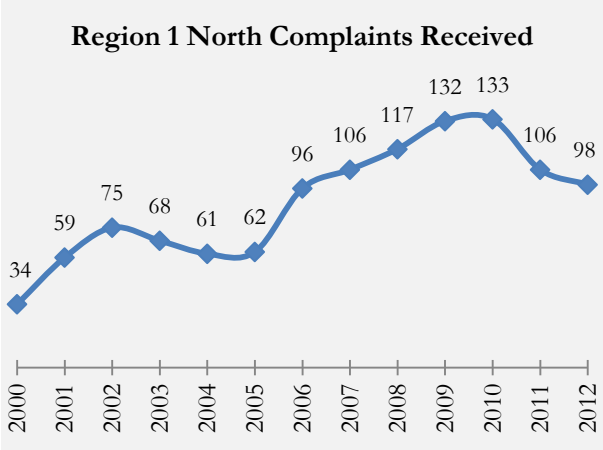
V. APPENDICES

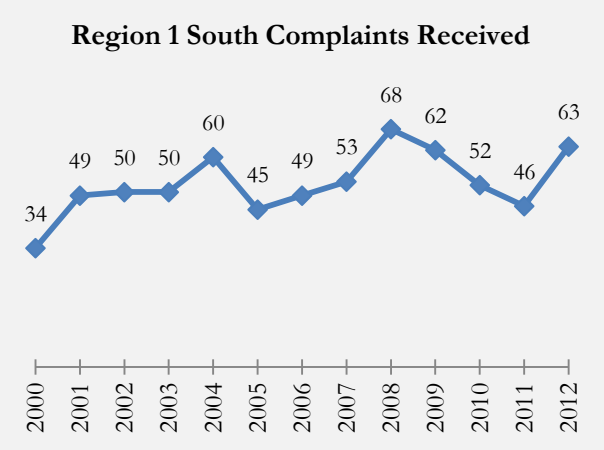
APPENDIX A:
Complaints Received by Region 2000-2012

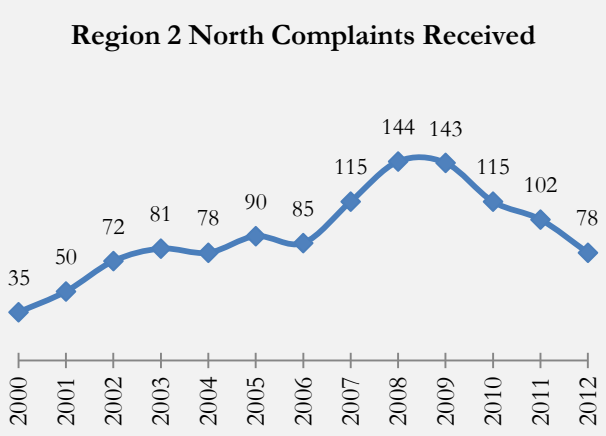
APPENDIX B:
Race/Ethnicity of Children Identified in Complaints to OFCO

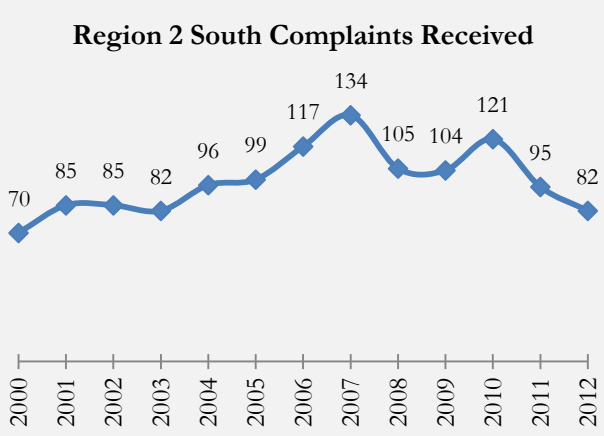
APPENDIX C:
Data Gathered From Child Fatalities and Near Fatalities Examined by OFCO

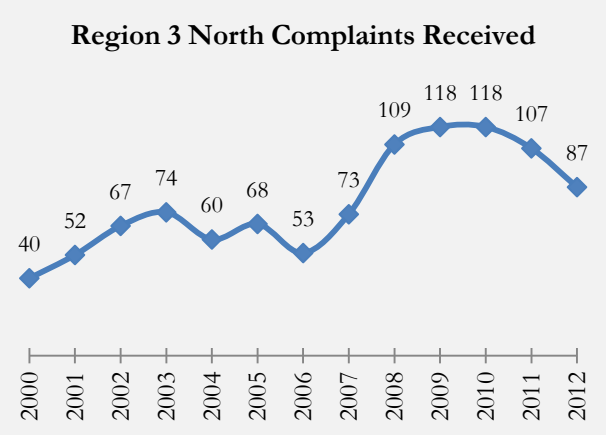
APPENDIX A: COMPLAINTS RECEIVED BY REGION 2000-2012

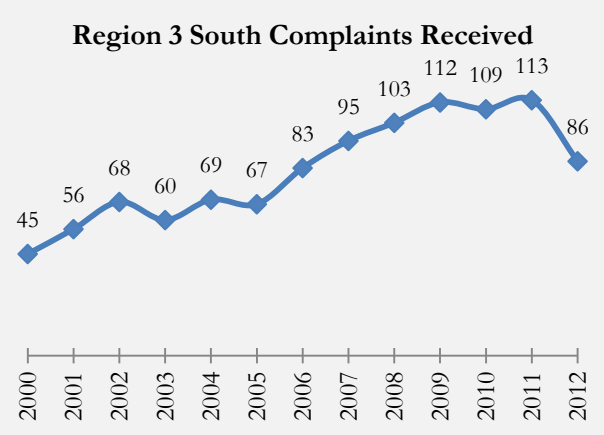












APPENDIX B: RACE/ETHNICITY OF CHILDREN IDENTIFIED IN COMPLAINTS TO OFCO

The following table provides a detailed breakdown of the race/ethnicity of children identified in complaints to the Ombudsman.

Not Hispanic	89.3%
African American	10.1%
African American & Native Hawaiian Pacific Islander	0.6%
African American & American Indian or Alaska Native	0.5%
African American & American Indian or Alaska Native & Caucasian	0.6%
African American & Asian	0.5%
African American & Some Other Race	0.7%
American Indian or Alaska Native	4.7%
American Indian or Alaska Native & Asian	0.1%
American Indian or Alaska Native & Some Other Race	0.0%
Asian	0.7%
Caucasian	58.1%
Caucasian & African American	5.3%
Caucasian & American Indian or Alaska Native	3.4%
Caucasian & Asian	0.7%
Caucasian & Native Hawaiian Pacific Islander	0.1%
Native Hawaiian Pacific Islander	0.2%
Other Race	1.1%
Declined to Answer	1.4%

Hispanic	10.7%
African American	0.1%
African American & American Indian or Alaska Native	0.0%
African American & American Indian or Alaska Native & Caucasian	0.2%
American Indian or Alaska Native	0.7%
Caucasian	7.1%
Caucasian & African American	0.7%
Caucasian & American Indian or Alaska Native	0.6%
Native Hawaiian Pacific Islander	0.2%
Other Race	0.7%
Declined to Answer	0.0%

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

FATALITIES BY DSHS REGION

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

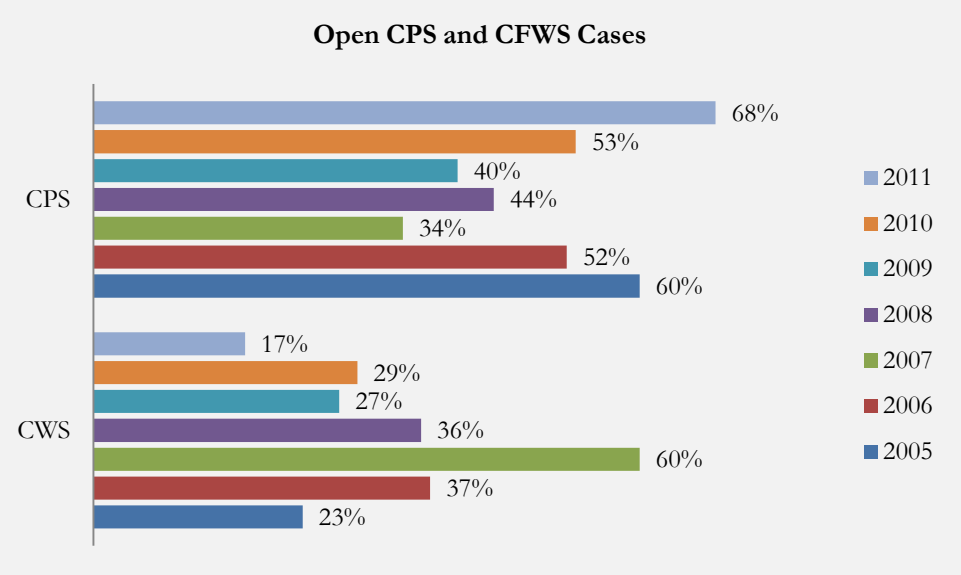
Regional Offices:	Children Served by CA Region[107]:
Region 1 North – Spokane	29,174
Region 1 South – Yakima	22,799
Region 2 North – Everett	34,037
Region 2 South – Seattle	39,281
Region 3 North – Tacoma	31,930
Region 3 South – Vancouver	37,238

OFCO CHILD FATALITY REVIEWS BY REGION

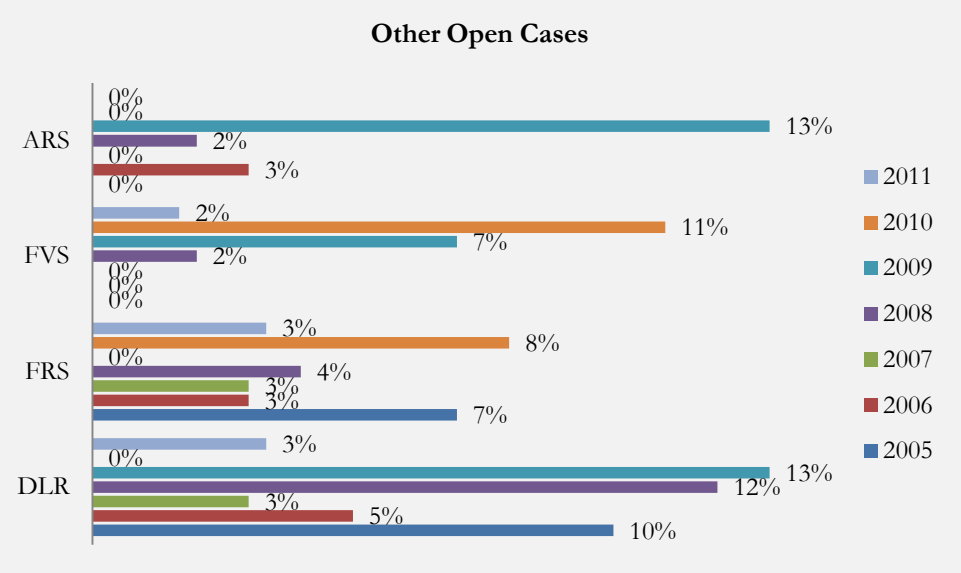
	2004	2005	2006	2007	2008	2009	2010	2011
Region 1 North	17	9	9	3	9	13	10	10
Region 1 South	7	10	7	10	15	2	11	15
Region 2 North	14	13	9	16	17	15	11	7
Region 2 South	13	16	13	9	15	17	14	10
Region 3 North	22	7	15	18	23	11	13	11
Region 3 South	14	16	10	11	19	6	17	7
Total	**87**	**71**	**63**	**67**	**98**	**64**	**76**	**60**

Source: Office of the Family and Children's Ombudsman, November 2012, based on analysis of DSHS CA data

[107] Taken from 2010 CA data, see http://clientdata.rda.dshs.wa.gov/



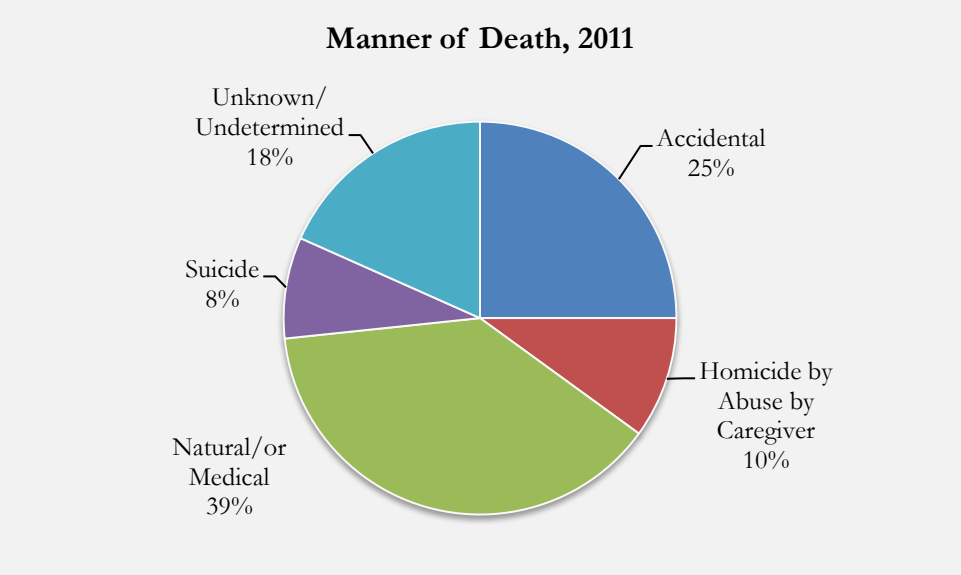
Source: Office of the Family and Children's Ombudsman, November 2012, based on analysis of DSHS CA data



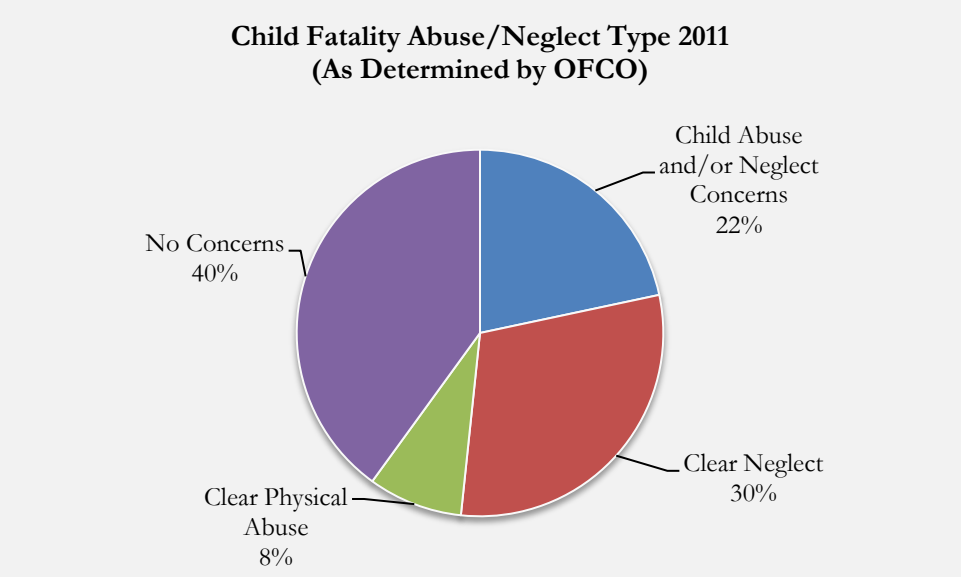
Source: Office of the Family and Children's Ombudsman, November 2012, based on analysis of DSHS CA data

MANNER OF DEATH

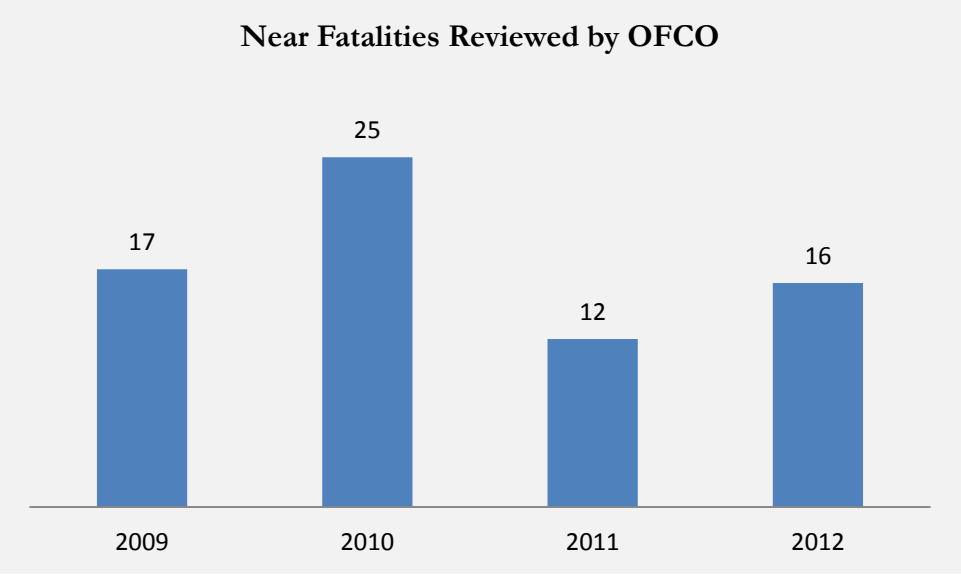
The manner and cause of death is determined by a medical examiner or coroner. The manner of death describes the context or circumstances of the death and is assigned to one of five primary categories: 1) unknown/undetermined, 2) natural/medical, 3) accidental, 4) homicide and 5) suicide. The cause of 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 2011.



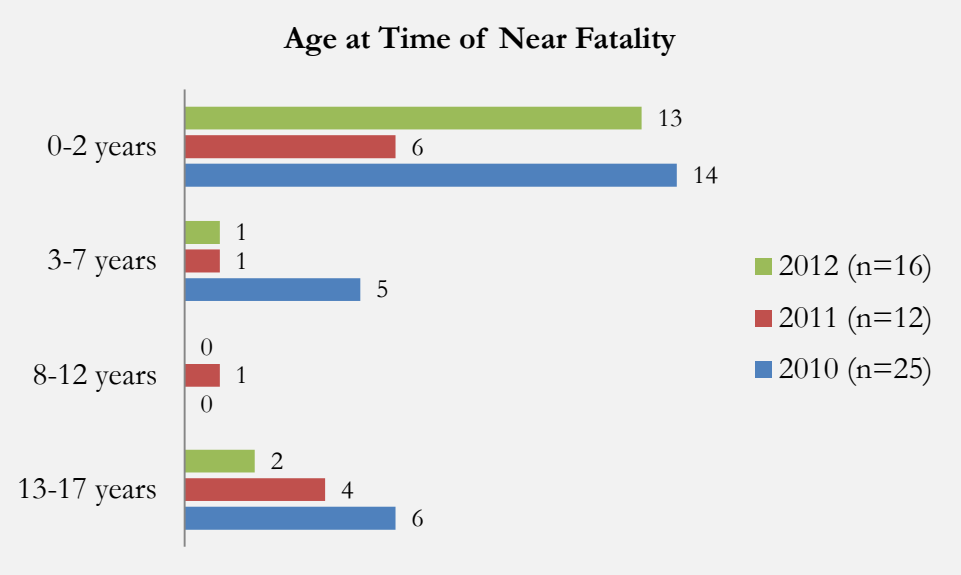
Source: Office of the Family and Children's Ombudsman, November 2012, based on analysis of DSHS CA data



Source: Office of the Family and Children's Ombudsman, November 2012, based on analysis of DSHS CA data



Source: Office of the Family and Children's Ombudsman, December 2012, based on analysis of DSHS CA data



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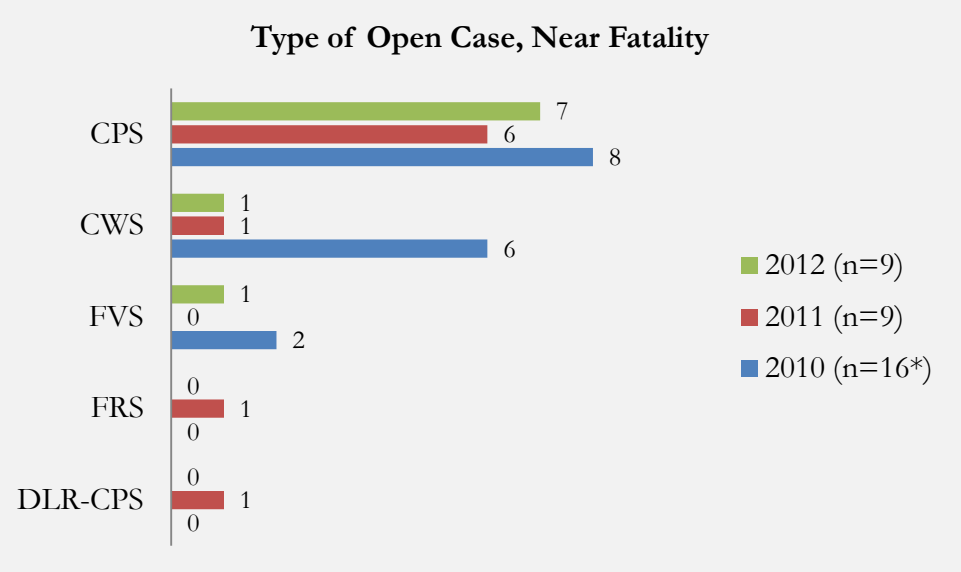

Source: Office of the Family and Children's Ombudsman, December 2012, based on analysis of DSHS CA data

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

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Catalyst for Kids, Seattle

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Seattle & King County Public Health Department, Seattle

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HEIKE LAKE
Lutheran Community Services, Spokane

ROSEY THURMAN
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32nd District

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27th District

SENATOR VAL STEVENS
21st District

SENATOR DEBBIE REGALA
39th District

*2011/2012 Legislative Session

STAFF

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

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. His extensive experience in child welfare law and policy includes his work as a managing attorney with the Washington State Office of Public Defense (OPD) Parents Representation Program and as an Ombudsman with OFCO from 1999 to 2005. 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. Prior to that, she served as a clerk to the Honorable Gabriel W. Gorenstein in the Southern District of New York. She received a 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.

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 a 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 Intake Screener.

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

Intake Screener/Office and Database Administrator
Kaity Zander holds a Bachelor's degree in Psychology from University of Wisconsin-Whitewater. Before joining OFCO in April 2012, Ms. Zander worked as a Child Advocate in Walworth County, Wisconsin. In this role she provided counseling and referral for children and families who had been affected by abuse and neglect, and collected and analyzed data relating to funding and grant compliance. Prior to this work, Ms. Zander completed an undergraduate internship with Child Protective Services, where she conducted initial assessment investigations and provided ongoing case management services.