Office of the Family and Children's Ombuds

An Independent Voice for Families and Children

2013 Annual Report

Mary Meinig, *Director*
governor.wa.gov/ofco

STATE OF WASHINGTON
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To the Residents of Washington State:

I am pleased to submit the 2013 Annual Report of the Office of the Family and Children's Ombuds. This report provides an account of OFCO's activities from September 1, 2012 to August 31, 2013 and our recommendations to improve the child welfare system.

During this reporting period, OFCO completed 512 complaint investigations regarding 849 children and 488 families. More than 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. As in past years, the separation and reunification of families and the safety of children living at home or in substitute care were by far the most frequently identified issues in complaints.

In addition to complaint investigations, OFCO monitors practices and procedures within the child welfare system and makes recommendations to better serve children and families. Systemic issues and recommendations discussed in this report include continued efforts to improve the adoption process and protect children, and the need for attorney representation for children in dependency cases.

I want to express my appreciation to Governor Inslee who has made protecting children from abuse and neglect and improving outcomes for foster children, a priority of *Results Washington*[1] which aims to make state government more effective, efficient, accountable and transparent, as well as to the Legislature, the Department of Social and Health Services, private agencies and advocates who are committed to excellence in child welfare outcomes. I also wish to welcome Department of Social and Health Services Secretary Kevin Quigley and Children's Administration Assistant Secretary Jennifer Strus. OFCO recognizes their leadership and dedication to improving the safety and welfare of children and families.

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

Sincerely,

Mary Meinig
Director Ombuds

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

TABLE OF CONTENTS

EXECUTIVE SUMMARY

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

This report provides an account of OFCO's complaint investigation activities from September 1, 2012, through August 31, 2013; OFCO's administrative reviews of child fatality cases (January through December, 2012); and administrative review of near fatalities (January through December, 2013). This report also provides recommendations to improve the quality of state services for children and families.

CORE DUTIES

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

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

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

System Oversight and Improvement:

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

Annual Reports:

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

[2] RCW 43.06A and RCW 26.44.030.

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

INQUIRIES AND COMPLAINT INVESTIGATIONS

OFCO received 980 contacts from families and citizens seeking assistance or information about the child welfare system in 2013. Approximately 54 percent of these contacts were formal complaints requesting an investigation. Between September 1, 2012 and August 31, 2013, OFCO completed 512 complaint investigations regarding 849 children and 488 families. These investigations resulted in 49 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. More than 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.

OMBUDS IN ACTION

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

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

Forty-three complaints required intervention by OFCO. In an additional 23 complaints, OFCO provided substantial assistance to resolve the complaint issue. The vast majority of complaints in which OFCO intervened or assisted resulted in the complaint issue being resolved.

In 2013, OFCO made 49 formal adverse findings against the CA. OFCO provides Children's Administration (CA) with written notice of adverse findings resulting from a complaint investigation. CA is invited to formally respond to the finding, and may present additional information and request a revision of the finding. This process provides transparency of OFCO's work as well as accountability for DSHS.[3]

REVIEW OF CRITICAL INCIDENTS

The Ombuds conducts administrative reviews of cases of recurrent child maltreatment as well as of all fatalities both involving child abuse or neglect and cases unrelated to child maltreatment, and near fatalities of children whose family had an open case with DSHS within a year prior to the child's death. During this reporting period OFCO conducted 193 administrative reviews of critical incident cases –42 child fatalities, 30 near fatalities and 121 cases of recurrent maltreatment. Through these reviews, OFCO identifies common factors and systemic issues regarding these critical incidents. Key points discussed in this section of the annual report include:

- The vast majority of child fatalities related to abuse or neglect involved children under the age of 3 years.

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

- Unsafe sleep practices continue to be a leading cause of infant deaths.
- Neglect continues to constitute the largest number of the founded reports and is more likely to recur than physical or sexual abuse.
- Caregiver substance abuse remains the most prevalent risk factor in cases of recurrent maltreatment.

WORKING TO MAKE A DIFFERENCE

Ongoing Efforts to Improve the Adoption System

OFCO's 2011 Annual Report discussed cases of severe abuse of adopted children. In response, OFCO and CA established a committee to examine this issue in greater detail and make recommendations to improve the adoption process. The committee's report and recommendations were published in September 2012. CA formed a work group to identify and prioritize recommendations within the agency's control and develop steps to carry out these reforms. Additionally, legislation was introduced this past year to strengthen adoption pre and post-placement reports. OFCO's 2013 Annual Report describes these efforts and also recommends that policymakers consider: the use of psychological evaluation or assessment tools when conducting an adoption pre-placement report; addressing specific topics related to child maltreatment in the pre- and post-placement reports; and requiring that all pre-placement reports, whether positive, negative, or incomplete, be filed with the court..

Attorney Representation for Children in Dependency Proceedings

In dependency and termination of parental rights cases, children have at least the same due process right to counsel as indigent parents. Generally, a court appointed special advocate (CASA) or guardian ad litem (GAL) is appointed to represent the child's best interest. These children who have suffered abuse or neglect should be represented by an attorney who will advocate for the child's stated interest on issues such as: placement; visits with parents, siblings and family members; mental health services; and the resolution of their dependency case. This report discusses changing state law to either appoint an attorney for every child in a dependency or termination of parental rights proceeding, or alternatively, to at least set forth specific circumstances where attorney representation is required.

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

OFCO's 2012 Annual Report discussed the long-term impact of a CPS finding of child abuse or neglect, which can bar a person from employment or volunteer positions that involve unsupervised access to children. Responding to this issue, the legislature directed that a work group *"explore options, including a certificate of rehabilitation for addressing the impact of founded complaints on the ability of rehabilitated individuals to gain employment or care for children . . ."*[4] This section of OFCO's annual report describes potential barriers to establishing a certificate of rehabilitation and that other efforts –such as to: modify the list of crimes and negative actions that disqualify a person from unsupervised contact with children; or change the procedures for the CA Administrative Review to improve accessibility and the quality of review decisions –may help address this issue.

[4] Chapter 162, Section 7, Laws of 2013

Child Welfare Legislation

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

- Improving the adoption process,
- Attorney representation for children in dependency proceedings, and
- Extending foster care for youth after age 18.

SYSTEM IMPROVEMENT EFFORTS

Because of OFCO's independent perspective and knowledge of the child welfare system, the Ombuds is often invited to participate in efforts to improve outcomes for children and families. During the past year, these efforts included: serving on the *Results Washington* Goal Council on Healthy and Safe Communities; 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.

Family Assessment Response

Additionally, the Ombuds has participated with efforts to radically change the way Child Protective Services (CPS) responds to allegations of child maltreatment. Beginning in January 2014, Family Assessment Response (FAR) will be piloted in three CPS offices. In responding to screened in reports of low to moderate abuse or neglect, the FAR caseworker engages the family to assess the circumstances leading to the report, and identifies community supports and services to help them safely care for their children. The focus is on quickly engaging the family with appropriate services, rather than determining whether the allegation of child maltreatment is substantiated. FAR is a voluntary program and a family eligible for FAR can opt instead for a traditional CPS investigation. Other states have found that FAR has had a positive impact on their child welfare system.[5] Specifically that FAR has resulted in:

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

[5] See, *Siegel & Loman, Extended Follow-up Study of Minnesota's Family Assessment Response- Final Report, (2006).* Available at: http://www.iarstl.org/papers/FinalMNFARReport.pdf

KEY FINDINGS AND RECOMMENDATIONS

ONGOING EFFORTS TO IMPROVE THE ADOPTION PROCESS

OFCO acknowledges the progress CA has made to implement recommendations from the Severe Abuse Report and that that are within the agency's control. OFCO urges the department to continue these efforts, and in particular that the Division of Licensed Resources (DLR) develop changes to the Washington Administrative Code (WAC) governing child placing agencies. Stakeholders, legislators and policy makers should also consider ways to assess and prepare applicants for the challenges of adoption; match the child with the right family; and provide necessary training and support for adoptive parents and children.

ATTORNEY REPRESENTATION FOR CHILDREN IN DEPENDENCY PROCEEDINGS

Whether or not a court exercises its discretion to appoint an attorney to represent a child in a dependency case varies widely from county to county. This practice of justice by geography is untenable as children have legal rights and interests deserving of at least the same due process right to counsel as indigent parents. OFCO recommends that the legislature amend state law to require either that: all children are appointed an attorney in dependency proceedings; or define objective circumstances that mandate the appointment of an attorney for a child.

TERMS AND ACRONYMS

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

I. THE ROLE OF OFCO

"OFCO has been more helpful than anyone I have been in contact with throughout this process. Thank you for all your help!"

~ Grandmother

THE ROLE OF OFCO

The Washington State Legislature created the Office of the Family and Children's Ombuds[6] (OFCO) in 1996, in response to two high profile incidents that indicated a need for oversight of the child welfare system.[7] OFCO provides citizens an avenue to obtain an independent and impartial review of Department of Social and Health Services (DSHS) decisions. OFCO is also empowered to intervene to induce DSHS to change problematic decisions that are in violation of the law or that have placed a child or family at risk of harm, and to recommend system-wide improvements to the Legislature and the Governor.

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

- **Impartiality.** The Ombuds acts as a *neutral investigator* 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 must maintain the confidentiality of complainants and of information obtained during investigations. This protection makes citizens, including professionals within DSHS, more likely to contact OFCO and to speak candidly about their concerns.

- **Credible review process.** OFCO has a credible review process that promotes respect and confidence in OFCO's oversight of DSHS. Ombuds are qualified to analyze issues and conduct investigations into matters of law, administration, and policy. OFCO's staff has a wealth of collective experience and expertise in child welfare law, social work, mediation, and clinical practice and is trained in the United States Ombudsman Association Governmental Ombudsman Standards. In 2009 OFCO and DSHS entered into an inter-agency agreement to improve communication, accountability and bring greater clarity to the working relationship between the two agencies.[8]

AUTHORITY

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

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

[7] 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.

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

including mental health professionals, guardians ad litem, and assistant attorneys general.[9] OFCO operates under a shield law which allows OFCO to protect the confidentiality of OFCO's investigative records and the identities of individuals who contact the office. This encourages individuals to come forward with information and concerns without fear of possible retaliation. Additional duties have been assigned to OFCO by the Legislature in recent years regarding the reporting and review of child fatalities, near fatalities, and recurrent maltreatment.[10]

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

WORK ACTIVITIES

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

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

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

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

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

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

II. LISTENING TO FAMILIES AND CITIZENS

- Inquiries and Complaints
- Complaint Profiles
- Complaint Issues

"You've been a wonderful resource for helping me to be patient."

~ Relative Caregiver

INQUIRIES AND COMPLAINTS

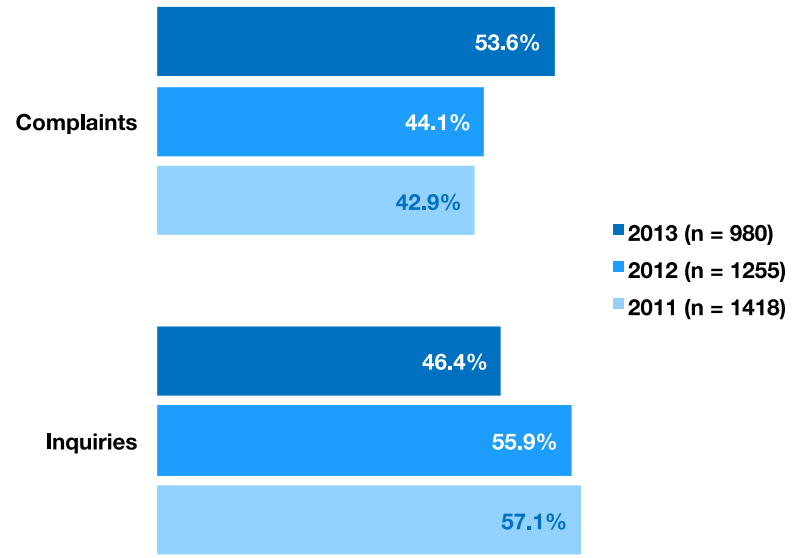
The Ombuds listens to families and citizens who **contact** the office with questions or concerns about services provided through the child protection and child welfare system. By listening carefully, the Ombuds is able to respond effectively to their **inquiries** and **complaints**.

This section describes contacts made by families and citizens during OFCO's 2013 reporting year—September 1, 2012 to August 31, 2013. Data from previous reporting years is included for comparison.

CONTACTS TO OFCO

Families and citizens contacted OFCO **980** times in 2013. Of these contacts, over 46 percent were **inquiries** made by people seeking information while over 53 percent were formal **complaints** seeking an investigation by an Ombuds. As figure 1 shows, complaints now encompass a majority of contacts to OFCO.

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



Source: Office of the Family and Children's Ombuds, September 2013

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

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

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

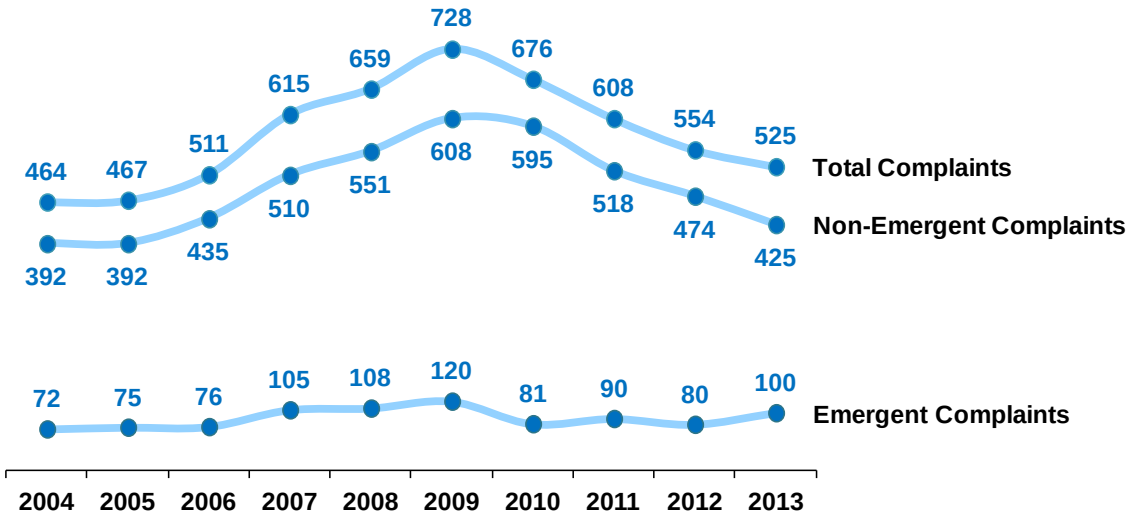
COMPLAINTS RECEIVED

A complaint to OFCO must involve an act or omission by DSHS or another 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

OFCO received 525 complaints in 2013. Of these, **100 complaints (19 percent) were emergent.** Emergent complaints most often involved child safety or situations in which timely intervention by OFCO could make a significant difference to a child or family's immediate well-being.

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



Source: Office of the Family and Children's Ombuds, September 2013

As figure 2 shows, complaints filed with OFCO have **decreased steadily** since an all-time high of 728 complaints in 2009. However, the number of complaints in 2013 was still higher than any year prior to 2007. Despite the decrease in overall complaints in 2013, the **number of emergent complaints increased by 25 percent from 2012**.

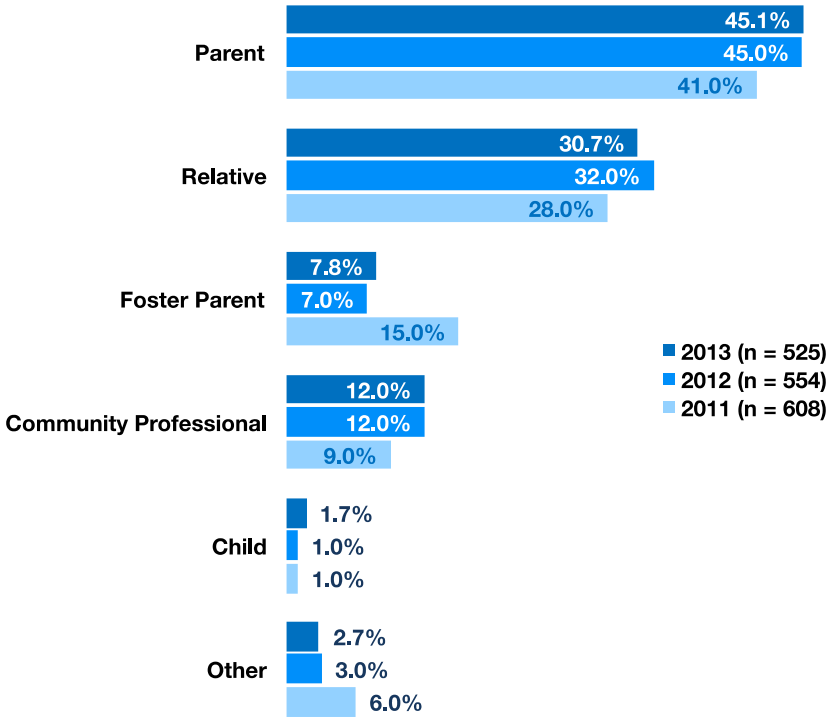
COMPLAINT PROFILES

PERSONS WHO COMPLAINED

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

As noted last year, complaints from foster parents have decreased in recent years. Quarterly statewide meetings between the CA Assistant Secretary and foster parents as well as outreach and assistance by the Foster Parent Association of Washington State (FPAWS) may be providing proper channels to address their issues and concerns.

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

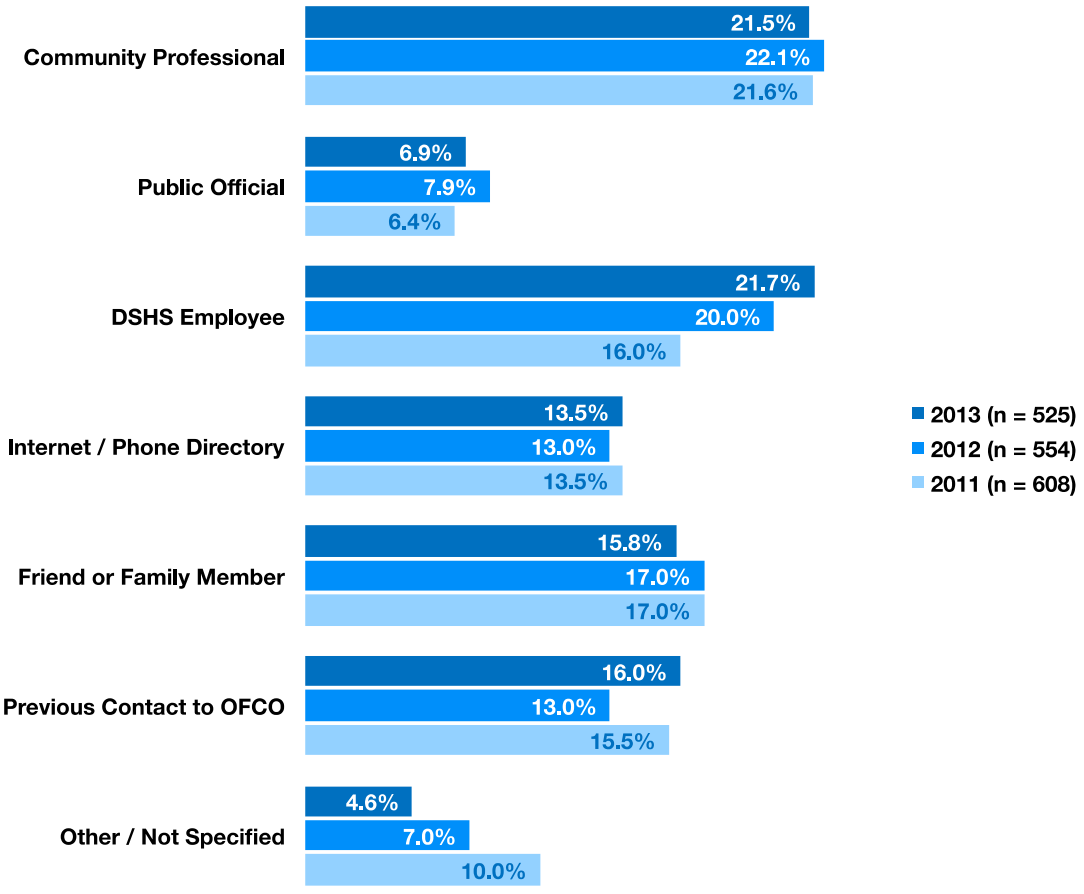


Source: Office of the Family and Children's Ombuds, September 2013

How Complainants Heard About OFCO

The majority of individuals filing complaints with OFCO indicated that someone else referred them to the office. **Community professionals and service providers** (e.g., teacher, counselor, child care provider, doctor, private agency social worker, mental health professional, attorney, CASA/GAL, legislator's office) referred over a quarter of complainants (28.4 percent). Complainants referred by a **DSHS employee** (21.7 percent) have continued to increase over the past three years. Complainants have consistently found OFCO through either an **internet search or a phone directory** (13.3 percent); or have been referred by a **family or friend** (15.8 percent). A similar proportion of complainants knew about OFCO from a **previous contact** (16 percent). The remaining complainants (4.6 percent) did not specify how they heard about OFCO. The figure below shows how each category has changed in recent years.

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



Source: Office of the Family and Children's Ombuds, September 2013

RACE AND ETHNICITY OF COMPLAINANTS

OFCO's complaint form has an optional question asking complainants to identify their race and ethnicity, for the purposes of tracking whether the office is hearing from all Washington citizens.

Table 1: **Race and Ethnicity of Complainants**
By Reporting Year (September 1st - August 31st)

	OFCO Complainants	WA State Population*
Caucasian	74.2%	77.3%
African American	8.8%	3.6%
American Indian/Alaska Native	4.6%	1.5%
Asian / Pacific Islander	1.0%	7.8%
Other	1.7%	5.2%
Multi-Racial	4.8%	4.7%
Declined to Answer	5.0%	--
Latino / Hispanic	8.6%	11.2%
Non-Hispanic / White	66.9%	72.5%
Non-Hispanic / Black	8.4%	3.4%
Other Race / Ethnicity	16.1%	12.8%

** Office of Financial Management (ofm.wa.gov/pop/), 2010*

RACE AND ETHNICITY OF CHILDREN IDENTIFIED IN COMPLAINTS

The table below shows the race and ethnicity (as reported by the complainant) of the 853 children identified in the 525 complaints received, compared with children in placement through CA and in the general state population.

Table 2: **Race and Ethnicity of Children Identified in Complaints**
By Reporting Year (September 1st - August 31st)

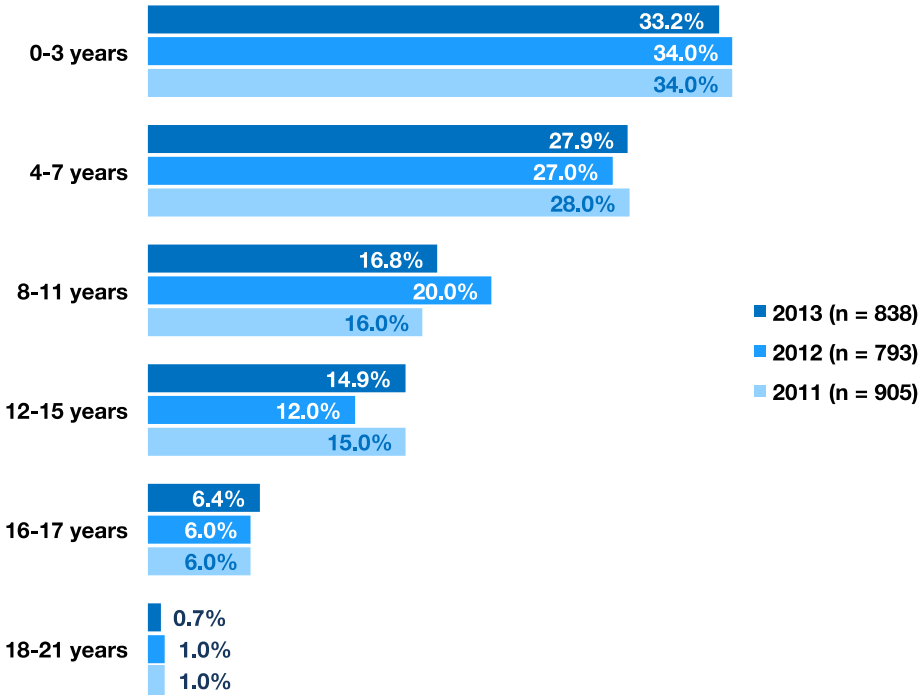
	OFCO Complaint Children	DCFS Placement*	WA Child Population**
Caucasian	66.5%	62.6%	68.5%
African American	10.1%	8.4%	4.2%
American Indian or Alaska Native	10.8%	12.7%	1.9%
Asian or Pacific Islander	0.5%	1.6%	7.4%
Other	2.6%	0.3%	8.3%
Multi-Racial***	7.9%	14.1%	9.7%
Declined to Answer	1.6%	0.4%	--
Latino / Hispanic	12.8%	16.9%	18.9%
Non-Hispanic / White	56.0%	49.6%	60.7%
Non-Hispanic / Black	10.0%	7.9%	3.9%
Other Ethnicity	21.2%	25.6%	16.4%

** Partners for Our Children (www.partnersforourchildren.org), 2012*
*** Office of Financial Management (ofm.wa.gov/pop/), 2010*
**** See Appendix B for a detailed breakdown of multi-racial categories*

AGE OF CHILDREN IDENTIFIED IN COMPLAINTS

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

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

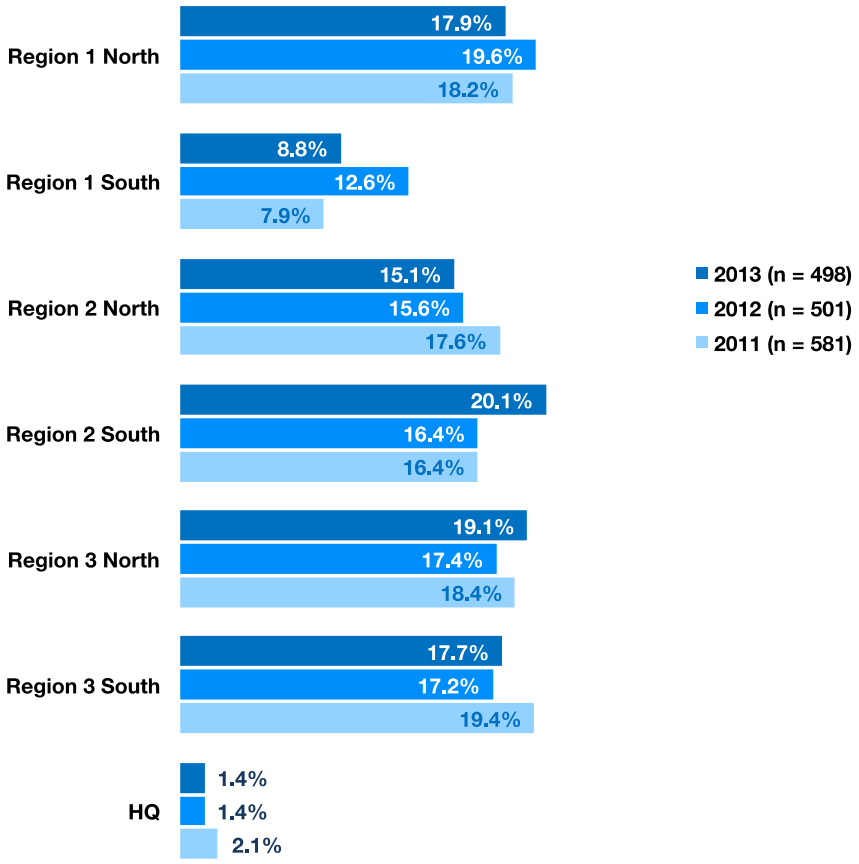


Source: Office of the Family and Children's Ombuds, September 2013
Note: Children identified in more than one complaint are counted more than once.

COMPLAINTS BY DSHS REGION

During the 2013 reporting year, 27 percent of complaints were directed at Region 1, 35 percent at Region 2, and 37 percent at Region 3, with the remaining one percent being directed at CA Headquarters. Since 2012, the largest changes in the percent of complaints involved two sub-regions—OFCO received over 30 percent fewer complaints from Region 1 South, whereas OFCO received nearly 22 percent more complaints from Region 2 South. That said, the percent of complaints in both sub-regions were similar to that of 2011. The breakdown of complaints directed at individual offices is provided in Appendix A.

Figure 6: **Complaints by DSHS Region**
By Reporting Year (September 1st - August 31st)



Source: Office of the Family and Children's Ombuds, September 2013

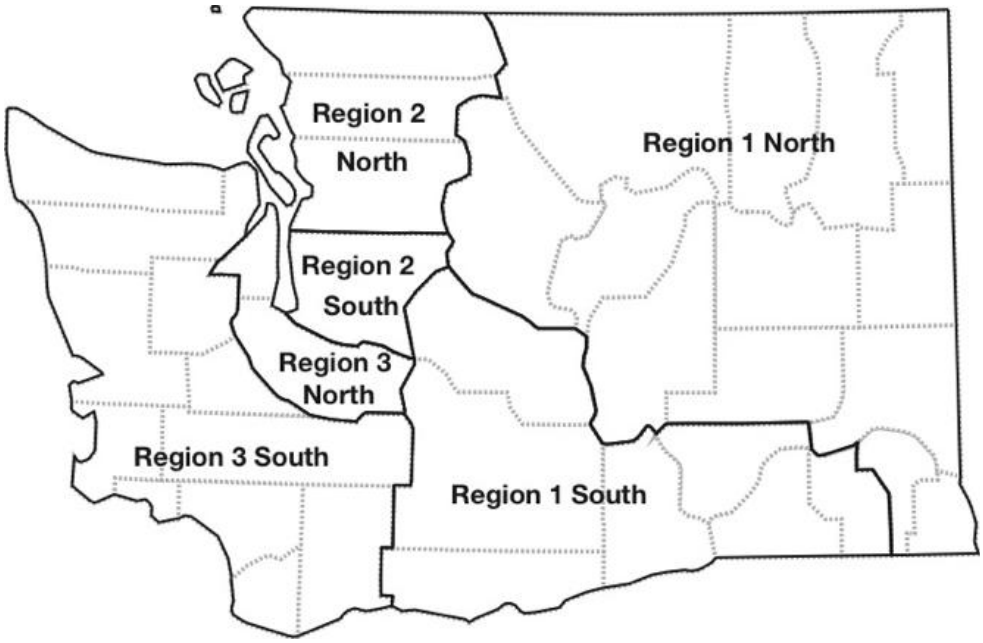


Table 3: **Populations by Region and Regional Office**

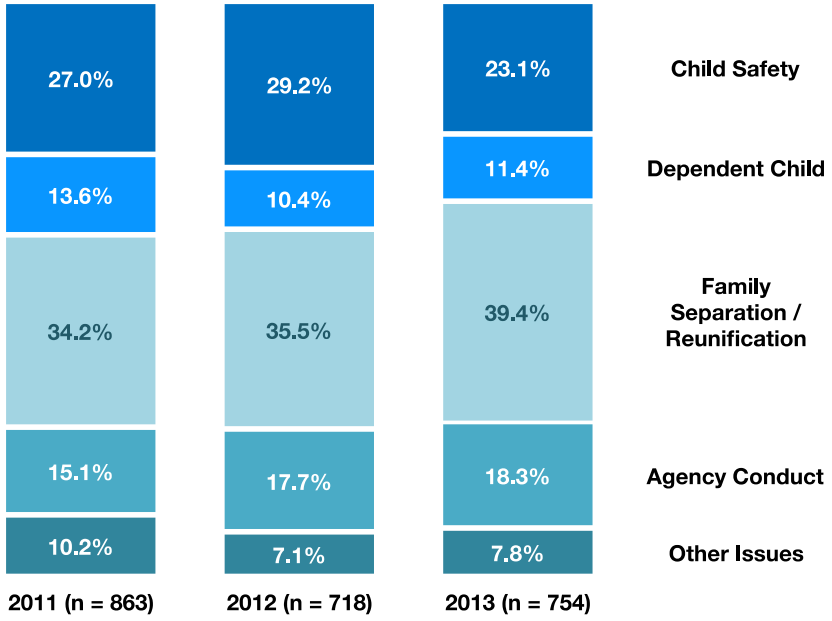
	Population*	CA Clients Served**
Region 1 North (Spokane)	874,391	29,174
Region 1 South (Yakima)	620,663	22,799
Region 2 North (Everett)	1,125,651	34,037
Region 2 South (Seattle)	1,931,249	39,281
Region 3 North (Tacoma)	1,046,358	31,930
Region 3 South (Vancouver)	1,126,228	37,238

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

COMPLAINT ISSUES

As in previous years, issues involving the **separation and reunification of families** (raised **297** times in complaints) and the **safety of children living at home or in substitute care** (raised **174** times in complaints), were by far the most frequently identified issues in complaints to OFCO. Complaint issues involving **family separation increased** from last year, while complaint issues involving **child safety decreased.**

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



Source: Office of the Family and Children's Ombuds, September 2013

The following table shows the number of times various specific issues within these categories were identified in complaints.[11]

Table 4: **Issues Identified by Complainants**
By Reporting Year (September 1st - August 31st)

	2011	2012	2013
Child Safety	**233**	**210**	**174**
Failure to protect children from parental abuse or neglect	**139**	**118**	**91**
- Physical abuse	43	38	22
- Sexual abuse	30	25	17
- Emotional abuse	12	5	6
- Neglect / lack of supervision	47	49	43
- Other child safety issue	7	2	5
Developmentally disabled child in need of protection	2	1	0
Children with no parent willing / capable of providing care	11	7	6
Failure to address safety concerns involving children in foster care or other non-institutional care	42	51	44
Child safety during visits with parent	5	5	10
Failure to address safety concerns involving child being returned to parental care	28	27	18
Safety of children in institutions / facilities (non-childcare)	1	2	3
Safety of children in childcare facilities (Department of Early Learning)	2	1	0
Failure by agency to conduct 30-day health and safety visits to child in out-of-home care	2	1	1
Dependent Child Health, Well-Being, and Permanency	**117**	**75**	**86**
Unnecessary / inappropriate change of child's placement, inadequate transition to new placement	47	28	25
Placement instability / multiple moves in foster care	2	3	1
Failure to provide child with medical, mental health, educational or other services, or inadequate service plan	31	15	21
Unreasonable delay in achieving permanency	5	3	0
Inappropriate permanency plan / other permanency issues	12	11	16
ICPC Issues	3	2	6
Extended foster care; independent living service issues	2	1	1
Failure to provide appropriate adoption support services / other adoption issues	15	15	11
Inadequate services to dependent / non-dependent children in institutions and facilities	0	0	5

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

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

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

	2011	2012	2013
Family Separation and Reunification	**295**	**255**	**297**
Unnecessary removal of child from parental care	58	36	49
Unnecessary removal of child from relative placement	14	16	15
Failure to place child with relative	77	61	73
Failure to place child with siblings	0	4	7
Failure to place child with other parent	1	1	1
Other inappropriate placement of child	18	20	23
Failure to provide appropriate contact between child and parent / other family members (excluding siblings)	41	37	39
Failure to provide contact with siblings	2	4	0
Failure to reunite family	76	67	33
Inappropriate termination of parental rights	5	7	8
Concerns regarding voluntary placement and / or service agreements for non-dependent children	2	2	1
Other family separation concerns	1	3	4
Complaints about Agency Conduct	**130**	**127**	**138**
Unwarranted / unreasonable CPS investigation*	11	19	24
Unreasonable CPS findings	30	28	21
Breach of confidentiality by agency	18	15	14
Unprofessional conduct, harassment, retaliation, conflict of interest or bias / discrimination by agency staff	7	4	23
Heavy-handedness, unreasonable demands on family by agency staff	2	1	3
Communication failures	39	43	43
Poor case management, high caseworker turnover, other poor service issu	3	2	1
Lack of coordination between DSHS Divisions	7	0	2
Inaccurate agency records	13	15	7
Other Complaint Issues	**88**	**51**	**59**
Foster parent retaliation	5	2	1
Foster care licensing issues	28	9	4
Lack of support / services to foster parent / other foster parent issues	19	4	5
Retaliation against relative caregiver	0	0	3
Lack of support / services and other issues related to relative / suitable other / fictive kin caregiver	8	11	8
Children's legal issues	8	4	12
Violation of parent's right	10	9	6
Failure to provide parent with services / other parent issues	8	12	15
Violations of the Indian Child Welfare Act (ICWA)	2	0	5

* Includes inadequate CPS investigation and delay in completing CPS investigation

As shown in the table above, in the **child safety** category, concerns about the *safety of non-dependent children reported for maltreatment in their parents' care* as well as concerns about the *safety of dependent children returning to parental care* have both **decreased steadily** since 2011.

Complaints regarding the **health, well-being, and permanency** of dependent children reflect a steady decrease in issues related to *unnecessary/inappropriate change of placement*. In contrast, complaints regarding the sub-categories of *inappropriate permanency plan* and *inadequate services to children in institutions* increased this year.

Complaints about **family separation and reunification** have changed over recent years:

- Complaints about *children being unnecessarily removed from parents* have fluctuated.
- Complaints about the agency's *failure to reunite families* **decreased by 50 percent** compared to the past two years.
- Complaints regarding *failure to place with relatives* overtook *failure to reunite families* as the most frequently identified issue in this category.
- Although the numbers are small, complaints alleging *failure to place siblings together* have steadily increased over the past three years (from zero in 2011 to seven in 2013).

In the category of complaints about **agency conduct**, complaints about *communication failures by agency staff* remain the most frequently identified issue (consistently about 30 percent of the complaints in this category). Complaints about various forms of *unprofessional conduct* **increased significantly in 2013, to 23 complaints**, up from only four in 2012 and seven in 2011. Complaints about *unwarranted, unreasonable, or inadequate CPS investigations* increased again this year, while complaints about *unreasonable CPS findings* decreased.

It is difficult to draw conclusions about patterns or trends in **other complaint issues** given their relatively small numbers, and the fact that OFCO captures only the major complaint issues in complaints that identify multiple issues. Nevertheless, some notable changes:

- Complaints about *retaliation against foster parents* have dropped again from five in 2011 to two in 2012 to only one in 2013. However, for the first time this year, OFCO received three complaints about *retaliation against relative caregivers*.
- Complaints about *licensing issues* dropped precipitously since an all-time high in 2011. Other complaints regarding *lack of support of foster parents* also decreased significantly.
- *Children's legal issues*, *failure to provide parents with services*, and *violations of the Indian Child Welfare Act* were identified by more complainants this year.

III. TAKING ACTION ON BEHALF OF VULNERABLE CHILDREN AND FAMILIES

INVESTIGATING COMPLAINTS

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

"OFCO's involvement definitely made a difference. I was having such a hard time until you got involved."

~ Relative Caregiver

INVESTIGATING COMPLAINTS

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

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

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

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

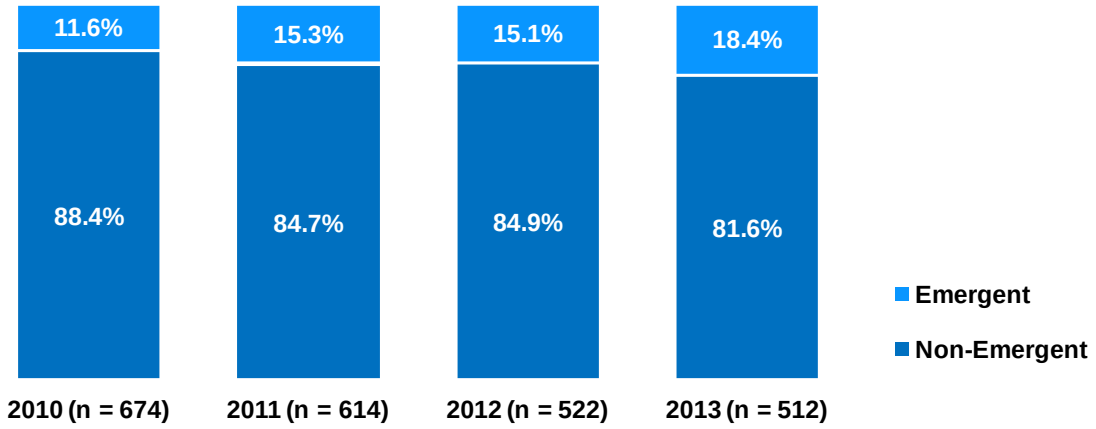
- Where OFCO finds that the agency is properly carrying out its duties with regard to the complaint issue, the Ombuds explains to complainants why the alleged conduct is not a violation of law or policy or clearly unreasonable under the circumstances and helps complainants better understand the role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

COMPLETED INVESTIGATIONS AND RESULTS

COMPLETED INVESTIGATIONS

OFCO completed **512 complaint investigations** in 2013. These investigations involved **849 children and more than 488 families**. As in previous years, the majority of these investigations were **standard non-emergent investigations** (81.6 percent). More than one out of every seven investigations (18.4 percent) met OFCO's criteria for initiating an **emergent investigation,** i.e. when the allegations in the complaint involve either a child's immediate safety or an urgent situation where timely intervention by OFCO could significantly alleviate a child or family's distress. When taking an emergent complaint, OFCO begins the investigation immediately after receiving a call from a complainant, or after screening a complaint received by mail as emergent. Over the years, OFCO has substantiated or intervened in emergent complaints at a higher rate than non-emergent complaints. In 2013, **OFCO intervened or provided assistance to resolve concerns in 28.7 percent of emergent complaints**, compared with 9.3 percent of non-emergent complaints.

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



Source: Office of the Family and Children's Ombuds, September 2013

INVESTIGATION RESULTS

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

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

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

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

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

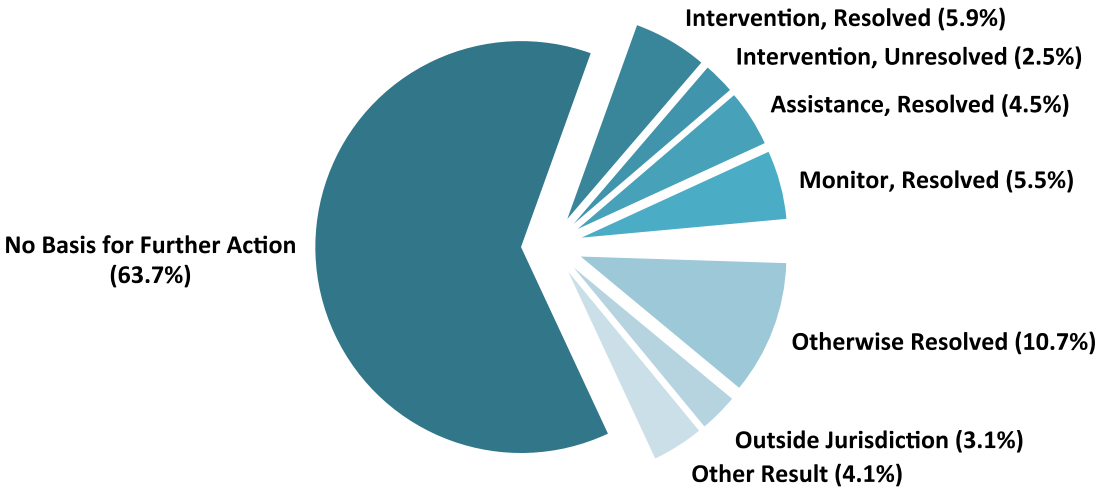
- **No Basis for Intervention:** The complaint was substantiated and OFCO made a finding that the agency violated law or policy or acted unreasonably, but there was no opportunity for OFCO to intervene, usually because the violation occurred in the past. Or, the complaint issue was unsubstantiated, and OFCO found no agency errors in reviewing the case. OFCO explained why the alleged action is not a violation of law or policy or unreasonable under the circumstances and helped the complainant better understand the role and responsibilities of the child welfare agency.

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

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

Investigation results have remained fairly consistent in recent years. OFCO **assisted or intervened** to resolve the situation in nearly **13 percent of complaints** in 2013—this represents **sixty-six complaints**. OFCO found **no basis for further action in nearly 64 percent** of complaints this year (compared to 67 percent in 2012 and 71 percent in 2011).

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



Source: Office of the Family and Children's Ombuds, September 2013

OFCO IN ACTION

OFCO takes action when necessary to avert or correct a harmful oversight or avoidable mistake by the DSHS Children's Administration or another agency. **Forty-three complaints required intervention by OFCO in 2013.** This represents 8.4 percent of all complaints, a significant increase from 2012, when OFCO intervened in 4.8 percent of complaints.

TYPES OF INTERVENTION BY OFCO

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

1. Interventions to **induce corrective action.**
2. Interventions to **facilitate resolution** of an agency error and/or a CA client's concerns.
3. Interventions to help the agency **avoid errors** and conduct better practice.
4. Interventions to help the agency **prevent future mistakes.**

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

OFCO IN ACTION: INDUCING CORRECTIVE ACTION

Key Issue	Investigative Finding	OFCO Action	Outcome
Failure to allow youth eligible for Extended Foster Care to enter the program	DCFS CFWS denied an 18-year-old previously dependent youth's request to enter the Extended Foster Care Program, despite the youth being eligible for the program. Prior to the youth's 18th birthday, the CFWS social worker had informed the youth that her dependency case would remain open for six months following her 18th birthday and during that time the youth would have the option of entering the program. OFCO found the dependency had been dismissed right after the youth's 18th birthday, contrary to law and policy. As a result, DCFS informed the youth she was no longer eligible.	OFCO obtained the youth's school records, which verified the youth was enrolled in school on her 18th birthday, making her eligible for the Extended Foster Care Program. OFCO provided these records to DCFS and discussed the error with the Attorney General's Office. DCFS agreed that dismissing the dependency was an error and it would be corrected.	DCFS agreed to meet with the youth, enroll her in the Extended Foster Care Program, and set aside the order dismissing her dependency.
Failure to accept intake alleging neglect	OFCO determined that DCFS CPS Central Intake failed to document a call to the hotline alleging neglect of three non-dependent children, ages 1, 4, and 5. Thus, a screening decision had not been made with respect to the allegations.	OFCO contacted Central Intake and confirmed that CPS is required to document all reports of child abuse or neglect, so that a screening decision can be made. OFCO facilitated communication between the intake worker and referrer.	A CPS intake was created and screened in for an investigation.

Failure to ensure the safety of an infant with significant medical needs	CPS was involved with the family of an 11-month-old infant who had been admitted to the hospital on three occasions for failure to thrive. Hospital staff continued to express concerns that the parents were not engaging in services to address the needs of their infant. OFCO found that CPS agreed to transfer the case to Family Voluntary Services following the child's discharge from the hospital. OFCO determined there was a sufficient basis for filing a dependency petition, which would provide a higher degree of supervision.	OFCO contacted the Area Administrator about the decision not to file a dependency petition despite the parents' history of medical neglect, of failing to visit the infant consistently in the hospital, and of failing to engage in voluntary services.	DCFS filed a dependency petition and the infant was placed in a medically-trained foster home.
Failure to address safety of children in relative placement	DCFS recently placed three siblings, ages 5 months, 3, and 5, with a foster care licensed relative. OFCO confirmed that there were unauthorized adults living in the relative's home who posed a safety risk to the children. These individuals had their own children removed from their care and were suspected to be active or recovering drug users. After being contacted by OFCO, the DLR licensor for the home expressed additional concerns regarding the relative's ability to care for these three young children.	OFCO contacted the Area Administrator about the safety concerns.	DCFS moved the children to a new placement within three days.

OFCO IN ACTION: FACILITATING RESOLUTION

Key Issue	Investigative Finding	OFCO Action	Outcome
Delaying move from long-term foster home to ensure that youth's position on placement change is heard	DCFS Adoptions Unit decided to move a 15-year-old legally free youth from her long-term foster parents due to non-safety related licensing issues. DCFS planned to move this youth 7 days prior to a scheduled court hearing. The youth had been placed in the foster home for over two years and wanted to stay and be adopted by the foster parents. OFCO found that moving the youth prior to the court date or prior to the youth being able to speak to her newly assigned attorney would be unreasonable.	OFCO contacted the Adoptions supervisor regarding the timing of the move and whether it could be delayed until the youth had an opportunity to speak to her attorney.	DCFS agreed to delay the youth's move until after the court hearing.
Unreasonable threat to remove children from long-term relative placement	DCFS CFWS determined that the long-term relative placement for four dependent siblings, ages 2, 5, 7, and 8, would likely not pass an adoption home study due to the relative's criminal and CPS history. Based on this assessment, the social worker was planning to seek CA management approval to move the children. OFCO determined this was unreasonable because the agency had been aware of the relative's history when it placed the children in this home, and the agency had approved a relative home study that addressed this history at length. The children were thriving in this placement.	OFCO contacted the CFWS supervisor and discussed the positive information regarding the caregiver to ensure that full and balanced information was provided to CA management. OFCO also discussed this situation with the Area Administrator prior to a permanency planning meeting to discuss the permanent plans for the children.	DCFS CFWS worked with the relative caregiver to develop a permanent plan that would allow the children to remain in her care.

Failure to hold Family Team Decision-Making (FTDM) Meeting	DCFS CFWS failed to ensure that all parties were notified of a FTDM meeting to discuss a recent placement move of a 10-year-old dependent child. CFWS did not reschedule the FTDM once this oversight was brought to their attention. The child was moved yet again and was now several hours away from his family's home and siblings' placement. This time, the court set a deadline for DCFS CFWS to schedule an FTDM. More than two weeks after the court's deadline, OFCO found that no FTDM had been scheduled and the child had not attended family visits.	OFCO notified the Area Administrator of OFCO's adverse finding against DCFS CFWS for failing to follow policy and convene an FTDM. OFCO formally requested that the meeting be scheduled as soon as possible to address visitation and other issues.	DCFS CFWS immediately scheduled an FTDM, in which the Ombuds participated by phone. The meeting was crucial for developing a plan for family visitation. The child was ultimately returned home.
Use of social security funds for youth with special needs	OFCO found that DSHS was using a 17-year-old dependent youth's Title 2 Social Security benefits to reimburse the agency for the cost of foster care for the youth. Although the U.S. Supreme Court has ruled that this use of Social Security monies is acceptable, there are exceptions in DSHS policy that allow DSHS to conserve or use the funds for a child's special needs instead. OFCO found that DCFS had not considered an exception to policy for this youth.	OFCO contacted the DCFS CFWS supervisor and requested that DCFS explore the option of conserving or using the youth's Title 2 Social Security benefits for the youth's special needs.	The CFWS social worker confirmed with the Regional Federal Funding Coordinator that it would be possible to forego reimbursement to cover specific services the youth needs.

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

Key Issue	Investigative Finding	OFCO Action	Outcome
Ensuring sibling unification is safe	DCFS CFWS planned to place two siblings, ages 4 and 7, together in a new placement. The siblings had previously been placed together, but then had been separated due to safety concerns—the older sibling had a history of hurting younger children, including her sister. Multiple professionals believed that placing the siblings together continued to be unsafe. OFCO found that the assigned CFWS social worker had never personally met with or observed the children because monthly health and safety visits were done by a courtesy social worker.	OFCO asked the Area Administrator to review the pending placement decision.	DCFS CFWS responded with a plan for the assigned social worker to observe at least one visit between the siblings, discuss the safety concerns with the professionals involved, and reassess whether it was safe to place the siblings together. CFWS determined that the safety concerns could be adequately managed with the siblings placed in the same home.
Unreasonable/ Premature plan to return home	OFCO found that DCFS CFWS was agreeing to return two dependent children, ages 7 and 14, to their parents despite a substantial history of child abuse and neglect by the parents, serious identified safety threats, and little evidence that either parent had made sufficient progress in services to remedy their parental deficiencies. DCFS had not sought the recommendations of counselors working with the family regarding the plan to return home.	OFCO contacted the Area Administrator to review the case prior to an upcoming court hearing regarding the return home.	The Area Administrator staffed the case with the Regional Administrator and the Attorney General and responded that whether the children went home or continued to have unsupervised visits, a stronger safety plan would be put in place immediately. The children were returned home through an agreed order with a detailed safety plan in place.

Failure to take action to address safety concerns	A 9-year-old non-dependent child had recently returned to his mother's care after the death of his legal guardian. CPS investigated allegations of neglect and physical abuse and offered intensive in-home services to assess and stabilize the child's return to his mother. However, the mother had declined services and DCFS closed the case. The child had not been in school or counseling for several weeks. CPS did not screen in an intake from the school since there was no specific allegation of child abuse or neglect. While reviewing this situation, OFCO found a pending CPS intake made by the mother calling to request out-of-home placement for the child.	OFCO contacted the Area Administrator for Central Intake and requested that the pending intake be screened in for CPS-Risk Only/24-Hour Response due to the imminent safety concerns expressed by community professionals.	DCFS CPS agreed to screen in the intake as CPS-Risk Only. A worker met with the family the same night and services were offered in an effort to maintain the child at home. After several weeks, the parent continued to request out-of-home placement for the child. DCFS filed a dependency petition.
Failure to include caregiver as subject of CPS investigation	OFCO determined that the father of a 1-year-old dependent child had not been listed as a subject in a CPS investigation regarding burns on the child's hands. The intake named only the child's relative caregivers as subjects of the investigation, despite facts in the narrative indicating that the child likely sustained the burns during an unsupervised weekend visit with his father.	OFCO contacted the CPS supervisor to bring this oversight to her attention.	After reviewing the allegations and the timeline, DCFS CPS added the father as an additional subject of the investigation. The allegation of neglect by the father was founded regarding this incident; it was unfounded for the relative caregivers.

Unreasonable visitation plan during sexual abuse investigation	During CPS and law enforcement investigations into sexual abuse allegations of a 10-year-old dependent child by a parent and sibling, DCFS CFWS planned for the child to attend a supervised family visit. OFCO found that this was clearly unreasonable because the child had not yet been interviewed and having even supervised contact with the alleged perpetrators could jeopardize the investigations and further traumatize the child.	OFCO contacted the Deputy Regional Administrator.	The Deputy Regional Administrator immediately directed that the 10-year-old child would not participate in visitation with alleged perpetrators of sexual abuse at least until the child had been interviewed by law enforcement and CPS.

OFCO IN ACTION: PREVENTING FUTURE MISTAKES

Key Issue	Investigative Finding	OFCO Action	Outcome
Inappropriate disclosure of confidential information	OFCO determined that DCFS CFWS inappropriately disclosed confidential information regarding a parent and a 16-year-old dependent youth to two different drug and alcohol providers. The disclosure exceeded the scope of information the provider would need to conduct the requested evaluation.	OFCO contacted the Deputy Regional Administrator to inquire as to whether this was a common practice in the office affecting other cases.	The Deputy Regional Administrator responded that the office has been provided additional training regarding discovery and confidentiality. A plan was put in place to ensure that inappropriate disclosure does not happen in future cases.
Agreed order despite continued disagreement	DCFS CFWS initially objected to returning two dependent siblings, ages 1 and 3, to their parents due to unaddressed safety concerns. The court ruled in favor of reunification and ordered DCFS to develop a transition plan, which it did. Thereafter, DCFS entered an agreed order transitioning the children home despite the agency's continued disagreement and assessment that this was unsafe.	OFCO contacted the Area Administrator to review this case.	The Area Administrator corrected the social worker and supervisor's impression that DCFS could not continue to object to the plan to transition the children home due to the court's prior order. The Area Administrator clarified that the agency can and should object on the record.

MOST INTERVENTIONS RESULT IN AGENCY CHANGING POSITION

As detailed in the complaint intervention examples summarized above, the **majority of complaints** in which OFCO intervened **resulted in the agency changing its position** and the complaint issue being resolved (70 percent).

In **13 complaints** in which OFCO intervened, **the agency did not change its position**. In ten of these cases, although the complaint issue remained unresolved, OFCO determined that the agency's decision not to change its position was ultimately acceptable. For example:

INADEQUATE NOTICE OF REMOVAL FROM RELATIVE CAREGIVER

The long-term relative caregivers of a 3-year-old legally free child alleged that DCFS Adoptions removed the child from their care without justification and without notice. The child had been placed with these relatives for more than a year, and they planned to adopt her. Within just a few days, DCFS had moved the child twice. Due to the time sensitivity, OFCO accepted this as an emergent complaint.

Through investigation, OFCO substantiated the complaint allegation regarding the lack of notice to the caregiver, as a violation of policy. DCFS asked the relatives to bring the child to a Family Team Decision-Making (FTDM) meeting at the DCFS office, where the child was removed. Prior to the meeting, DCFS had not told the relatives that DCFS was planning to move the child, or that DCFS had obtained a court order to move the child.

During the FTDM, DCFS staff explained to the relative caregivers that the child was removed because the Regional Administrator had denied the administrative waiver for disqualifying criminal history necessary for the relatives' adoption home study. The original waiver that had been approved at the outset of the child's placement in the home was somehow insufficient. In addition, DCFS Adoptions provided multiple services to the family in an attempt to stabilize what they considered a marginal relative placement. Thus, DCFS believed there was no way to move forward with permanency for the child with these relative caregivers.

OFCO contacted the Children's Administration Headquarters to request a review of the decision to remove this child from her long-term relative caregivers. **By this time, the child moved to yet another placement—her third in less than a week.**

Ultimately, after reviewing reports from the service providers who worked with the family, **OFCO was unable to conclude that the decision to move the child from these relatives was clearly unreasonable under the circumstances. However, OFCO did make an adverse finding that the way in which the child was moved was clearly unreasonable,** because DCFS had not identified an appropriate alternative placement for the child prior to the move and the child did not have time to transition away from the caregivers she considered "mom" and "dad."

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

FAILURE TO PLACE DEPENDENT CHILD WITH PRIOR RELATIVE CAREGIVERS

A complainant alleged that DCFS CFWS was unreasonably failing to place a 1-year-old dependent child with his previous relative caregivers when the child was removed from his parent on a trial return home due to physical abuse. The child had been placed with these relatives for the first 18 months of his life until the trial return home began less than two months prior. There had been no complaints regarding the relatives' care of the child. However, the relationship between the relatives and the parent had grown contentious due to the relatives' substantiated concerns regarding the child's safety in the parent's care.

OFCO contacted the Regional Administrator regarding DCFS's unreasonable decision to place the child into a foster home rather than back into the relatives' care where he had resided for all but two months of his life. The Regional Administrator maintained DCFS's position that the child should remain in foster care while DCFS assessed the relatives' criminal and CPS history, as well as the relatives' ability to work with DCFS and the parent. OFCO disagreed with this position given that DCFS knew about and had assessed the relatives' criminal and CPS history at the time the agency originally placed the child in the home. Also, the relatives' ability to care for the child was not in question, and the relatives had a track record of working cooperatively with DCFS, even when they disagreed with the plan to return the child to his parent.

In addition, OFCO found that DCFS CFWS was unreasonably prohibiting these relatives from having any contact with the child while their suitability for placement was being re-assessed. OFCO requested that CA Headquarters review this decision given the child's lack of contact with anyone familiar to him during this stressful time in his young life. Thereafter, DCFS allowed the child to have visits with his prior relative caregiver, but continued to oppose placement with them.

Ultimately, the court ordered that the child be placed with these relatives, over DCFS' objections.

OFCO Offers Assistance to Resolve Complaints

Complaints receiving "OFCO Assistance" are different from complaints in which OFCO intervenes, as the agency's conduct was not a clear violation of law or policy or clearly unreasonable. Even so, the complaint had validity justifying OFCO's assistance in resolving the concerns. In 2013, **23 complaints** were resolved by OFCO in this manner by ensuring that *critical information was obtained and considered* by the agency, by *facilitating timely communication* among the people involved in order to resolve the problem, or by *mediating a compromise*.

For example:

OFCO Assists Relative Resolve Conflict with Social Worker

A complainant alleged that the social worker for a 1-year-old dependent child was placing unreasonable conditions on approving a family member to babysit the child while the relative caregiver worked. Because the family member had once been arrested (but released with no charges) for a domestic violence incident, the social worker was requiring the family member to complete a six-month domestic violence treatment program. Then, if the reports from the program were positive, the social worker agreed to prepare and submit a waiver for the family member to have unsupervised contact with (and babysit) the child. The relative caregiver felt that if she tried to challenge this seemingly unreasonable requirement, the social worker would remove the child from her care. This was causing a high level of stress for the family, who was juggling work schedules and taking time off to ensure that the child had full-time care.

OFCO confirmed that the CFWS social worker was unwilling to submit a waiver for the family member to babysit the child until the family member completed domestic violence treatment and provided a positive report from the provider. This could take several months to resolve and could result in a significant financial hardship for the relative caregiver.

As a result of conversations between the supervisor and OFCO, the following resulted:

- DCFS immediately communicated with the relative caregiver that another extended family member was cleared to babysit the child, alleviating the immediate child care crisis;
- The supervisor clarified with the social worker that a waiver is not needed for an arrest that did not result in a conviction; and
- The supervisor affirmed that the domestic violence counselor will determine the type and duration of treatment necessary for the family member, as well as criteria for progress and completion.

COMPLAINTS RESOLVED AFTER MONITORING BY OFCO

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

REPEATED PLACEMENT DISRUPTION WARRANTS OFCO MONITORING

OFCO received a complaint regarding a 7-year-old legally free child experiencing significant disruption to placement and permanency. The child had been in out-of-home placement since birth. For six years, he and an older sibling had been placed together in multiple different relative placements. Recently, a relative adopted the older sibling but asked DCFS to move the 7-year-old. Since there were no other approved relatives available for placement, DCFS Adoptions placed him in a pre-adoptive foster home. The child's therapist recommended that the child not have contact with his extended family during the transition to the new home.

Due to the critical factors in this case, OFCO monitored the child's case for the next six months. OFCO expressed concern to the Area Administrator when the child's new pre-adoptive foster parents chose to move the child to their local school rather than transport him to his former school (where his sibling attended), as originally planned. Within three months, the pre-adoptive placement failed and the child experienced another change of placement and another change of school. OFCO monitored the status of the child's contact with his extended family, including his sibling and prior relative caregivers. At the time OFCO closed the complaint investigation, the child was stable in a new home and was having regular contact with his biological family.

COMPLAINTS RESOLVED WITHOUT SIGNIFICANT ASSISTANCE BY OFCO

In 2013, **10.7 percent of complaints were resolved between the agency and the complainant without significant assistance or intervention by OFCO**. In most of these cases, the Ombuds contacts the agency, or reviews agency records, to confirm that steps are being taken to resolve the issue. **Some complainants report that the mere fact of OFCO contacting the agency and asking questions appears to assist in ensuring that any problems are resolved.**

For example:

TEAM MEETING RESOLVES CONFLICT BETWEEN PARENT AND DCFS

A parent of a 2-year-old dependent child who had returned home alleged that the DCFS CFWS social worker was creating unreasonable impediments to the parent maintaining appropriate housing and child care. The social worker disagreed with the parent's decision to leave temporary housing where the parent felt his sobriety was in jeopardy. The social worker's disapproval of a potential babysitter led the parent to temporarily drop out of school. Further, since the child had been home with her parent for almost six months, the dependency could be dismissed shortly. However, the social worker was requesting that the dependency be extended another six months, which the parent believed was unreasonable because the parent had completed all services and there were no safety concerns.

The social worker admitted being frustrated with the parent's recent choices. DCFS CFWS was threatening to remove the child if the parent did not comply with DCFS directives, and a Family Team Decision-Making meeting was scheduled for the following week.

OFCO confirmed that the parent had completed all services and the only legal barrier to the dependency being dismissed was that the parent did not have custody of the child through family court. OFCO contacted the Area Administrator due to concern that the relationship between the DCFS social worker and the parent had deteriorated to the point that if it was not resolved, the reunification may be jeopardized despite there being no identified safety risk to the child.

At the team meeting, the facilitator was able to bring the team to a unanimous agreement that there were no safety concerns for the child in the care of her parent, which eliminated the threat of removal. With this threat eliminated, both DCFS and the family were able to "reset" and come to a mutual agreement to quickly resolve the housing and child care issues. The court dismissed the dependency a month later.

OFCO FINDS NO BASIS FOR INTERVENTION

In 2013, 63.7 percent of complaint investigations were closed after OFCO either found no basis for the complaint, or found no unauthorized or clearly unreasonable actions by the agency warranting intervention. If OFCO did find an unauthorized or clearly unreasonable action by the agency, there was no opportunity at the time of the complaint investigation to intervene to change the agency's position, usually because the violation occurred in the past.

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

It is important to note that in some cases, although OFCO found no basis to intervene with the agency to change its position, OFCO made an adverse finding against the agency for violating law, policy, or procedure or acting clearly unreasonably (see pages 45-48 for more detail on adverse findings), as in the following example:

UNREASONABLE DELAY IN PERMANENCY

The foster parents of a 2-year-old dependent child alleged that DCFS CFWS had unreasonably changed their position from supporting the child's adoption by the foster parents, to supporting the child's move to a relative placement out-of-state. The child had been placed with the same foster parents since her birth and they had provided excellent care. For the past year, DCFS had opposed multiple motions by the parents asking that the child be moved to the out-of-state relative. DCFS' position was based on their assessment that disrupting this long-term placement would be harmful to the child. Two-and-a-half years after the child entered state care, DCFS CFWS reevaluated the case plan. Recognizing that both the foster parent and the relative would be excellent adoptive options for the child, DCFS now concluded that moving the child to her relative for adoption was in the child's long-term best interest.

After careful investigation and review of the decision-making process, OFCO determined that there was no basis to intervene, as the agency's current position is in line with law and policy. In addition, the placement issue was being litigated in court and all of the legal parties were now in agreement.

However, OFCO made an adverse finding "that permanency for the now 2 ½ year-old child was unnecessarily delayed due to the department's initial case plan of adoption by the foster parents rather than by relatives…. OFCO found that the department's change in position was appropriate, but OFCO is troubled by the fact that the agency's assessment of the same facts and case plan changed completely with the reassignment of the case. OFCO believes that in any given case, the same facts should be interpreted in a consistent manner and in accord with law and policy.... [T]he delay in permanency has had an adverse impact to all involved."

OFCO's Adverse Findings

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

Adverse findings fall into three broad categories:

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

If these criteria are met and OFCO believes that the agency's action or inaction could cause foreseeable harm to a child or family, the Ombuds intervenes to persuade the agency to correct the problem. OFCO shares the adverse finding with supervisors or higher level agency officials, and may recommend a different course of action, or request a review of the case by higher level decision makers. When the adverse finding involves a past action or inaction, the Ombuds documents the issue and brings it to the attention of agency officials.

In 2013, OFCO made a total of 49 adverse findings.

Communication of Adverse Findings to DSHS

Pursuant to the Inter-Agency Agreement between OFCO and DSHS,[13] OFCO provides written notice to the Children's Administration of any adverse finding(s) made on a complaint investigation. The agency is invited to formally respond to the finding, and may present additional information and request a modification of the finding. In 2013, CA provided a detailed response to OFCO's finding in one-third of all cases, and infrequently requested a request for a modification of OFCO's finding. OFCO modified the adverse finding in three cases this year.

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

[13] Available at http://www.governor.wa.gov/ofco/interagency_ofco_dshs.pdf

Table 5: **Adverse Findings by Issue**

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

	2012	2013
Child Safety	**14**	**10**
Failure by CFWS to ensure/monitor dependent child's safety		
· Findings regarding health and safety visits	2	-
· Unsafe placement of dependent child	1	1
· Failure to provide safe parent-child visitation plan	1	1
· Inappropriate plan for transport of dependent child	1	-
· Failure to provide foster parent with information about child's needs	1	-
· Failure to recognize physical abuse	-	1
Failure by CPS/FVS to ensure/monitor non-dependent child's safety	3	-
Inadequate CPS investigation/case management	2	4
Failure to screen in CPS referral for investigation/other screening errors	-	1
Failure to staff case with Child Protection Team prior to return home	1	-
Inappropriate CPS or DLR/CPS finding (unfounded)	2	-
Failure to notify tribe of CPS intake	-	1
Failure to complete safety assessment	-	1
Family Separation and Reunification	**6**	**5**
Failure to provide appropriate contact between parent and child	2	-
Failure to provide sibling visits	1	-
Failure to provide contact with relative/fictive kin	2	1
Failure to place child with relative	1	3
Failure to conduct relative search	-	1
Dependent Child Health, Well-Being and Permanency	**3**	**10**
Placement issues (incl. placement delays, inadequacies, unavailability)		
· Unnecessary/multiple moves	-	1
· Inadequate transition plan	-	2
· Unreasonable threat to move child from long-term relative care	1	2
· Inadequate foster home	1	-
· Inadequate relative placement	-	1
Inappropriate permanency plan for dependent child	1	-
Delay in permanency	-	4

Table 5 (cont.): **Adverse Findings by Issue**
By Reporting Year (September 1st - August 31st)

	2012	2013
Parents' Rights	**8**	**9**
Failures of notification, public disclosure or breach of confidentiality	1	4
Delay in completing/closing CPS investigation	7	5
Poor Casework Practice Resulting in Harm to Child or Family	**6**	**12**
Inadequate adoption home study	1	-
Failure to conduct supervisory reviews	2	2
Inaccurate, incomplete or delayed documentation	3	2
Other poor practice	-	8
Foster Parent / Relative Caregiver Issues	**3**	**1**
Violation of foster parent rights		
· Failures of notification	2	-
Unreasonable licensing delays/other licensing errors	-	-
Failure to notify caregiver of move of dependent child	1	1
Other Findings	**1**	**2**
Delay in completing DLR/CPS investigation (licensed daycare)	1	-
Violation of ICWA (non-child safety)	-	1
Delay in ICPC	-	1

	2012	2013
Total Number of Findings	**41**	**49**
Total Number of Closed Complaints With One or More Findings	**31**	**34**

The number of adverse findings against the agency **increased in 2013** (a total of **49 findings**) from 2012 (41 findings).

Poor casework practice resulting in harm to a child or family was the most common category of adverse findings (accounting for **24 percent** of the adverse findings). Four out of the eight findings regarding "other poor practice" involved the failure of DCFS to hold required Family Team Decision-Making meetings (see pages 51-52 for an example).

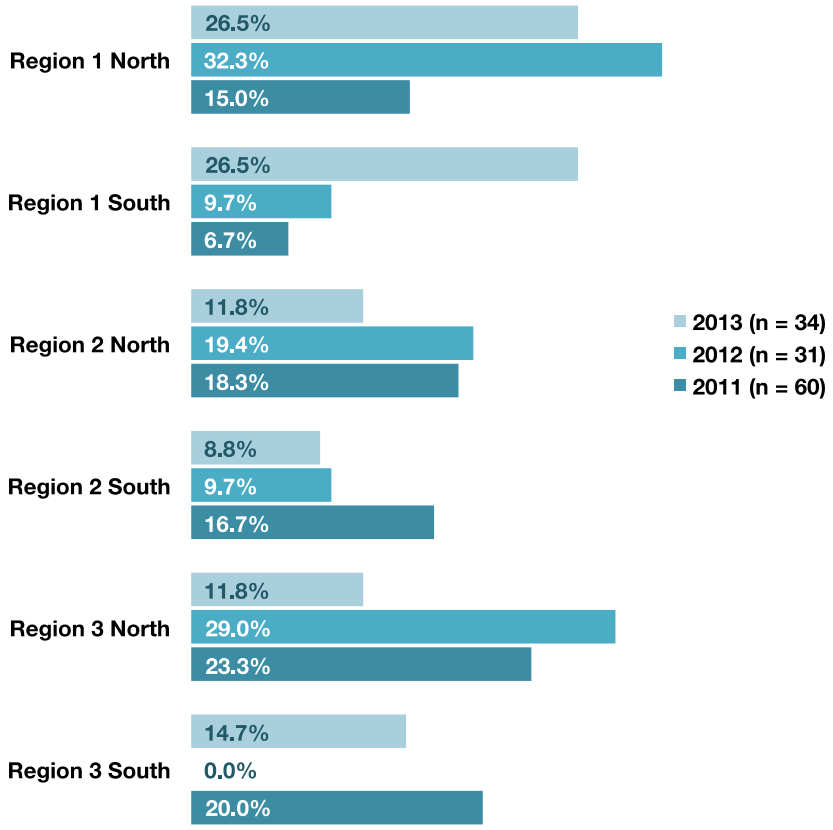
The next largest categories of adverse findings involved **child safety** and **dependent child health, well-being, and permanency** (each accounting for **20 percent** of the total findings).

ADVERSE FINDINGS BY DSHS REGION

This year, the **number of complaints with adverse findings varied considerably across each of the three larger DSHS Regions: Region 1** had **18 findings**; **Region 2** had **seven findings**; and **Region 3** had **nine findings**.

Compared with 2012, adverse findings in Region 1 increased significantly, while findings in Region 2 decreased, and findings in Region 3 remained the same. The largest proportional increase in adverse findings was in Region 1 South, while the largest decrease was in Region 3 North.

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



Source: Office of the Family and Children's Ombuds, September 2013
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

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

The following summaries of correspondence between CA and OFCO illustrate this process.[14]

CA AGREEMENT WITH ADVERSE FINDING, NO REQUEST FOR MODIFICATION

EXAMPLE 1:

OFCO FINDINGS

Violation of Policy: DLR/CPS failed to complete the required Safety Assessment "immediately following the initial face-to-face contact with the child." See Practices and Procedures Guide, §2335(A). According to Famlink records, the Safety Assessment was not initiated by the social worker until almost three months after the intake and initial face-to-face contact with the victim occurred. Furthermore, the Safety Assessment determined that the child was "Unsafe," requiring a safety plan and/or provision of services.

OFCO was informed that DLR/CPS will be receiving additional training regarding the use of the new Safety Assessment Tool. Hopefully, this will help to resolve this issue in other cases going forward.

Violation of Policy: DLR/CPS did not conduct an on-site visit to the licensed foster home where the CA/N was alleged to have occurred. See Investigating Abuse and Neglect in State-Regulated Care, XI(S): "The DLR/CPS investigator will make one or more on-site visits to the licensee's facility or foster home during the course of the investigation."

CA RESPONSE

DLR agrees that the Safety Assessment was untimely. The policy regarding Safety Assessments changed several times in 2012 during implementation of the new Child Safety Framework. However, even under the most recent policy, the investigator was required to complete the Safety Assessment within 30 days of the intake. See Practices and Procedures Guide §1120.

In DLR's continued efforts to integrate the Child Safety Framework into its policy and practice for facility investigations, DLR will address Safety Assessment requirements in local trainings. Additional training will be provided to DLR/CPS staff in this local office to clarify the expectations for use of the Safety Assessment, and will specifically address the timeframes for completion.

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

With respect to OFCO's finding that the investigator did not conduct an on-site visit to the foster home, the investigator did make an appointment for an on-site visit to the licensed foster home, but this visit was canceled due to a snowstorm and hazardous road conditions. The visit should have been rescheduled but was not. A social worker did go out during this time frame to the home to conduct a Health and Safety visit with the foster children but the family was not at home. In response to this adverse finding, the investigator and his supervisor have been counseled to ensure all facility investigations receive an on-site visit pursuant to CA policy.

EXAMPLE 2:

OFCO FINDING

Poor Casework Practice: A CPS Risk-Only intake was screened in after a mother gave birth to a baby prematurely at 26 weeks. The mother and baby tested positive for opiates and the mother admitted to a history of heroin and prescription narcotic abuse. At the time of the CPS intake, the baby was in the NICU, but the CPS case was still open when the baby was discharged home to the parents three months later. CPS entered minimal documentation of efforts to make contact with the family for approximately two months following the baby's discharge from the hospital. When OFCO contacted the CPS supervisor, the case had already been brought to the supervisor's attention due to concerns for child safety and a lack of investigative activities such as contact with the family and child, and collateral contacts. As a result, the supervisor ultimately took over the investigative activities. Based on the high risk involved, OFCO found it clearly unreasonable that more timely efforts were not made to locate the child, and to assess the child's safety.

CA RESPONSE

The Area Administrator reviewed the case file and concurred that the investigation initially completed was not thorough and noted some practice concerns, specifically that the time frames entered by the social worker were incorrect, and there was an apparent lack of engagement with the family. The social worker did make a Public Health Nurse referral after learning the child was being released from the hospital.

After staffing the case with the CPS supervisor, the agency decided that the investigation would be completed by the supervisor. Additional steps, described in detail in the agency's letter, were taken to engage the family and complete a thorough investigation.

CA DISAGREEMENT, OFCO MODIFICATION OF AN ADVERSE FINDING

OFCO'S ORIGINAL FINDING

Violation of Law and Policy: OFCO received a complaint alleging that the department failed to make diligent efforts to notify the aunt of a dependent child, and consider her for placement when her nephew entered state care. OFCO found that this was **a violation of state law and department policies** as this aunt was known to the department, and had previously cared for a dependent sibling of this child.

State laws and CA policies require the department to make diligent efforts to identify and notify all adult relatives when a child enters state care and the DCFS social worker must search for appropriate relatives to care the child prior to consideration of placement in other types of out-of-home care. Placement with an appropriate and qualified relative is preferred over placement with a foster parent who has no previous relationship with the child. The required initial relative search activities include: a review of the case files/records to identify names of relatives or extended family who could be contacted, and a search in FamLink to identify names associated with the child or parent. See RCW 13.34.060(2) and RCW 13.34.130; CA Practices & Procedures Guide, Sections 4261 and 45273.

Despite the mother's statement that she did not have any relatives, a review of FamLink would have not only identified her sister, but also revealed that the aunt had previously been willing and capable of caring for her dependent nephew. The department's failure to make diligent efforts to identify and notify relatives deprived the child of the opportunity to be raised and cared for by family.

CA REQUEST FOR MODIFICATION OF FINDING

Although **the Department disagrees with your conclusion that its actions constituted a violation of state law,** it does agree that our records do not reflect the due diligence search for relatives required by our policies.

This DCFS office regrets any oversight, especially given that our office had previously placed the child's sibling with the relative. We are one of several offices in the state with high relative placement rates. However, our review of this case has given us an opportunity to reexamine our practice so that we can strengthen our early engagement with relatives at all program levels.

The following actions have been taken to strengthen our practice:

1. An attempt was made to formally address this issue with social service specialists and their supervisors; however, we were unable to continue this action because all who were involved with this case no longer work for our Administration.
2. An Interim practice improvement plan is in place to ensure that relatives of all children entering care are contacted and assessed for possible placement. Also included in this interim plan is the documentation of relative search and engagement efforts.

3. To address this systematically, we have undertaken a 100% practice review of all cases where children are not placed with relatives.
4. We have designated a full-time Social Service Specialist position within the office to support our continuous quality improvement efforts in family engagement and placement practices. Among other duties, the incumbent will review FamLink history and follow up with background checks for relatives identified by the Relative Search Unit.
5. We will continue to ensure that Family Team Decision Making meetings (FTDM) are occurring in all cases involving new placements, placement changes and reunifications. We are working closely with our FTDM facilitator and her supervisor to support our improvement efforts.
6. We are collaborating with the Regional Relative Search Unit to ensure follow up on relative lists generated by this unit. The Relative Search Unit has an out-stationed Social Service Specialist at the local office who will be working with our designated staff to increase efforts to identify relatives who may be appropriate placements throughout the life of a child's case. An initial meeting has taken place between the office management team and the Relative Search Unit to begin this collaboration.

We are committed to continuous quality improvement of our relative search, engagement and placement practices.

OFCO'S MODIFIED FINDING

Violation of Policy: OFCO agrees with your conclusion that the department's actions did not constitute a violation of state law, but that the department failed to conduct a due diligence search for relatives as required by department policies. OFCO has therefore modified the Adverse Finding accordingly to delete references to state law. All other aspects of the finding remain unmodified.

OFCO WITHDRAWAL OF AN ADVERSE FINDING

OFCO'S ORIGINAL FINDING

Violation of Law and Policy: OFCO received a complaint alleging that DCFS failed to notify a tribe after receiving information that a then-dependent child may have Native American ancestry. The child was in state care for four years prior to being adopted.

Case records indicate that when the child entered state care, DCFS was told that a relative of the child was enrolled in a federally recognized Indian tribe. However, there is no documentation that DCFS took any further action. OFCO found that DCFS did not make ongoing efforts throughout the life of the case to fully discover whether the child is of Indian ancestry, document the results in case records, or notify the child's tribe that the child was in state care.

This failure was clearly unreasonable under the circumstances. Additionally, OFCO could not find any evidence indicating that DCFS notified the child's tribe, as required by the federal Indian Child Welfare Act (ICWA). 25 U.S.C. § 1912(a). OFCO could not find any documentation that DCFS lacked sufficient evidence such that notification to the tribe was unwarranted.

The lack of notice to the child's tribe had an adverse impact as the tribe did not have an opportunity to intervene and offer services to the child and the family, nor did the tribe have the opportunity to sign off on the child's subsequent adoption. Furthermore, the child and the adoptive family missed out on the opportunity to explore the child's tribal heritage and participate in cultural activities.

The child has four younger dependent siblings and one non-dependent sibling. OFCO understands that DCFS is currently pursuing Native American identification for the four dependent siblings, and it has encouraged the adoptive mother for this child to pursue enrollment for the child.

OFCO'S WITHDRAWAL OF ADVERSE FINDING

After receiving the Notice of Adverse Finding, the DCFS office did find documentation indicating that DCFS did make efforts to contact the tribe regarding this child's eligibility for enrollment. The documentation indicates DCFS sent the tribe a family ancestry chart that listed the relative who was alleged to be an enrolled member of the tribe. The tribe responded that based on the information provided, the dependent child "cannot be traced in our tribal records through the adult relative(s) listed above."

Through OFCO's investigation, we could not locate this document or any other documentation that DCFS had received notice from the tribe regarding the child's eligibility. **However, given the additional information provided by DCFS, OFCO is withdrawing the Notice of Adverse Finding.**

We encourage DCFS to share this documentation, including the information with the ancestry chart that was submitted to the tribe, and the tribe's response, to the child's adoptive family.

IV. IMPROVING THE SYSTEM

PART ONE: WORKING TO MAKE A DIFFERENCE

- Attorney Representation for Children
- Ongoing Efforts to Improve the Adoption System
- Addressing the Long-Term Impact of an Administrative Finding of Child Maltreatment
- Addressing Delays in Completing CPS Investigations within 90 Days

PART TWO: OFCO CRITICAL INCIDENT CASE REVIEWS

- Summary of Findings
- Child Fatality Reviews
  - 2012 Fatality Data
- Near Fatality Reviews
- Systemic Investigation: Recurrent Maltreatment

PART THREE: 2013 LEGISLATIVE UPDATE

"The Ombuds did a great job. You saved my son's life."

~ Parent

PART ONE: WORKING TO MAKE A DIFFERENCE

ATTORNEY REPRESENTATION FOR CHILDREN

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

Whether or not a child is represented by an attorney in a dependency proceeding depends largely on local practices in the county where the child's case is heard. As a result, a child in one county may have an attorney advocating for the child's stated interests and protecting the child's legal rights on issues such as placement, sibling visits, educational rights and school moves, or the appropriateness of psychotropic medications. In a neighboring county, a similarly situated child may have only a volunteer Court Appointed Special Advocate (CASA), or Guardian Ad Litem (GAL) making recommendations to the court based on their belief of what is in "the best interest of the child."

In recent years, the legislature enacted laws to better protect the child's legal interests by: ensuring that children 12 years of age or older are informed of their right to request appointment of an attorney; and developing practice standards for attorneys representing children in dependency cases. These steps alone are inadequate. In order to protect the rights and interests of children who have suffered abuse or neglect, state law should provide that all children subject to a dependency or termination of parental rights court proceedings are represented by an attorney.

ABSENT "GOOD CAUSE" THE COURT *MUST* APPOINT A CASA OR GAL

Washington state law requires that, absent good cause, the court must appoint a CASA or GAL for a child in a dependency proceeding[15] to advocate for the best interest of the child.[16] In fulfilling this role, the CASA or GAL is required to:

- investigate and report to the court information about the best interests of the child;
- meet with, interview, or observe the child, and report any views or positions expressed by the child on issues pending before the court;
- monitor all court orders for compliance and brings to the court's attention any change in circumstances that may require a modification of the court's order;
- report information on the legal status of a child's membership in any Indian tribe or band; and
- make recommendations based upon an independent investigation regarding the best interests of the child.[17]

[15] RCW 13.34.100(1). Washington is the **only** state with a statutory good cause exception. This is in direct conflict with the federal Child Abuse Prevention and Treatment Act (CAPTA) which requires that a guardian Litem be appointed to represent the child in dependency proceedings. *Chapter 8: Court-Appointed Special Advocates (CASA) and Guardians ad Litem (GAL)*. Court Improvement Training Academy, School of Law, University of Washington. Available at: http://www.uwcita.org/chapter-8-court-appointed-special-advocates-casa-and-guardians-ad-litem-gal.html

[16] RCW 13.34.105

[17] Id.

Counties throughout the state employ different models for assigning CASAs or GALs—most counties have CASA programs, which recruit, train and supervise volunteers to report to the court on what the CASA believes is in the best interest of the child. In other counties, the court appoints private GALs, who may be attorneys, to report on the best interest of the child.[18] In some counties, there is a waiting list for a CASA/GAL to be assigned for a child at the outset of the dependency proceedings. ***In some counties, the CASA withdraws from an assignment once parental rights are terminated and the child is "legally free."***

SOME LEGALLY FREE CHILDREN ARE NOT ASSIGNED A CASA OR GAL

Over two years ago, two siblings (now ages 3 and 4) were removed from their home due to neglect related to the parent's mental health issues and substance abuse. The children were placed in foster care and the court appointed a CASA to represent their best interest. During this dependency, two younger siblings were placed with a relative. Efforts to reunite these 3 and 4 year old children with the parent, as well as an attempt to place the children with the relative who was raising the younger siblings, were unsuccessful. The children were returned to the care of a previous foster parent and the department pursued a case plan of termination of parental rights and adoption. Once parental rights were terminated, the CASA withdrew from representing the children's best interest even though issues regarding the children's adoption remained unsettled. As a result, no one was representing the children's "best interest" at a critical point in this case, on issues regarding: possible return to the relative's care; adoption by the foster parents; and post-adoption contact between these children and their siblings and relatives.

THE COURT *MAY,* IN ITS DISCRETION, APPOINT AN ATTORNEY TO REPRESENT THE CHILD

The court has the discretion to appoint an attorney to represent the child ***if*** the child requests legal counsel ***and*** is age 12 or older, or if the CASA/GAL or the court determines that the child needs to be independently represented by counsel.[19] If there is no CASA or GAL, the court is required to appoint an attorney for the child, upon the request of a party or on the court's own initiative.[20]

An attorney appointed to represent a dependent child has duties and responsibilities fundamentally different from that of a CASA or GAL. First and foremost, an attorney can provide legal counsel to a child and keep communication with the client confidential. A child's attorney can also:

- Explain the child's legal rights in the dependency proceeding;
- Advocate for the child's legal interests and rights regarding placement, education, visitation, medical care and services; and

[18] *Chapter 8: Court-Appointed Special Advocates (CASA) and Guardians ad Litem (GAL)*. Court Improvement Training Academy, School of Law, University of Washington. Note 1.
[19] RCW 13.34.100(6)(f)
[20] JuCR 9.2(c)(1). Available at : http://www.courts.wa.gov/court_rules/?fa=court_rules.display&group=sup&set=JuCR&ruleid=supJuCR09.2

- Ensure financial benefits for foster youth aging out of care. [21]

Most importantly, an attorney can ensure that the child's voice is heard in the dependency proceeding and provides advocacy for the child's stated interest. The Rules of Professional Conduct (RPC), which governs an attorney's role and responsibilities, recognizes that even young children are capable of informing their attorney and directing representation: "[C]hildren as young as five or six years of age, and certainly those of ten or twelve, are regarded as having opinions that are entitled to weight in legal proceedings concerning their custody."[22]

10 YEAR OLD HAS NO ATTORNEY TO ADVOCATE FOR AND PROTECT HIS LEGAL INTERESTS

In 2005, a now 10 year old child and his four siblings were removed from their parents' care based on numerous reports of child abuse and neglect. In late 2006, he was returned home, only to re-enter foster care in the fall of 2007. The mother and father ultimately relinquished parental rights in 2010. While his four siblings have been adopted, permanency for this 10 year old child has not been established. He has experienced over 17 different foster care and group home placements. He has undergone a psychological evaluation and a sexually aggressive youth evaluation and has been prescribed psychotropic medications. This child has repeatedly asked to visit his biological parents and his siblings, and has requested a cell phone so he can at least text his siblings and parents. No visits have been provided with the father on the advice of the child's therapist.

In 2013, OFCO received a complaint regarding this child's case. Based on the factors described above, including the lack of permanency, multiple placements, prescription of psychotropic medications, and issues surrounding contact with siblings and a biological parent, OFCO concluded that this youth should have an attorney. OFCO contacted the department and requested that a motion to appoint an attorney for this child be brought before the court. The department disagreed, as the child has a volunteer guardian ad litem who is actively involved, and believed that appointment of an attorney would be counterproductive.

While OFCO disagrees with the department, OFCO determined that its decision on this issue is consistent with current state law.

LEGISLATIVE EFFORTS TO PROTECT THE CHILD'S RIGHTS AND INTERESTS

Recently, the legislature has taken steps to ensure that children in dependency proceedings are notified of their existing right to request appointment of an attorney, and that when an attorney is appointed, the attorney is well-trained and meets certain practice standards. Recognizing inconsistent practices throughout the state and that few children were being informed of their right to ask for an attorney, the legislature in 2010 amended state law to require the department and the CASA/GAL to notify every child 12 years of age or older of their right to request an attorney and to ask the child if they want an attorney. The child must be notified at least once a year and whenever

[21] The Legislature recognized the unique role of attorneys for dependent children in Chapter 180, Laws of 2010. HB 2735 (sec. 1).
[22] RPC 1.14 comment 1

a motion affecting the child's placement, services, or familial relationships is filed.[23] The legislature also noted that "when children are provided attorneys in their dependency and termination proceedings, it is imperative to provide them with well-trained advocates so that their legal rights around health, safety, and well-being are protected" and directed the Administrative Office of the Courts to develop recommended standards for attorneys who represent youth in dependency proceedings. [24]

OFCO believes that efforts to notify children of their right to request an attorney are inadequate and fail to address the disparity in legal representation throughout the state. First of all, while the court has the discretion to grant a child's request for an attorney, the court also has the discretion to deny the request. This has resulted in disparate practices around the state. It is common practice, for example, in King and Spokane Counties, for children age 12 and older to be appointed an attorney in a dependency case. In Benton and Franklin Counties, children age nine and older are appointed attorneys and children age eight and younger are appointed a CASA. Until recently, Asotin, Garfield and Columbia counties had a long-standing practice of appointing attorneys for every child (of any age) removed from the parents' care because of alleged abuse or neglect.[25] In many other counties, however, children are rarely appointed an attorney, regardless of age.[26] According to Judicial Information System data, only 41 percent of children ages 12 to 18 are represented by an attorney in dependency and termination of parental rights cases in our state.[27] Whether or not a child has an attorney depends more on where the case was filed than on the facts and circumstances of the case.

THE CHILD'S RIGHTS AND INTERESTS IN A DEPENDENCY PROCEEDING ARE AS GREAT AS THE PARENT'S AND DESERVE THE SAME RIGHT TO COUNSEL

"[C]hildren have at least the same due process right to counsel as do indigent parents subject to dependency proceedings."
- Washington State Supreme Court, *In the Matter of the Dependency of MSR and TSR*

"All children subject to a dependency or termination of parental rights court proceedings should have legal representation as long as the court jurisdiction continues."
- Statewide Children's Representation Workgroup, appointed by the Washington State Supreme Court Commission on Children in Foster Care

[23] RCW 13.34.100(6)(a)-(e)
[24] Chapter 180, Laws of 2010. HB 2735. The Child Representation Practice Standards are published in *Meaningful Legal Representation for Children and Youth in Washington's Child Welfare System,* available at: http://www.law.washington.edu/Directory/Docs/kelly/HB2735.pdf
[25] County commissioners passed a resolution stating that funding for child legal representation will be provided on a case-by-case basis. *Acey's Dream: Attorneys for Kids in Need,* K. Sandaine The Lewiston Tribune, October 28, 2013.
[26] *Chapter 8: Court-Appointed Special Advocates (CASA) and Guardians ad Litem (GAL)*. Court Improvement Training Academy, School of Law, University of Washington, note 1. *A Child's Right to Counsel, A National Report Card on Legal Representation for Abused & Neglected Children, 3rd Ed.* Available at: http://www.firststar.org/library/report-cards.aspx
[27] Judicial Impact Fiscal Note, filed February 15, 2013, Bill Number: 1285 2S HB H-1337.2

In 2012, the Washington State Supreme Court recognized that children have at least the same due process right to counsel as indigent parents subject to dependency proceedings.[28] The court determined that the child's rights and interests at stake in a dependency proceeding, while different from those of a parent, are at least as great as a parent's and warrant the same right to counsel. Specifically, the Court noted that the child may be physically removed from a parent's home and become a ward of the State (with the State making crucial decisions about every aspect of their lives—where they live, who they live with, who they visit with, where they go to school, what services they are provided, and so on). For a child, changes in foster home placement may result in multiple changes of schools, and friends, over which the child has no control.

Children have fundamental liberty interests in freedom from unreasonable risks of harm and a right to reasonable safety.[29] Children also have a fundamental liberty interest in maintaining the integrity of the family relationships.[30] Our legislature also recognizes that the rights of a child include: basic nurture, health and safety; a safe, stable, and permanent home; and a speedy resolution of any dependency proceeding.[31] In 2010, a multidisciplinary workgroup of professionals representing organizations involved in dependency proceedings including the court, CASA and GAL programs, private attorneys, public defense, and the Office of the Attorney General also concluded that all children who are the subject of a dependency or termination of parental rights case should be represented by an attorney.[32]

OFCO RECOMMENDATIONS

Given the Supreme Court's strong pronouncement regarding dependent children's legal rights in the *M.S.R. and T.S.R.* decision, OFCO presents two options to improve legal representation for Washington's children in dependency and termination of parental rights proceedings. These options are: mandate that all children are appointed an attorney; or define in statute objective circumstances requiring the appointment of an attorney for the child.

AMEND STATE LAW TO PROVIDE THAT ALL CHILDREN SUBJECT TO A DEPENDENCY OR TERMINATION OF PARENTAL RIGHTS PROCEEDING SHALL BE APPOINTED AN ATTORNEY

Washington State statutes should be amended to require the appointment of counsel for all children in dependency and termination proceedings and implement standards of representation. In 2010 the legislature directed the Administrative Office of the Courts in conjunction with the State Supreme Court Commission on Children in Foster Care to develop recommended standards for attorneys who represent children in dependency proceedings. The group's report—*The Child*

[28] *In the Matter of the Dependency of MSR and TSR* **[cite]** The court concluded that the current statutory frame work, authorizing the court to appoint counsel, is "constitutionally adequate" and that the deprivation of the child's right to counsel may be protected by appellate review. However, given the time and expense involved, appellate review is an impractical means of assuring that the child's rights and interests are protected. And, since the child was without counsel during the dependency proceeding, it is unclear who would file an appeal on the child's behalf.
[29] *Braam v. State*, 150 Wn.2d 689, 81 P.3d 851 (2003)
[30] Infra, note 15. See also, *Braam v. State*
[31] RCW 13.34.020
[32] *Meaningful Legal Representation for Children and Youth in Washington's Child Welfare System,* note 8.

Representation Practice Standards—represent best practices for child representation. Legislation should implement these standards and assure that the attorney represents the child's stated interest; the attorney has adequate training, education and experience; and the attorney abides by reasonable caseload limits.

The child's age alone should not bar legal representation. The standards developed by the Supreme Court Commission workgroup contemplate an attorney representing even pre-verbal or non-verbal children. As required by the Rules of Professional Conduct, the child's attorney determines whether the child's capacity to direct the representation is diminished and this decision is not based solely on the child's chronological age.[33] When the child is unable to communicate a stated interest, the attorney protects the child's legal interests, based on relevant laws, the child's specific needs, and timely resolution of the case so the child can remain or return home, or be placed in a safe, nurturing and permanent environment.[34] Additionally, Washington can look to the American Bar Association and to other states that have been providing legal representation to children of all ages for guidance on this issue.[35]

Appointing an attorney for all children provides the same due process right to counsel afforded to parents involved in dependency and termination of parental rights proceedings and assures that children's fundamental liberty interests are protected.

14-YEAR-OLD YOUTH WHO SPENT EIGHT YEARS IN DEPENDENCY SYSTEM WAS NEVER REPRESENTED BY AN ATTORNEY

In 2005, a then-5-year-old child and her siblings were removed from their parents due to abuse and neglect. Over the next eight years, she would: experience over 20 placements; be separated from her siblings; be moved across the state and out-of-state; be removed from a long-term foster parent who had successfully cared for her and wanted to become her legal guardian; have her biological parents' rights terminated; be placed unsuccessfully in three different homes for the purpose of adoption; and be placed in group care facilities due to her behavioral issues. At no point during her dependency did this now-14-year-old youth have an attorney to talk to her about her case, explain her rights, and advocate for her stated interest.

In 2006 this child was placed in a foster home, where she would remain for the next four years. While this foster parent was committed to raising this child permanently, she wanted to do so through a legal guardianship, rather than adoption, due to financial and legal risks associated with the child's current and future needs. In 2009 the child became "legally free" as her parents' parental rights were terminated. In early 2010, the department identified a potential adoptive home out-of-state. After a transition period and several visits, the now-ten-year-old child was placed in this pre-adoptive home. Less than two months later however, the placement disrupted. The child then moved to another out-of-state placement with individuals interested in adopting. This placement also failed after the child was arrested for assault against the foster mother. In 2011, she returned to Washington State.

[33] Child Representation Practice Standards, 1.1 Role of Child's Attorney (2). Note 8.
[34] Child Representation Practice Standards, 1.1 Role of Child's Attorney (7). Note 8.
[35] CITE TO THE ABA Model Law and practice standards (ESM can help find these).

Between 2011 and 2013, this child was placed in multiple group care facilities due to her behavioral issues, and multiple foster homes. She was again placed in a foster home interested in adoption, where she was the seventh child in the home, and shared a bedroom with two other teenagers. Within two weeks, she had repeatedly run from the home and the foster mother asked the department to find a new placement. She was then returned to a group care facility. In 2013, after eight years in state care, and legally free since 2009, she was adopted by foster parents with whom she had lived for the previous five months.

An attorney could have advocated for this child and addressed issues including: multiple placements; achieving permanency; sibling separation; and mental health services.

DEFINE IN STATE LAW OBJECTIVE CIRCUMSTANCES REQUIRING APPOINTMENT OF COUNSEL FOR THE CHILD

Alternatively, at a minimum, state law should set forth specific circumstances where the child's fundamental liberty interests are at greatest risk and require appointment of an attorney. This approach is modeled on bills[36] sponsored by Representative Roger Goodman and Senator Jeannie Darneille during the 2013 legislative session. For example, circumstances requiring appointment of counsel might include:

- Filing a petition to terminate the parent and child relationship.
- Multiple (more than 4) out-of-home placements for the child.
- Placing the child in a group-care facility.
- Placing the child in an inpatient treatment facility.
- The child is prescribed psychotropic medications.
- The child is referred for a mental health or psychological/psychiatric evaluation.
- The child has run away from a placement. [Or is missing from care?]
- Court ordered services for the child have not been offered or provided.
- Adoption is identified as the primary permanent plan.

While this approach falls short of the due process protections afforded parents, it would be a significant step towards ensuring that a child has legal representation when the child's physical or fundamental liberty interests are at stake. This approach and would begin to address inconsistent practices across the state that can result in children's rights not being protected by an attorney at critical points in their dependency cases.

[36] HB 1285 and SB 5461

ONGOING EFFORTS TO IMPROVE THE ADOPTION SYSTEM

BACKGROUND

OFCO's 2011 Annual Report[37] documented an alarming cluster of cases of severe child abuse and neglect occurring in adoptive or pre-adoptive placements. What is particularly disturbing in these cases is that the child abuse and neglect occurred in homes that had been scrutinized and approved by public or private child welfare agencies, and or by the court, as safe and appropriate adoptive homes for the children.

Common elements of 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 accusing the child as being untruthful;
- Exaggerating or misstating the child's negative behaviors;
- Forcing the child to remain outside the home;
- Physical abuse of the child;
- Denying the child access to toilet facilities; and
- Isolating the child from the community, such as removing the child from public school.

2012 WORK GROUP & RECOMMENDATIONS

At the request of then-Governor Gregoire, Children's Administration (CA) and OFCO convened a statewide committee in February 2012 to address these concerns and recommend changes to the adoption process. The committee was co-chaired by Denise Revels Robinson, then-Assistant Secretary of CA and Mary Meinig, Director of OFCO. Members of the committee represented various professions and organizations within the child welfare and adoption system including: CA; private child placing agencies who conduct domestic and international adoptions; the Office of the Attorney General; the court; public defense attorneys; the Governor's Office; researchers; and medical professionals.

Topics reviewed by the committee included:

- Case reviews of incidents of severe abuse of adopted children;
- Adoption legal framework: Hague 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;
- Medical perspective on child maltreatment including starvation; and
- Summary of research on adoption attachment and abuse.

[37] Available at http://www.governor.wa.gov/ofco/reports/2011/ofco_2011_annual.pdf

While cases of severe abuse of adopted children are not unique to Washington State, Washington is the only state that we know of that has partnered with public and private organizations and agencies to examine this issue in order to improve the adoption process to protect children.

The *Severe Abuse of Adopted Children Committee Report* [38] (hereinafter "Severe Abuse Report") identified opportunities to strengthen the adoption system and provide greater safeguards to protect children and strengthen families. These recommendations fall under the following categories:

1. **State Oversight of Private Child Placing Agencies**
   - Strengthen state regulations and oversight of child placing agencies
   - Develop and distribute a list of key concerns or "Red Flags" regarding troubled adoptions
   - Track adoption disruption and dissolution

2. **Assessing Prospective Adoptive Families**
   - Strengthen qualifications for individuals conducting adoption home studies and post-placement reports
   - Enhance minimum requirements for adoption home studies and post-placement reports
   - Ensure that all adoption home studies, including those when a prospective adoptive family withdraws or is disqualified prior to completion of a home study, are filed with the court as required by state law
   - Require an independent review and approval of adoption home studies
   - Establish an internal committee within CA to make adoption decisions for dependent children

3. **Training and Post Adoption Support Services**
   - Improve training and preparation for prospective adoptive parents
   - Establish minimum training requirements for child placing agency staff
   - Provide training for professionals directly or indirectly involved with the adoption process
   - Enhance post-adoption support services for adoptive families

[38] Available at: http://www.governor.wa.gov/ofco/reports/Severe_Abuse_Adopted_Children_Report.pdf

DSHS' EFFORTS TO IMPLEMENT RECOMMENDATIONS

The *Severe Abuse Report* also directed CA to develop a work plan identifying and prioritizing recommendations within the agency's control and describing necessary steps to carry out these reforms. CA formed a work group to take on this task. Listed below are recommendations identified by CA as areas of particular focus for the agency, and a brief summary of implementation efforts to date.

Strengthen State Regulations and Oversight of Child Placing Agencies

The Division of Licensed Resources (DLR) is in the process of developing potential changes to the Washington Administrative Code (WAC) governing child placing agencies. Initial recommendations for changes to the WACs will be reviewed by CA administration.

Develop and Distribute a List of Key Concerns or "Red Flags"

CA is developing a list of "red flags," drawn from research, regarding troubled adoptions for use by DLR in home study assessments and by CFWS and adoption staff in assessing appropriate placement of children. This tool would also be available to private agencies.

Establish an Internal Committee to Make Adoption Decisions for Dependent Children

CA has established a "Selection Committee" process for adoption decisions in one region, and the workgroup recommends that it be incorporated state-wide. The work group created a plan to increase positive placement outcomes for children by assessing family and children characteristics throughout the case. The assessment begins with the initial Family Team Decision Making meeting and continues at various case planning events.

Enhance Minimum Requirements for Post-Placement Reports

CA is working on incorporating changes to a standardized post-placement report used by CA adoption workers. These changes will address the following factors:

- Any change in the adoptive family relating to health, finances or composition that could affect the child;
- Providing the adoptive parents with any medical information on a child's birth family received after the child was placed for adoption; and
- Discipline practices of the adoptive family.

Provide Training for Professionals Involved with the Adoption Process

The CA work group has drafted training recommendations for CA staff and other professionals involved with adoptions. Once finalized and approved, CA will meet with the University of Washington Court Improvement Training Academy to strategize a training plan.

LEGISLATIVE EFFORTS TO IMPROVE THE ADOPTION PROCESS

In 2013, Representative Mary Helen Roberts introduced legislation to address some of the issues identified in the *Severe Abuse Report.* ESHB 1675[39] aimed to strengthen adoption pre- and post-placement reports; track failed adoptions; and assess DSHS' progress implementing the *Severe Abuse Report's* recommendations. Specifically, this bill required that pre- and post-placement reports must address the adoptive parents' planned approach to child discipline and punishment, while it reaffirmed that evaluation of the fitness of a parent may not be based on child discipline and punishment practices that do not otherwise constitute a violation of state law. The background check must include any prior pre-placement reports, whether complete or incomplete, and while an applicant may withdraw from a pre-placement assessment, the incomplete report must still be filed with the court.[40] The bill also required the Secretary of DSHS to establish procedures to identify, track, and report adoption disruption and dissolution. Under the legislation, OFCO would report information about DSHS' progress in implementing recommendations in the *Severe Abuse Report.* ESHB 1675 did not pass during the 2013 legislative session. Representative Roberts continues to work on these issues, meeting with stakeholders and exploring ways to strengthen Washington State's adoption process.

OFCO believes that future action to improve adoption outcomes might also include:

Strengthen Requirements for Pre-Placement Reports

Using Psychological Evaluation or Assessment Tool: Some states require a psychological evaluation if questions arise during the application process. In Colorado, every adoption home study includes a Structured Analysis Family Evaluation (SAFE).[41] Washington State should explore the use of an assessment tool or psychological evaluation when conducting pre-placement reports.

Addressing Child Abuse and Neglect: Presently, the pre-placement report must document that the preparer discussed with the prospective adoptive parents various issues including: the concept of adoption; separation and loss from the birth parents; the child's relationship with siblings; and the child's racial, ethnic and cultural heritage. State law should also require the individual conducting the pre-placement report to discuss with the prospective adoptive parents issues regarding child maltreatment. At a minimum, this discussion should address topic such as: the legal definition of child abuse and neglect; permissible forms of discipline; the applicant's plan for child discipline, and the potential consequences of child maltreatment on the family.

Filing all Pre-Placment Reports with the Court

As noted in the *Severe Abuse Report,* adoption pre-placement reports, whether positive or negative, are not always filed with the court as required by RCW 26.33.190(5). Additionally, there is no record when a prospective adoptive parent withdraws from an adoption home study process prior to

[39] Available at: http://apps.leg.wa.gov/billinfo/summary.aspx?bill=1675&year=2013

[40] RCW 26.33.190 states: " (1). . . A person may have more than one preplacement report prepared. All preplacement reports shall be filed with the court in which the petition for adoption is filed." "(5) . . . If the person requesting the report has not filed a petition for adoption, the report shall be indexed in the name of the person requesting the report and a cause number shall be assigned."

[41] Home Study Requirements for Prospective Parents in Domestic Adoptions (2012, Child Welfare Information Gateway. Available at: https://www.childwelfare.gov/systemwide/laws_policies/statutes/homestudyreqs_adoption.pdf

completion. This can create child safety concerns if a prospective adoptive parent seeks a new adoption home study from a different agency and fails to disclose a previous report. State law should be amended to require that all pre-placement reports, whether positive, negative or incomplete, are filed with the county superior court. The court must also establish procedures to facilitate the filing of an adoption home study either before or after an adoption petition has been filed, as required in current state law.

SHOULD THE HOMICIDE BY ABUSE LAW PROTECT CHILDREN OVER 15 YEARS OF AGE?

In 2008, Hana, age 11, was adopted from Ethiopia by Larry and Carri Williams. In May 2011, Hana was found dead, face down, naked and emaciated in the backyard. The parents deprived Hana of food for days at a time, made her sleep in a cold barn or a closet, and made her shower outside with a hose. Hana was often whipped with a plumbing tool, leaving marks on her legs. She had been beaten the day of her death. A medical consultation report concluded that Hana died from a culmination of chronic starvation caused by intentional food restriction, severe neglect, physical and emotional abuse, and endangerment.[42]

Larry and Carri Williams were charged with homicide by abuse under RCW 9A.32.055 for Hana's death. Following a trial in 2013, Mrs. Williams was found guilty of homicide by abuse. Mr. Williams was found guilty of first-degree manslaughter. The jury also convicted them both of assault. A key issue at trial was whether the state would be able to establish, beyond a reasonable doubt, that Hana was under the age of 16 at the time of her death. Doubts as to the accuracy of adoption and birth records from Ethiopia led to the exhumation of Hana's body and forensic tests to establish her true age. Various experts were unable to definitively determine Hana's age at the time of her death as either older or younger than 16. Hana's cousin testified that Hana would have been about 13 when she died based on his memory and a record of her birth written in a family Bible. His testimony, however, was stricken.

Exhumation of this child, forensic testing and related testimony was necessary due to an interpretation that the homicide by abuse statute only applies if the child victim is under 16 years of age. Given the text of the statute as written, it is unclear why the homicide by abuse statute was narrowly interpreted in this way. RCW 9A.32.055, defining homicide by abuse, applies to four distinct categories of homicide victims[43]—the death of a:

- Child;
- Person under sixteen years of age;
- Developmentally disabled person; or
- Dependent adult

[42] Skagit County Sheriff Office Affidavit, September 28, 2011. http://msnbcmedia.msn.com/i/MSNBC/Sections/NEWS/Abuse-probable.pdf

[43] Id. See also, Washington Pattern Jury Instruction WPIC 29.04

State laws define the terms “child,” “children,” “juvenile” or “youth” as any individual under the age of eighteen years.[44] Inclusion of both the terms “child,” and “person under sixteen years of age,” can only be reconciled if the statute is read to exclude an emancipated minor, who is sixteen or older, and considered to have the powers and capacity of an adult.[45] Any other interpretation of the homicide by abuse statute—such as excluding children sixteen years of age or older—seems to render the term “child” meaningless and redundant.

OFCO RECOMMENDATION: Amend RCW 9A.32.055 to clarify that a person is guilty of the crime of homicide by abuse if, under circumstances manifesting an extreme indifference to human life, the person causes the death of a child, a developmentally disabled person, or a dependent adult, and the person has previously engaged in a pattern or practice of assault or torture of said child, developmentally disabled person, or dependent adult. For the purposes of this statute, as is the case elsewhere in state law, “child” means any individual under the age of eighteen years who has not obtained a decree of emancipation.

[44] RCW 13.34.030; RCW 26.44.020; RCW 74.13.020; RCW 26.33.020
[45] See, RCW 13.64

ADDRESSING THE LONG-TERM IMPACT OF AN ADMINISTRATIVE FINDING OF CHILD MALTREATMENT

BACKGROUND

OFCO's 2012 Annual Report[46] discussed the long-term impact of an administrative finding that a person abused or neglected a child. Specifically, prior involvement with Child Protective Services (CPS) resulting in a finding of child abuse or neglect can bar a person from future employment or volunteer positions that involve unsupervised access to children or other vulnerable individuals. A CPS finding of abuse or neglect may also block a grandparent or other relative from being considered as a placement resource for a child.

In response to this issue, the legislature directed that a work group *"explore options, including a certificate of rehabilitation, for addressing the impact of founded complaints on the ability of rehabilitated individuals to gain employment or care for children, including volunteer activities . . . and report recommendations to the appropriate committees of the legislature . . ."*[47] An overview of the issue, and the work group's efforts, are discussed below.

OFCO participated in this work group. As discussed below, the work group identified significant barriers to creating a certificate of rehabilitation. Rather than pursue this option, one strategy for addressing this issue is to modify existing procedures, such as the Children's Administration (CA) administrative waiver process, making it more accessible to individuals who would otherwise be disqualified from having unsupervised access to children.

SCREENING APPLICANTS WHO MAY HAVE UNSUPERVISED CONTACT WITH CHILDREN

Department records regarding founded allegations of child maltreatment are used to screen for potential employees or volunteers who will have significant contact with children. In order to assure the safety and well-being of the children it serves, the department is required to investigate the criminal history, civil and administrative findings of abuse or neglect, disciplinary board decisions, and any pending charges, concerning[48]:

- Any current employee or applicant seeking a position with the department who will or may have unsupervised access to children, vulnerable adults, or individuals with mental illness or developmental disabilities;
- Individual providers who are paid by the state or by home care agencies to provide in-home services involving unsupervised access to persons with physical, mental, or developmental disabilities or mental illness, or to vulnerable adults; and

[46] http://www.governor.wa.gov/ofco/reports/2012/ofco_2012_annual.pdf
[47] Chapter 162, Section 7, Laws of 2013; SSB 5565.
[48] RCW 43.20A.710. Background checks are also required by Federal legislation- Title IV-E of the Social Security Act; The Adoption and Safe Families Act of 1997; and The Adam Walsh Child Protection and Safety Act of 2006.

- Individuals or businesses or organizations providing care, supervision, case management, or treatment of children, persons with developmental disabilities, or vulnerable adults.

Department rules and standards govern how this information is used to assess a person's character, suitability, and competence to have unsupervised access to children or other vulnerable individuals.[49] The *DSHS Secretary's List of Crimes and Negative Actions*[50] identifies offenses that disqualify a person from having unsupervised access to children or vulnerable adults. Some crimes permanently disqualify an applicant, while others are "five year disqualifiers"— after five or more years have passed since the conviction the department may conduct an overall assessment of the person's character, competence, and suitability to have unsupervised access to children or vulnerable adults. A person with a pending charge on this list is denied unsupervised access until the charge is adjudicated. An administrative finding of child abuse or neglect is not a permanent or "5 year" disqualifier. Rather, a finding of child abuse or neglect is considered a "Negative Action" which may lead to the denial of unsupervised access to vulnerable adults or children.

CA Administrative Review

The department may grant an administrative approval or waiver for a person with a disqualifying crime or negative action. This process is initiated by the department social worker, licensor, or contract manager, who must first determine that allowing the individual unsupervised access to a child will not jeopardize the child's health and safety.[51] Requests that are denied may be re-submitted based on new information or a substantial change in circumstances, such as results of an evaluation or the recommendations from a professional.

Work Group Activities

As directed by the legislature, *Catalyst for Kids*[52] convened a workgroup which included representatives from CA, the courts, veteran parents, foster parents, the Office of the Attorney General, the Office of Public Defense, OFCO, the Governor's Office, and the legislature. The work group examined: 1) the feasibility of creating a new process for "certificate of rehabilitation" process, and 2) possible modifications to make the CA administrative waiver process more accessible. Due to several barriers with creating a certificate of rehabilitation process discussed below, the work group concluded that efforts are better focused on improving existing procedures, such as the CA Administrative Review process.

Certificate of Rehabilitation

The work group explored procedures and standards for requesting and granting a certificate of rehabilitation regarding an individual with a prior finding of child abuse or neglect. This proposed process would empower a board, agency administrator, or court to review requests and determine whether the circumstances surrounding the prior finding of abuse or neglect have been remedied and issue a certificate of rehabilitation. In Vermont, for example, a person founded for child abuse

[49] RCW 43.43.832
[50] http://dshs.wa.gov/bccu/bccucrimeslist.shtml
[51] Children's Administration Operations Manual, Section 5523
[52] *Catalyst for Kids* is a coalition of child welfare professionals, consumers, advocates, and decision-makers. http://catalystforkids.org/about.html

or neglect may file a written request with the commissioner of the state's child welfare, to expunge department records of abuse or neglect. The petitioner has the burden of proving that a reasonable person would believe that he or she no longer presents a risk to the safety or well-being of children.[53]

While a certificate of rehabilitation would allow a person to establish that he or she has successfully addressed issues that led to CPS involvement, the work group identified several barriers to establishing this process. These barriers include:

What Entity Should Grant or Deny a Certificate for Rehabilitation? Either CA or the court was initially identified as possible options. After exploring this issue in greater depth, however, the work group recognized valid concerns regarding either the court or CA undertaking these duties. For example, conflicts of interest may arise if CA is responsible for: investigating and determining if an allegation of child maltreatment is founded; assessing the individual's character, suitability, and competence to have unsupervised access to a child or vulnerable adult; and, ultimately, granting or denying a certificate of rehabilitation. The work group discussed, but was not able to identify an existing board or panel that was presently equipped to review cases and grant certificates of rehabilitation.

Workload Demands The workload for processing these reviews could potentially be very high, as there were approximately 5,500 to 6,000 individuals founded for child maltreatment per year, in state fiscal years 2011- 2013. This creates significant issues with establishing an infrastructure and operating costs for handling a potentially high caseload.

Establishing Objective Standards for Review The work group discussed various factors that should be considered when granting or denying a certificate of rehabilitation. The work group questioned whether a decision maker could adequately determine whether or not a person is "rehabilitated" or "suitable" to have unsupervised contact with a vulnerable individual. At best, a decision maker would only be able to objectively find that a certain period of time had passed since the finding of child maltreatment, and whether or not the petitioner had any subsequent criminal convictions, findings of abuse or neglect, or other negative actions.

Would a Certificate of Rehabilitation Have a Meaningful Impact? Even if an individual was granted a certificate of rehabilitation, the administrative finding of child abuse or neglect would remain on the person's record with DSHS. While the certificate may have persuasive value, DSHS would still need to go through its own process to assess the person's "character, suitability, and competence" to have unsupervised access to children or other vulnerable individuals. Similarly, it is unclear whether a certificate would have relevance in other systems that work with vulnerable individuals, such as health, or education, or with private agencies.

[53] Vermont Stat. Tit. 33, §§ 4916c

CA Administrative Review

While the current administrative review process gives the department flexibility when assessing an individual's character, suitability, and competence to have unsupervised access to children, this process also has notable limitations.[54] For example, the administrative review can only be initiated by the agency worker. If the worker does not believe a waiver is appropriate, the person with a disqualifying crime or negative action cannot seek an administrative review and has no other avenue to address this issue.

CA and stakeholders within the child welfare system are working on ways to improve the efficiency and timeliness of the background check and administrative review process. Possible changes to the CA administrative review process discussed by the legislative work group include:

Improve Accessibility Allow a person with criminal history or a founded allegation of child maltreatment or other negative action to initiate the administrative review process.

Team Decision An "Administrative Review Team" made up of two or more CA staff would review and decide waiver requests.

Portability An approved waiver request would be portable, so that absent a new negative action or criminal infraction, CA would accept the Administrative Review Team's previous decision and not require the individual to go through the waiver process again.

These steps could improve the administrative review process and make it more accessible to individuals otherwise disqualified from having unsupervised access to children. However, an administrative waiver is limited in scope and only applies to decisions made by a state child welfare agency—for example, when the state child welfare agency wants to place a child with a relative who has a disqualifying crime or negative action. An administrative waiver could not be utilized to assist an individual seeking employment or a volunteer position with an outside organization, such as a school.

[54] Additionally, Children's Administration cannot claim Title IV-E or federal adoption support funds for any child placed in the home with a disqualifying crime on the Permanent List or the 5 Year List and it is less than 5 years since conviction. This means that for any child placed with an individual who has been granted a waiver, only state funds will be accessible to pay for the child's placement.

ADDRESSING DELAYS IN COMPLETING CPS INVESTIGATIONS WITHIN 90 DAYS

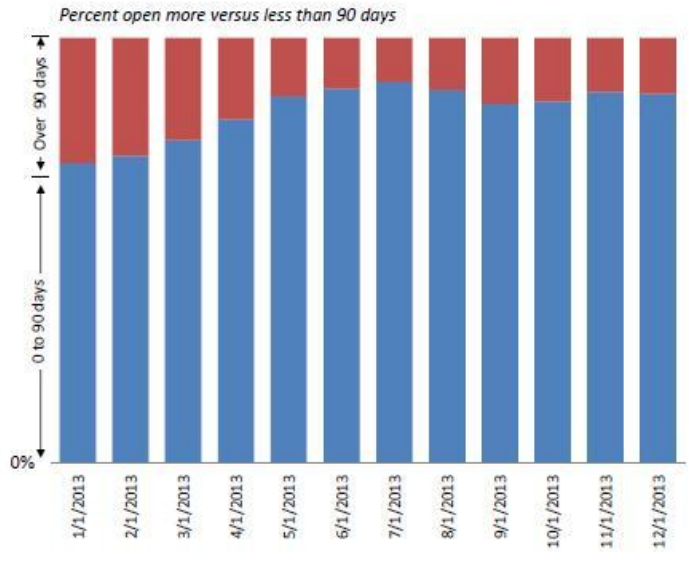
TIMELY COMPLETION OF CPS INVESTIGATIONS

Previous OFCO reports (2010, 2011 and 2012) discussed Child Protective Services' failure to complete investigations of child abuse or neglect within 60 days as required by policy or within 90 days as required by state law. OFCO emphasized that 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. During the past year, DSHS and CA administration has taken steps to complete CPS investigations in a timely manner.

As discussed below, OFCO has noted improvement, based on cases OFCO reviewed in 2013:

- In 2012, OFCO found that nearly half (49 percent) of the recurrent maltreatment cases had at least one CPS investigation that remained open beyond the 90 day deadline. In 2013, OFCO found that 37.5 percent of these cases had at least one CPS investigation open beyond 90 days.
- In 2012, OFCO made seven adverse findings against the department for failure to complete and close a CPS investigation in a timely manner. In 2013 this number dropped to five adverse findings.

CA data also documents improvements have been made in completing CPS investigations within 90 days. CPS investigations open beyond 90 days have dropped from 29 percent in January 2013 to 13 percent in December 2013.



PERCENT OPEN INVESTIGATIONS BY TIME

	0 - 90 Days	> 90 Days
Jan-13	70.6%	29.4%
Feb-13	72.3%	27.7%
Mar-13	75.9%	24.1%
Apr-13	80.8%	19.2%
May-13	86.3%	13.7%
Jun-13	88.0%	12.0%
Jul-13	89.7%	10.3%
Aug-13	87.8%	12.2%
Sep-13	84.5%	15.5%
Oct-13	85.0%	15.0%
Nov-13	87.3%	12.7%
Dec-13	86.9%	13.1%

Source: FamLink Data Warehouse, CATS, DSHS Children's Administration. Investigations only on opened or re-opened cases as of the first of each month. Days calculated from first linked intake to the supervisory approval date or the first of the month. Approved extensions are evaluated against the approved extended date. Investigations linked to initial intakes prior to FamLink are excluded due to inaccurate conversion data.

PART TWO: OFCO CRITICAL INCIDENT CASE REVIEWS

BACKGROUND

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

- **Child Fatalities[55]-** 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[56]-** 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.[57]

- **Recurrent Maltreatment[58]-** 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. OFCO briefly reviews each of these cases to assess whether there is any unaddressed safety issue, and if so, may conduct a more thorough review.

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

- 42 reviews of child fatalities both involving child abuse or neglect and cases unrelated to child maltreatment;
- 30 reviews of child near fatalities;
- 121 reviews of cases of recurrent maltreatment; and
- Over 400 brief reviews of other critical incidents.[59]

[55] 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.
[56] RCW 74.13.640(2) requires the department to promptly notify the Ombuds in the event of a near fatality of a child who is in the care of or receiving services from the department or a supervising agency or who has been in the care of or received services from the department or a supervising agency within one year preceding the near fatality. The department may conduct a review of the near fatality at its discretion or at the Ombuds' request.
[57] RCW 74.13.500.
[58] RCW 26.44.030(13) requires CA to notify the Ombuds of "three founded" cases.
[59] Based on notifications received.

OFCO'S REPORTING PERIOD FOR VARIOUS CRITICAL INCIDENTS

CHILD FATALITIES: This section discusses 42 reviews of child fatalities both involving child abuse or neglect and cases unrelated to child maltreatment, occurring between January 1, 2012 and December 31, 2012. 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 2012 calendar year and prior.

CHILD NEAR FATALITIES: In 2013, OFCO reviewed 30[60] near fatalities occurring between January 1, 2013 and December 31, 2013.

RECURRENT CHILD MALTREATMENT: For the period September 1, 2012 through August 31, 2013, OFCO reviewed 121 cases of recurrent maltreatment.

OFCO'S ADMINISTRATIVE REVIEW PROCESS

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

When conducting critical incident reviews, OFCO focuses on whether child 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 OFCO to take action to protect children and develop recommendations to protect our state's most vulnerable population.

These reviews provide OFCO with a unique perspective on common factors in child fatalities and critical incidents.

[60] Data final as of January 2, 2014.

SUMMARY OF FINDINGS

FATALITY REVIEWS

- In 2012, OFCO reviewed 42 child fatality cases, both involving child abuse or neglect and cases unrelated to child maltreatment. This represents a 28 percent decrease from 2011, and the lowest number since 2004.
- 16 child fatalities were directly attributed to physical abuse or neglect and of these fatalities, 11 involved children under the age of 3 years.
- Unsafe sleep practices continue to be a leading cause of infant deaths.
- Major risk factors in these child fatalities include: substance abuse; domestic violence; and mental health issues.

NEAR FATALITY REVIEWS

- OFCO reviewed 30[61] near-fatality cases in 2013, an increase from those reviewed in 2012.

RECURRENT MALTREATMENT REVIEWS

- OFCO received 121 notifications of recurrent maltreatment in its 2013 reporting period, a 9.0 percent increase over the same period last year.
- Neglect continues to constitute the largest number of the founded reports (72.1 percent) and is more likely to recur than physical or sexual abuse.
- Caregiver substance abuse remains the most prevalent risk factor in these cases (53.7 percent of cases in 2013, a decrease from 60 percent of cases last year).

[61] Data final as of January 2, 2014.

CHILD FATALITY REVIEWS

State law requires DSHS to conduct a child fatality review when the child's death is suspected to be caused by child abuse or neglect and the child was in the department's custody, or receiving services from the department within the last 12 months.[62] DSHS is also required to consult with OFCO to determine if a fatality review should be conducted in any case in which it cannot be determined whether the child's death is the result of suspected maltreatment.[63] In 2012, the department conducted 20 executive child fatality reviews.[64]

OFCO reviews all fatalities whose family had an open case with DSHS CA at the time of death or within one year prior, regardless of whether the subject child received services from the department. This includes child fatalities were the death is suspected to be caused by child abuse or neglect, as well as cases unrelated to child maltreatment. OFCO conducts these reviews to: identify critical factors and patterns; assist policymakers develop strategies to avoid these tragedies; and to determine whether a DSHS fatality review is required based on suspected child abuse or neglect. In 2012, OFCO reviewed 42 child fatalities. Because OFCO reviews more cases than receive a full DSHS executive child fatality, data compiled by CA and OFCO may vary.

The following data describes the profile of child fatalities reviewed by OFCO in 2012 as well as cumulative data between 2009 and 2012. The accidental or natural death of a child, unrelated to abuse or neglect, is not included in this data.

2009-2012 OFCO CHILD FATALITY REVIEWS – KEY FINDINGS

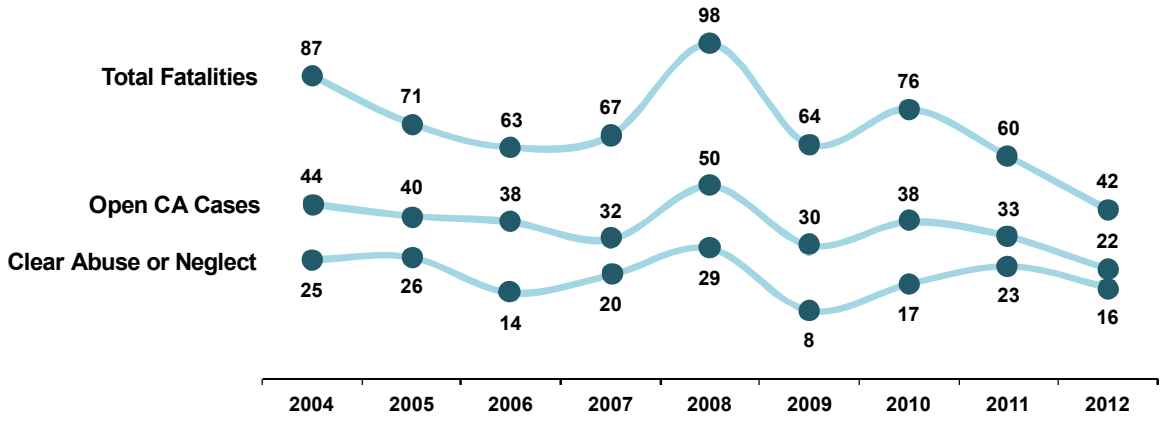
- The vast majority of fatalities related to abuse or neglect—70 percent—involved children under the age of 3 years.
- Unsafe sleep practices continue to be a leading cause of infant deaths.
- Fatalities of Native American and African American children are disproportionally high relative to their percentage of the state population.
- Major risk factors in child fatalities include: substance abuse; history of domestic violence; and mental health issues.

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

[63] This law also states that DSHS may review any near fatality at its discretion or at the request of OFCO.

[64] The CA fatality review team is made up of individuals who had no previous involvement in the case, and includes individuals whose professional expertise is pertinent to the case. CA fatality review reports are distributed to the appropriate committees of the legislature, and are posted and maintained on the department's web site at: http://www.dshs.wa.gov/ca/pubs/fatalityreports.asp. (RCW 74.13.640)

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



Source: Office of the Family and Children's Ombuds, December 2013, based on analysis of DSHS CA data

In 2012, DSHS conducted executive fatality reviews regarding the deaths of 20 children.[65] The department conducts executive fatality reviews only when the child's death is suspected to be caused by abuse or neglect. OFCO, however, reviews all deaths of children whose family had an open case with CA at the time of death or within one year prior, including families that were the subject of a CPS referral that was not accepted for investigation. Neither DSHS nor OFCO reviews child fatalities that were expected, due to an existing medical condition. An example of a child fatality reviewed by OFCO, but that would not meet the statutory requirements for a DSHS executive fatality review is when a medical examiner determines that an infant's death is attributed to "Sudden Infant Death Syndrome."[66] Absent any suspicions of child abuse or neglect, this fatality would not receive a DSHS executive fatality review, but would be reviewed by OFCO.

INFANT FATALITY REVIEWED BY OFCO, BUT NOT MEETING CRITERIA FOR CA EXECUTIVE FATALITY REVIEW

CPS received a report from hospital staff that the mother and newborn infant tested positive for amphetamines. The mother has a history of heroin addiction. CPS opened this case for investigation. CPS met with the parents, and observed them with the baby. The parents were attentive to their baby and cooperative with CPS. The mother denied any current drug use, agreed to a urine analysis drug test, and the test results were negative. CPS confirmed that the mother had received pre-natal care and that she was currently involved with the Well Infant and Child program. Approximately one month after the CPS referral was received, the infant died. According to the medical examiner, the parents slept in the same bed with their infant. The medical examiner found no concerns regarding abuse or neglect and attributed the death to SIDS.

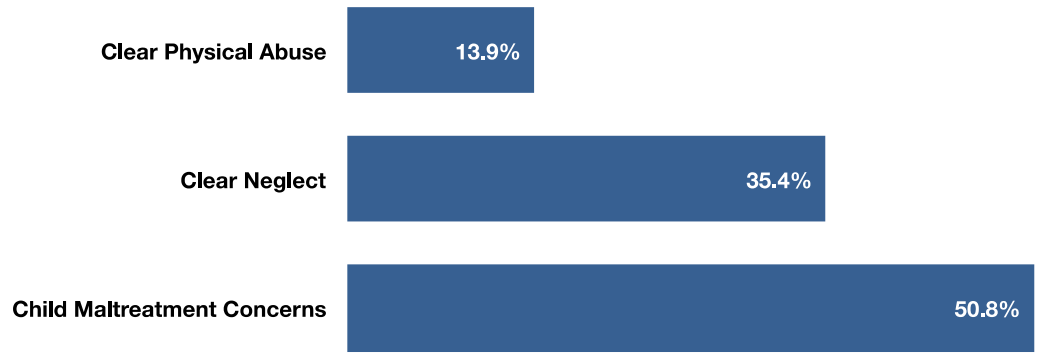
[65] CA Individual Child Fatality Reports are available at: http://www.dshs.wa.gov/ca/pubs/fatalityreports.asp
[66] Sudden Infant Death Syndrome (SIDS) is defined as the sudden death of an infant less than 1 year of age that cannot be explained after a thorough investigation is conducted, including a complete autopsy, examination of the death scene, and review of the clinical history. SIDS is the leading cause of death among infants aged 1–12 months. http://www.cdc.gov/SIDS/

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

OFCO identifies child fatalities that were directly caused by child abuse or neglect, as well as child deaths where abuse or neglect concerns *contributed to the fatality*. Child neglect directly caused more child fatalities than physical abuse. From 2009- 2012, OFCO child neglect directly caused the death of 46 children, while 18 children died as a result of physical abuse.

OFCO found that, in 2012, physical abuse caused the child's death in six cases and neglect caused the child's death in ten cases. OFCO also found that in an additional 18 cases, child abuse or neglect factors were present and may have contributed to the child's death.

Figure 12: **Fatalities Caused by Child Abuse or Neglect, and Fatalities where Child Maltreatment Concerns were Present 2009 - 2012**
Total Number of Fatalities (130)[67]



Source: Office of the Family and Children's Ombuds, December 2013
Note: Fatalities are reported by calendar year; fatalities with no maltreatment concerns are excluded

DEFINITIONS

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

Clear Neglect: Circumstances in the family's case history documented that neglect (e.g. leaving an infant unattended for 12 hours) caused the child's death.

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

[67] This chart does not include expected fatalities due to a medical condition or fatalities determined to be clearly accidental.

CASE EXAMPLES

CLEAR PHYSICAL ABUSE

Two-year-old child was killed by his parent. Medics arrived at the home after the parent called 911, and found the child suffered from blunt force trauma to the head and was unresponsive. The child was taken to the hospital, where the child later passed away. The parent later stated that God said to kill the child. The parent had taken the child to the hospital a few days earlier, stating that the child was sick. The hospital noticed odd behavior from the parent. The child was fine however and was discharged to the parent. The parent's prior CPS history included allegations of child neglect, and concerns regarding domestic violence, substance abuse and mental health issues.

CLEAR NEGLECT

14-year-old youth died from alcohol intoxication. The parents were aware she had consumed alcohol and was intoxicated and put her to bed after she passed out, but failed to seek medical treatment or provide adequate care for the youth. The following morning, the youth was found dead. The parents' ability to respond to this situation was impaired by their own intoxication. The parents have an extensive CPS history and at one time their children were in out of home care due to child maltreatment.

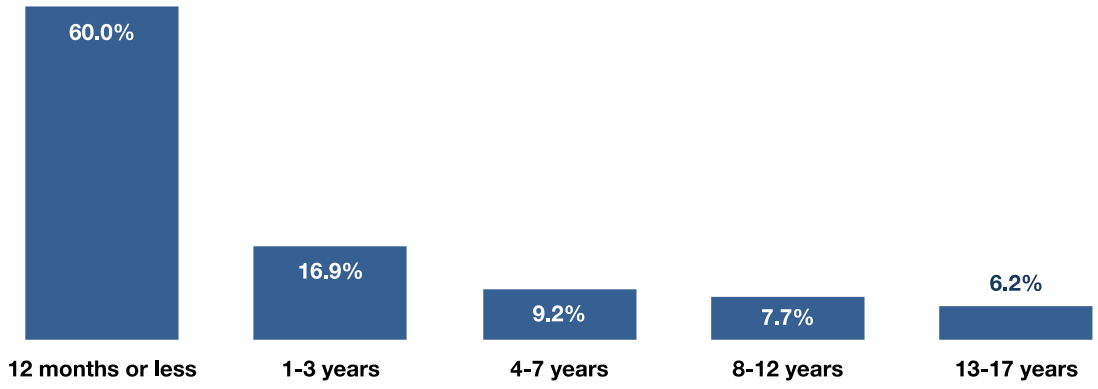
CHILD ABUSE/NEGLECT CONCERNS

Four-month-old infant was determined to have died from SIDS. The parent described co-sleeping with the infant, and waking to find the infant unresponsive. The parent reportedly shook the infant gently, attempting to revive the infant, and then called 911. Hospital staff reported that the infant had burns on the front and back of both legs and a bruise on the buttock. Within the year prior to the death, the parent was founded for physically abusing the 3-year-old half-sibling of the infant. Prior CPS history also documented domestic violence concerns regarding this parent.

CHILD'S AGE AT TIME OF DEATH

As in previous years, between 2009 and 2012, an overwhelming majority of fatalities reviewed by OFCO involved children below the age of three years old. As discussed in this, and previous reports, the majority of deaths reviewed of children 12 months of age or less, are related to unsafe sleep practices (see Figure 16). Conversely, less than a third of all fatalities involved older children.

Figure 13: **Child Age at Time of Death 2009 - 2012**
Total Number of Fatalities (130)



Source: Office of the Family and Children's Ombuds, December 2013, based on analysis of DSHS CA data
Note: Fatalities are reported by calendar year; fatalities with no maltreatment concerns are excluded

IMPROVING CHILD SAFETY: CHILDREN AGES 0-3 YEARS

Critical incident reviews conducted both by OFCO and CA continues to identify children ages 0 to three years as the primary victims of child fatalities and near fatalities. These children are the most vulnerable for maltreatment. CA reports that between 2009 and 2012, 70 percent (84 of 120) of child abuse and neglect related fatalities and near-fatalities were of children under the age of three years. Responding to this issue, in June 2013, CA established a state-wide workgroup to improve safety outcomes for this vulnerable group of children by developing strategies supporting the following goals:

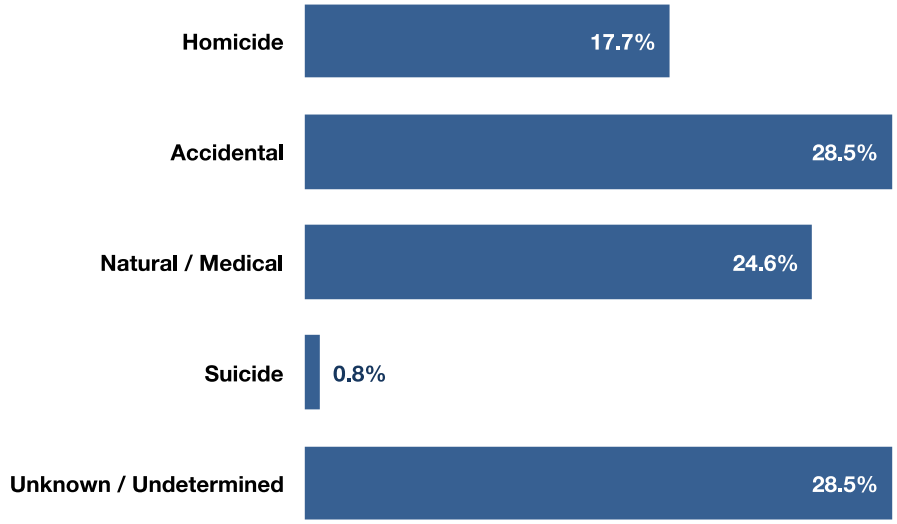
- CPS intakes will reflect an understanding of child safety, child development and vulnerability for children birth to three years old.
- Assessments, safety plans and interventions will address child safety for children birth to three years old.
- CPS response for children birth to three years old will be comprehensive and relevant to child safety needs, child development and vulnerability.
- Quality assurance and continuous quality improvement will be developed and implemented.

Through diverse membership, this workgroup draws on the expertise of various state agencies and private organizations associated with the child welfare system. OFCO also participates in this workgroup and provides its prospective investigating complaints and reviewing critical incidents. This also enables the workgroup to develop comprehensive strategies, and coordinate the efforts of public and private entities to protect these children from harm.

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

Figure 14: **Manner of Death 2009 - 2012**
Total Number of Fatalities (130)



Source: Office of the Family and Children's Ombuds, December 2013, based on analysis of DSHS CA data
Note: Fatalities are reported by calendar year; fatalities with no maltreatment concerns are excluded

CHILD FATALITIES AND RACIAL DISPROPORTIONALITY 2009-2012

Child fatalities directly caused by abuse or neglect, or where child maltreatment was identified by OFCO as a contributing factor, continue to be disproportionally high for Native American and African American children. For example, while Native American children make up two percent of the children in Washington State, they represent 22.3 percent of the child fatalities related to abuse or neglect that OFCO reviewed. Similarly, African American children make up 4.2 percent of the state's child population yet represent 5.4 percent of the fatalities OFCO reviewed.

Table 6: **Race and Ethnicity of OFCO-Reviewed Child Fatalities 2009 - 2012**

Total Number of Fatalities (130)

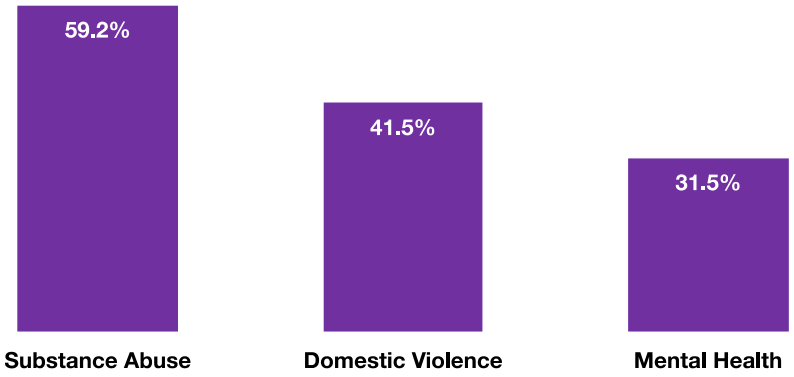
	OFCO Fatality Reviews*		Comparison Populations	
	Clear Abuse or Neglect	Maltreatment Concerns	DCFS Placement**	WA State Children***
Caucasian	60.9%	66.7%	62.6%	68.5%
African American	6.3%	4.6%	8.4%	4.2%
American Indian or Alaska Native	23.4%	21.2%	12.7%	1.9%
Asian or Pacific Islander	1.6%	3.0%	1.6%	7.4%
Multiracial	6.3%	3.0%	14.1%	9.7%
Other	1.6%	1.5%	0.3%	8.3%
Latino / Hispanic	7.8%	6.1%	16.9%	18.9%
Non-Hispanic / White	57.8%	62.1%	49.6%	60.7%
Non-Hispanic / Black	6.3%	4.6%	7.9%	3.9%
Other Ethnicity	28.1%	27.3%	25.6%	16.4%

** Office of the Family and Children's Ombuds, September 2013, based on analysis of DSHS CA data; Number of cases (64 clear abuse or neglect; 66 with maltreatment concerns); Fatalities are reported by calendar year; fatalities with no maltreatment concerns are excluded*

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

**** Office of Financial Management (ofm.wa.gov/pop), 2010*

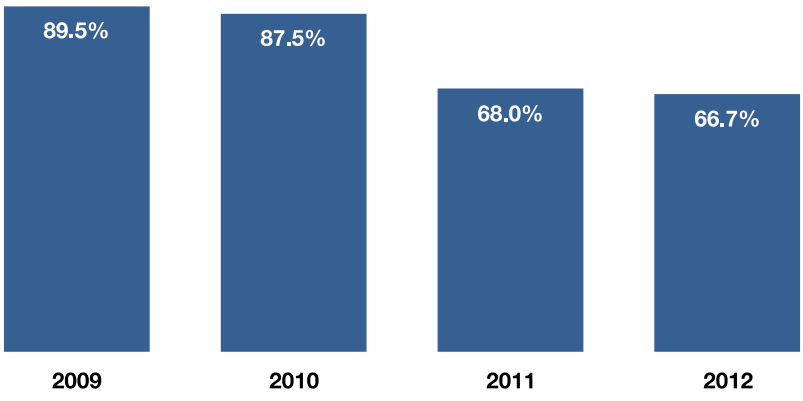
Figure 15: **Family Risk Factors Among Child Fatalities 2009 - 2012**
Total Number of Fatalities (130)



Source: Office of the Family and Children's Ombuds, December 2013, based on analysis of DSHS CA data
Note: Fatalities are reported by calendar year; fatalities with no maltreatment concerns are excluded

The majority of the children who died (59 percent) came from families with a history of drug or alcohol abuse. Domestic violence and mental health issues were also identified as significant risk factors in many of these fatalities. At least one of these three risk factors was present in 80 percent of the fatalities OFCO reviewed. All three risk factors were identified in 13 percent of these child fatalities.

Figure 16: **Unsafe Sleep Among Infant Fatalities**
Total Number of Fatalities (130)



Source: Office of the Family and Children's Ombuds, December 2013, based on analysis of DSHS CA data
Note: Fatalities are reported by calendar year; fatalities with no maltreatment concerns are excluded

INFANT SAFE SLEEP ENVIRONMENTS

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

In 2012, two-thirds of the maltreatment-related infant deaths (12 infant fatalities) that OFCO reviewed involved unsafe sleep practices. Eight of these deaths involved a parent or other adult bed-sharing with the child. Nine of these deaths related to sleep environment were of children seven months of age or less.

Parent and parent's partner were bed-sharing with seven-month-old infant. Child was found deceased, partially under parent's partner.

Nine-month-old infant was sleeping with parent on parent's bed, with pillows placed around child. Cause of death was "positional asphyxiation." Parent's home lacked a crib or bed proper for an infant.

One-week-old Infant's death ruled SUID. Contributing factors identified by the medical examiner include bed sharing with the parent, parent on methadone therapy, and soft bedding.

PRESCRIPTION DRUG USE AND ABUSE

Additionally, OFCO identified child fatalities where one or more of the parents or caregivers in the home used or abused prescription opioid medications. Commonly prescribed opioids include powerful painkillers such as methadone, hydrocodone, oxycodone, and codeine. Even when properly used, these medications can have a sedative effect on the user, which compounds the risk associated with unsafe sleep environment.

In 2012, prescription opioid use and abuse were identified in one-third (33 percent) of infant deaths related to child abuse or neglect. The combined risk factors of unsafe sleep environments and opioids were present in 22 percent of infant fatalities in 2012. Some incidents involved parents or caregivers who were prescribed methadone as part of chemical dependency treatment, while other cases involved medications that were illicitly obtained.

NEAR-FATALITY REVIEWS

State law requires DSHS to notify OFCO of the near fatality[68] of any child who has been in the department's custody, or receiving services from the department, within the last 12 months.[69] DSHS *may* conduct a review of any near fatality at its discretion, or at the request of OFCO.[70] In determining whether to conduct a review of a near fatality, DSHS Children's Administration generally applies the same criteria as mandated for a fatality[71]—that is, CA convenes a near fatality review committee when the near fatality is suspected to be caused by child abuse or neglect and the child received services within 12 months of the near fatality incident.

OFCO reviews all near fatalities both involving child abuse or neglect and unrelated to child maltreatment, of children whose family had an open case with CA at the time of the near fatality or within one year prior, even if the subject child was not the recipient of services from the department.[72] OFCO conducts these reviews to: identify critical factors and patterns; assist policymakers develop strategies to avoid these tragedies; and to determine whether to request a DSHS near-fatality review.

OFCO reviewed the near fatalities of 30[73] children in 2013. Of these, DSHS CA conducted (or will conduct in early 2014) 15[74] child near-fatality reviews.

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

NEAR FATALITIES REVIEWED BY OFCO, BUT NOT BY CA CHILD NEAR-FATALITY REVIEW

A 17-year-old dependent youth attempted suicide by ingesting a combination of prescription and non-prescription medications. The youth disclosed this to the assigned social worker in time for the social worker to have the youth transported to the hospital for emergency medical intervention. Although this youth was in the custody of CA at the time of this near-fatality incident, *child abuse or neglect by the youth's caregivers did not contribute to the incident*. Following the incident, a Youth Supervision Plan was put in place with the caregivers and youth to address suicidal ideation.

A 4-month-old infant was hospitalized with acute bilateral subdural hematomas, believed to be caused by the father suffocating and/or shaking the baby. Although the infant's mother had been the subject of a CPS investigation six months prior to this incident (which was closed prior to this

[68] RCW 74.13.500 defines "near fatality" as "an act that, as certified by a physician, places the child in serious or critical condition."
[69] RCW 74.13.640(2).
[70] Id.
[71] RCW 74.13.640(1).
[72] For example if the family had only screened out intakes within the past year, and thus no open case, OFCO will review the intake screening decisions made by CA.
[73] Data final as of January 2, 2014.
[74] Confirmed per conversation with CA HQ Paul Smith on January 2, 2014.

infant's birth), *neither the infant nor her father had ever received any services from the department*. Thus, although OFCO reviewed the prior investigation, OFCO agreed that a Child Near-Fatality Review was unnecessary.

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 protection system can be more effective in preventing child maltreatment.

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

INFANT SUFFERS ABUSIVE HEAD TRAUMA DAYS AFTER MOST RECENT IN-PERSON CONTACT WITH CPS

A seven-month old infant was hospitalized with an acute subdural and retinal hemorrhage, resulting from abusive head trauma. The child's father was charged with assault. At the time of the near fatality, Child Protective Services was investigating multiple intakes regarding the care of this child and his twin sibling by their adolescent parents.

Following the twins being born 10-weeks prematurely, the family situation changed frequently, with the parents separating and reuniting and living with various relatives. CPS received the first intake when the twins were 2-months-old; the home (of a paternal relative) was assessed to be safe and the infants appeared well-cared for by their parents and extended family. Two months later, a domestic violence advocate alleged to CPS that the twins—now in their father's care—were unsafe. The mother reported a recent incident in which the father physically assaulted her when she attempted to retrieve the infants from him. CPS screened out this intake. A few days later, the advocate contacted CPS again reporting the mother's concerns that the father would lose his temper and shake one of the infants. A medical professional also reported to CPS that the father had failed to bring the twins to a number of recent medical appointments; at prior visits one twin was noted to not be gaining adequate weight. The CPS social worker conducted a home visit with the father and the twins in the home of a paternal relative and noted no concerns. The father declined offered voluntary services, and took the infants to medical appointments a few days later. A month later, the social worker met with both parents, who had reunited. They declined offered voluntary services. Another month later, family members reported to CPS that the infants—now in their mother's care—were being neglected. Five days before the near-fatality, the CPS worker conducted an unannounced visit at the home of a maternal relative and noted no concerns regarding the infants' care. This time, the mother agreed to participate in voluntary services to help her establish stable housing.

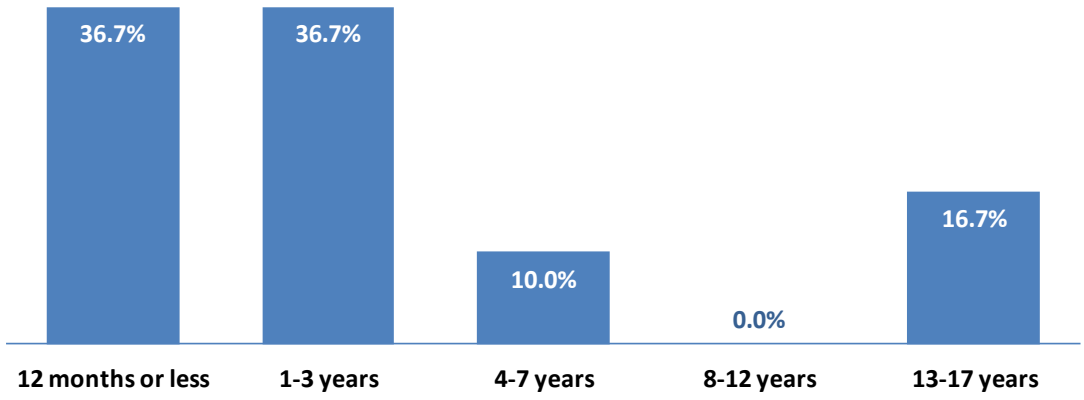
The CNFR committee's discussion focused on CPS case activities over the five months preceding the near fatality. The committee learned that the CPS social worker had a high workload and that the supervisor was conducting casework activities due to staff shortages and workload in addition to supervising the entire office. The committee discussed whether CA's Safety Framework is an effective model in situations, such as this case, where no safety threats are identified but concerns about risk remain. The committee made several findings relating to service delivery in this case, including that the family situation and special health needs of the twins would have been best monitored with more frequent in-person contact by the assigned social worker.

Based on the frequent occurrence of domestic violence in families served by CA, and how domestic violence impacted this specific case, the committee recommended that all CA social workers and supervisors be provided with training on domestic violence. A team of professionals from a variety of disciplines should be invited to develop and participate in this training in order to promote partnerships between CA and domestic violence agencies and advocates.

CHILD'S AGE AT TIME OF NEAR FATALITY[75]

More than one-third of the near fatalities reviewed by OFCO in 2013 involved children below the age of one year old. More than two-thirds involved children below the age of four years old. In contrast to fatalities, where the majority of deaths reviewed of children one year of age or less are related to unsafe sleep practices, a majority of near fatalities of children one year or younger are related to abusive head trauma. Near fatalities of teenagers are often suicide attempts.

Figure 17: **Child Age at Time of Near Fatality**
By Calendar Year, 2013



Source: Office of the Family and Children's Ombuds, January 2014

[75] Data final as of January 2, 2014.

SYSTEMIC INVESTIGATION: RECURRENT MALTREATMENT

The Children's Administration is required to notify OFCO of all families or children who experience three or more founded[76] reports[77] of alleged abuse or neglect within the last twelve month period.[78] This notification requirement enables OFCO to review potentially problematic cases and intervene as needed. Additionally, a close review of cases of recurrent maltreatment can indicate whether Washington State's child welfare system is effective at reducing the recurrence of child maltreatment and inform practice.[79]

Governor Inslee's *Results Washington* initiative will bring increased attention to recurrent maltreatment. A leading indicator under "Goal 4: Healthy and Safe Communities" is "Decrease the percentage of children with a founded allegation of abuse or neglect who have a new founded allegation within six months from 7.9% to 6% by July 30, 2014."[80] Although this is a different measure than three or more founded reports within the last twelve months, the goal of both is to reduce the number of children experiencing recurrent maltreatment in Washington.

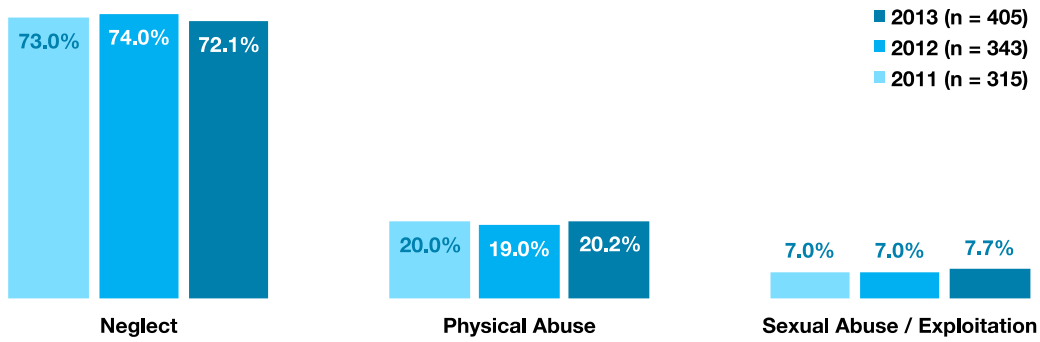
For the period of September 1, 2012 through August 31, 2013, **OFCO received a total of 121 notifications, a nine percent increase** from the same period ending in August 2012. The number of cases meeting the criteria of three founded reports of alleged abuse or neglect within the last twelve month period **has risen substantially since notification began in 2008**. During OFCO's 2009 reporting year, OFCO received a total of 59 notifications—less than half of the total in 2013. A variety of factors may have contributed to this increase, including a change in the law which eliminated "inconclusive" determinations of abuse or neglect by child protective services.[81] OFCO anticipates that the number of notifications may begin to decrease once the Children's Administration implements its differential response system, called Family Assessment Response (FAR), beginning in 2014.[82]

[76] "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).
[77] In this context, "report" means a "referral" to Child Protective Services, which DSHS/CA calls an "intake."
[78] RCW 26.44.030(13).
[79] "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.*
[80] http://www.results.wa.gov/whatWeDo/measureResults/documents/communitiesGoalMap.pdf
[81] RCW 26.44.020(10); WAC 388-15-005.
[82] RCW 26.44.260.

TYPE OF CHILD MALTREATMENT IN RECURRENT MALTREATMENT CASES

The graph below summarizes the type of maltreatment substantiated in the first, second, and third founded reports.[83] **Consistent with previous years, neglect is—by far—the most common type of maltreatment experienced by children in these recurrent cases**, comprising 72.1 percent of all founded reports reviewed by OFCO.

Figure 18: **Type of Child Maltreatment**
By Reporting Year (September 1st - August 31st)

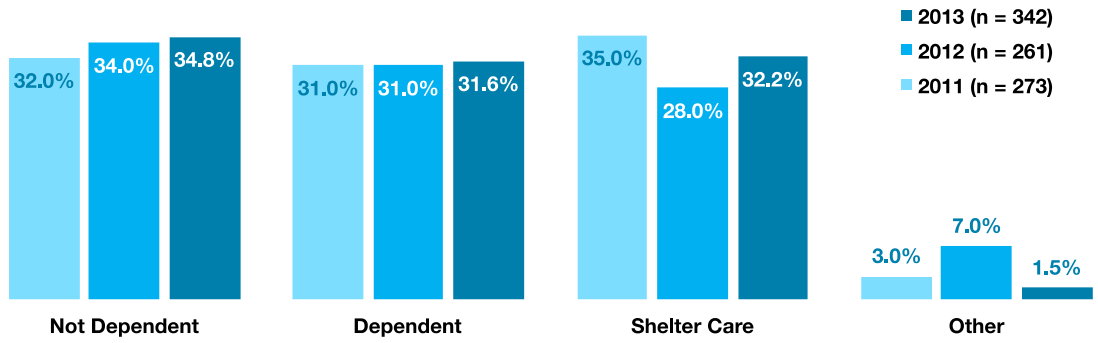


Source: Office of the Family and Children's Ombuds, September 2013

AGENCY ACTION: LEGAL STATUS OF CHILDREN AT TIME OF NOTIFICATION

For a large majority (63.8 percent) of the cases reviewed, the agency had already taken affirmative legal action – either through an in-home or out-of-home dependency – to ensure the safety of the children who were the victims of three or more founded reports.[84]

Figure 19: **Legal Status of Children**
By Reporting Year (September 1st - August 31st)



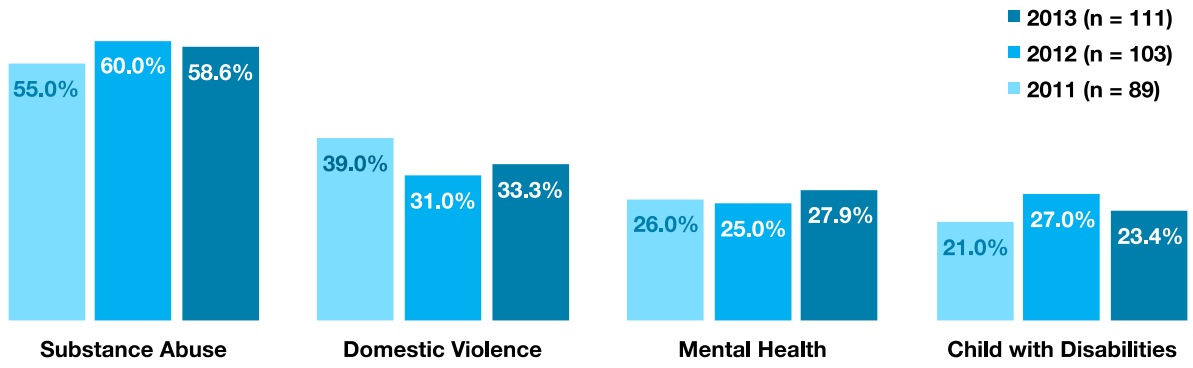
Source: Office of the Family and Children's Ombuds, September 2013

[83] 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."
[84] Because of the time lag between when CPS receives an intake and when OFCO is notified of the third founded report, when the CPS investigation is complete, CA has usually had sufficient time to determine whether or not legal action will be taken.

Risk Factors in Recurrent Maltreatment Cases

Caregiver substance abuse is consistently the most prevalent risk factor (affecting 58.6 percent of the families) in these recurrent maltreatment cases.

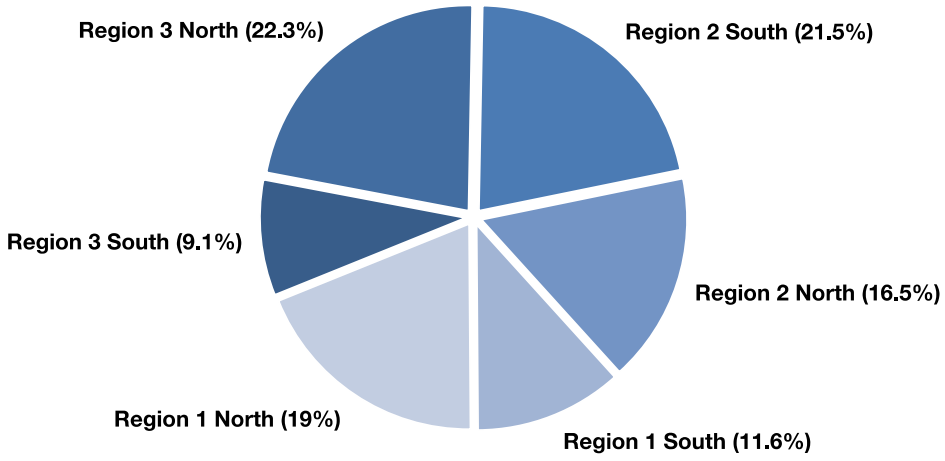
Figure 20: **Family Risk Factors**
By Reporting Year (September 1st - August 31st)



Source: Office of the Family and Children's Ombuds, September 2013

Recurrent Maltreatment Cases by DSHS Region

Figure 21: **Recurrent Maltreatment by Region**
By Reporting Year (September 1st - August 31st)



Source: Office of the Family and Children's Ombuds, September 2013

OFCO Intervention in a Recurrent Maltreatment Case

Within a two-month period, three siblings—ages 1, 4, and 6— experienced four founded incidents of physical abuse and neglect. After the first two incidents, DCFS CPS provided Intensive Family Preservation Services (IFPS) to the family. Shortly after the IFPS intervention completed, the other two incidents of physical abuse were reported to CPS. Following the fourth incident, the children's mother told a mandated reporter that she was concerned about the father's aggressive behavior towards the children and disclosed an additional incident in which the father threw a shoe at the 4-year-old child, causing a bloody lip.

DCFS records indicated that the father had been charged with criminal mistreatment of children with a different partner in 2004 and had two founded reports for physical abuse of those children in 2002. The past allegations included concerns that the father had punched a then 4- year-old in the head and kicked a 1-year-old in the abdomen and chest.

Due to the high risk and safety concerns, a Child Protection Team (CPT) staffing was held and the team recommended that the parents engage in further services, specifically Parent-Child Interaction Therapy (PCIT). Although the parents agreed to participate in PCIT, over the next month, the provider's attempts to connect with the family to begin the service were unsuccessful. The FVS social worker's attempts to connect with the family following the CPT were also unsuccessful.

At the time OFCO received notification of this case due to the three or more founded reports, the case was pending transfer to a new FVS social worker. **Due to the history of physical abuse despite intensive services, and the fact that the DCFS had lost contact with the family since the CPT, OFCO contacted the FVS supervisor.** The supervisor immediately reassigned the case so that a social worker could attempt to see the children, assess the situation, and engage the parents in PCIT.

OFCO also brought the case to the attention of Children's Administration Headquarters and the local Area Administrator (AA). After reviewing the case, the AA believed that DCFS CPS should have filed a dependency petition for the children following the fourth report of physical abuse. However, given that the most recent report was now almost two months prior, the AA did not believe that DCFS currently had sufficient legal basis for imminent risk of harm to justify filing a petition at this point.

Two months later, CPS received another report that the father had inappropriately disciplined the now 5-year-old. Three weeks after this report, DCFS held a Family Team Decision Making meeting and decided to file dependency petitions for all three children.

OFCO Findings in Recurrent Maltreatment Cases

OFCO carefully reviews each of the recurrent maltreatment cases to identify trends as well as case-specific or systemic practice issues. When intervening with the agency to change a problematic action or inaction is no longer feasible, OFCO can make an adverse finding to bring the violation or concern to the attention of agency management. In 2013, OFCO made formal adverse findings in three of the recurrent maltreatment cases reviewed. These are summarized below.

OFCO Finding:

DCFS Family Voluntary Services (FVS) failed to conduct (or failed to document) monthly health and safety visits with the family on a case open for FVS for a period of four months. See CA Practices and Procedures Guide §4420(B)&(E).

CA Response:

The assigned social worker was directed by the supervisor to input and update all case notes reflecting any health and safety visits as well as other activities regarding this case. The social worker indicates that the health and safety visits were conducted but were not yet documented in Famlink.

The supervisor is in the process of developing a performance improvement plan to include policy requirements and "best practice" standards for health and safety visits, assessments, family engagement and timely documentation.

OFCO Finding:

DCFS CFWS's agreement for the dependency to be dismissed for a 5-year-old child was clearly unreasonable given outstanding concerns regarding the step-father's ability to safely parent and the mother's ability to protect.

Following three founded reports of physical abuse and neglect—involving significant bruising inflicted by the child's step-father—DCFS CPS filed a dependency petition against the child's mother and placed the child into foster care. A month later, the court returned the child to the mother's care, over DCFS's objection. At that time, the step-father was not permitted to live in the home. Over the next few months, the mother and step-father engaged in various services.

Thereafter, despite ongoing suspicions that the step-father was in the home more frequently than approved by DCFS, and despite the fact that he had not yet completed a psychological evaluation or the services recommended by his domestic violence assessment, DCFS CFWS agreed that the step-father could return to the home, but could not be left alone with the child. Before long, the social worker learned that the mother was leaving the child alone in the step-father's care. The step-father's therapist reported to the CFWS social worker that the step-father "goes to extreme consequences for negative behavior."

The case was transferred to a new social worker weeks before the six-month dependency review hearing. The social worker submitted an ISSP recommending dismissal of the dependency "with the understanding that there are no new services identified to alleviate the concerns that remain [primarily regarding the step-father's parenting style]."

At the time of writing the ISSP, the social worker had only a verbal report from the provider regarding the step-father's psychological evaluation.

Prior to the review hearing, CFWS received the written report of the step-father's psychological evaluation, which **concluded that the step-father "does not have the capacity to safely and adequately parent [the child] appropriately at this time."** The evaluator wrote, "the information available…suggests that the mistreatment of [the child] involves the collusion of [the mother] in covering up the abuse and possibly her direct participation in the abuse….In the final analysis, if [the child] is returned to the permanent custody of this couple, it is important that one, if not both of her parents are invested in her safety and well-being." Thus, the evaluator recommended a parenting assessment of the mother, marriage counseling, and family counseling to include the child. The evaluator concluded: "The recommendation for permanent placement would depend on the progress these parents make in counseling. It is anticipated that six months should be long enough to determine if [the] parents have created a family atmosphere that will provide a healthy form of protection and guidance."

DCFS did not provide the court with a copy of the step-father's psychological evaluation, although the evaluation was discussed on the record. The dependency was dismissed with DCFS making no recommendation that the mother and step-father first engage in the services recommended by the psychological evaluation. The mother signed a "protective action plan" stating that the step-father would not be the primary caregiver for the child and child would remain in daycare. The CASA opposed dismissing the dependency due to the high risk.

The day after the dependency was dismissed, CPS received an intake alleging that the child was brought to the emergency room with a spiral fracture of her arm. This intake was founded for physical abuse by the step-father and as well as neglect because he delayed seeking medical care for the injury. There was no finding made against the mother, despite the fact that she had allowed him to care for the child a day after signing an agreement that he would not be the child's primary caregiver. A new dependency petition was filed and the child was placed in foster care.

Given the circumstances, especially the conclusions and recommendations of the psychological evaluation, OFCO found that DCFS's agreement to dismissal of the dependency without recommending any further interventions for this family was clearly unreasonable. Additionally, DCFS's failure to provide the step-father's psychological evaluation to the court to fully inform the decision-maker of the concerns and recommendations of additional services was unreasonable under the circumstances.

CA RESPONSE:

The first incident of physical abuse was investigated and substantiated to be founded for neglect as to the mother and founded for physical abuse as to the step-father. The parents were offered services through the military, and the case was closed.

After the second incident of physical abuse was reported, the Department filed a dependency petition, requesting out of home placement. However, against the Department's recommendation, the court returned the child home to mother. The court ordered the mother to participate in services and the step-father agreed to participate in services to include Family Preservation Services (FPS) and individual counseling for mother; domestic violence treatment, individual counseling and psychological evaluation for step-father. Throughout the life of the dependency, contacts with service providers confirmed both mother and step-father were participating in services and making progress.

Providers reported to the Department progress in services specific to two rounds of FPS, parenting classes, anger management class, individual counseling, domestic violence treatment, and a psychological evaluation with parenting component. More important than participation, over the lifetime of the case, providers reported that the parents were able to demonstrate the use of new parenting skills and discipline methods learned from the FPS provider. At no time did anyone report concern regarding the parents continued use of physical discipline.

The Department was consistent in the report to the court regarding concerns should step-father become the primary caregiver to the child. This concern was made clear to the mother, who gave every indication of being protective and verbalized her understanding and agreed that step-father would not be a primary caretaker for child.

The evaluator completed the parent-child observation and reported to the Department the child was not fearful of step-father, never displayed fear of step-father and that child and step-father had positive interactions. The evaluator recommended six months of services which were completed at time of dismissal.

The Department utilized the provider's reporting to assess risk and safety concerns to the child and to make case planning decisions. As we engage with more and more military families it is imperative the Department has a clear understanding of their services. It is important to understand the basis of their assessment regarding child safety and risk. For each case, there needs to be transparent understanding and discussion with military social service programs regarding our expectations regarding child safety decision making, expected outcomes around behavioral change, and the plan to work together on the case to identify concerns to the child and ensure the child's safety.

OFCO'S FINDING:

OFCO found that DCFS CFWS's position in support of 7-year-old and 14-year-old dependent children returning home was clearly unreasonable given the six founded referrals for physical abuse and neglect against the adoptive parents and the fact that the parental deficiencies which led to the dependency had not yet been addressed. Most importantly, the six safety threats identified in the Safety Assessment completed less than two months prior, requiring an out-of-home plan, still existed. Although the attorneys for both children represented their clients' wishes to return home, OFCO found that DCFS's support of this was clearly unreasonable.

CA RESPONSE:

As OFCO acknowledged, the Area Administrator (AA) responded immediately to OFCO's request that she review the Department's position for the court hearing that was scheduled to occur the following day. The AA ensured that a safety plan was put in place prior to the children returning which included in-home service providers visiting the home three days per week, weekly unannounced home visits, and an emergency phone contact list for the children.

The Department did agree to the plan of trial in-home placement for these two children based on information gathered by the social worker on the parents' progress in addressing the issues which brought the children into care. The parents immediately engaged in services after dependency was established six weeks prior, and they have worked with the social worker to demonstrate compliance with court ordered services.

The concerns regarding the parents in the dependency matter can be summarized as inappropriate discipline in the form of excessive exercise or excessive chores. Most importantly, there appeared to be an issue of targeting non-relative adoptive children. A 13-year-old (who was not returned home) appeared to be the consistently targeted child.

The 7-year-old is the only child who has not made any disclosures of abuse or neglect, despite having had every opportunity to do so. He has insisted that he wanted to go home. At the fact finding hearing, the court ordered an early 30 day review to review compliance with services and the 7-year-old's placement with the goal for him to be the first child likely to return home. The Department had anticipated the court would order this child to be placed back in the home at this review and worked with the parties to develop an agreed order that would best meet the needs of the children, ensure the parents would continue in appropriate services, and allow the Department to continue to monitor and assess the family's progress.

Two weeks before the hearing, the 14-year-old called the Department social worker and stated that she wanted to go home. She was adamant that she felt safe in the care of her adoptive parents. She is old enough to be able to self-protect by making reports to treatment providers, social workers, school personnel, coaches, and law enforcement. The Department has some reservations about this trial return home. The child, through her attorney, was very adamant about returning home.

When the order was entered for a trial return home of these two children, strict terms and

conditions were written into the order. This order required the parents to continue to engage in counseling and all court ordered services.
In response to OFCO's concern that the parental deficiencies necessitating the finding of dependency were not addressed, the Department assessed that the parents did engage in services and had demonstrated progress and the ability to safely parent the two children who were returned home.

In response to OFCO's concern that the six safety threats identified in the original Safety Assessment still exist, the Safety Assessment completed on that date pertains to all of the children in the home at the time. However, the primary allegations were about three other children. These six safety threats may have been alleviated as pertaining to the 14-year-old and 7-year-old. But because a new Safety Assessment was not documented, the absence or reduction of these threats remains unclear.

The Department continues to monitor safety in the home and the parents' progress in services.

PART THREE: 2013 LEGISLATIVE UPDATE

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

During the 2013 legislative session, OFCO reviewed, analyzed, and commented on several pieces of proposed legislation aimed at strengthening Washington's child welfare system. OFCO provided written or verbal testimony on the following legislation:[85]

EXTENDED FOSTER CARE FOR YOUTH 18 YEARS OF AGE AND OLDER[86]

In 2011, state law was amended to allow youth to receive foster care services after age 18 if the youth was participating in a secondary education program or a secondary education equivalency program. In 2012, the Legislature expanded the eligibility to include youth who were enrolled, or had applied for and demonstrated intent to enroll, in a postsecondary academic or postsecondary vocational program. This past legislative session, eligibility for extended foster care services[87] was expanded to include youth who have an open dependency proceeding upon turning age 18 and are participating in a program or activity designed to promote or remove barriers to employment.[88] At least six months before the dependent youth turns 18, the department must provide the youth with written documentation explaining the availability of extended foster care services and instructions about how to access those services.[89]

OFCO's testimony expressed concerns that current state law did not address the needs of foster youth who were not involved in academic pursuits, and who may be in greater need of basic assistance. OFCO noted that for our own children, we support and encourage their career ambitions and provide basic assistance while they gain education and or work experience. We should provide equal support to our foster youth in pursuing their ambitions. By providing the basic services to assist foster youth successfully transition into adulthood, we can help prevent negative outcomes for youth exiting foster care. For example, studies of youth who leave foster care without a safe, permanent family reveal over half of the youth experienced one or more episodes of homelessness, and nearly 30 percent were incarcerated at some point.[90] Extended foster care services will also help break the cycle of generational child abuse or neglect- where foster youth who aged out re-enter the child welfare system, this time as young parents.

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

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[85] Written testimony is available at http://www.governor.wa.gov/ofco/legislation/default.asp.
[86] ESSB 5405; ESSHB 1302; Chapter 332, Laws of 2013
[87] Extended foster care services may include the following: (1) placement in licensed, relative, or otherwise approved care; (2) supervised independent living settings; (3) assistance in meeting basic needs; (4) independent living services; (5) medical assistance; and (6) counseling or treatment. RCW 13.34.030(8).
[88] RCW 74.13.031(11)
[89] RCW 13.34.145(3)
[90] 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
[91] Chapter 332, Laws of 2013

THE IMPACT OF A CPS FINDING OF CHILD ABUSE OR NEGLECT[92]

OFCO's *2012 Annual Report* discussed the lasting impact of a CPS finding of child abuse or neglect. In many cases, the subject of the CPS finding has turned their life around and successfully addressed the circumstances that led to the CPS investigation. However, the finding of abuse or neglect prevents the individual from being a placement resource for a relative child in state care or work that involves the unsupervised contact with children or vulnerable populations.

In addition to addressing background information the department may consider in denying an application for employment or unauthorized contact with children, this legislation also established a work group to consider options, including a certificate of rehabilitation, to address the impact of founded complaints on the ability of rehabilitated individuals to gain employment or care for children. The workgroup must report its recommendations to the Legislature by December 31, 2013. *Activities and recommendations from this work group are discussed in greater detail on pages 69-71 of this report.*

OFCO's testimony noted that while there is an administrative process to challenge the sufficiency of the evidence of child abuse or neglect[93], there is no avenue for such person to demonstrate that their life and personal circumstances have changed and that they should not be prevented from working with children or other vulnerable populations. While there is obviously a rational basis for restricting a person's contact with vulnerable populations when there is a prior finding of abuse or neglect, the process should also be flexible enough to consider the totality of the person's circumstances and recognize changes made in their life.

STATUS- This legislation was signed into law by Governor Inslee.[94]

IMPLEMENTING RECOMMENDATIONS OF THE POWELL FATALITY REVIEW COMMITTEE[95]

In February 2012, during an intended supervised court ordered visit, Josh Powell killed his two sons, himself, and set his home afire. This was a highly complex case—the children were dependent, and Mr. Powell was a person of interest in criminal investigations involving several law enforcement agencies from different jurisdictions. This legislation implements recommendations from the "Powell Fatality Review,"[96] including requirements that:

- The court must articulate the reasons for ordering placement of a dependent child with a relative over a parent's objection.
- When a parent or sibling who desires visitation with a child is an identified suspect in an active criminal investigation that would impact the safety of the child, DSHS must make a concerted effort to consult with the assigned law enforcement officer before recommending any changes in parent/child or child/sibling contact.

[92] ESSB 5565; Chapter 162, Laws of 2013
[93] RCW 26.44.125
[94] Chapter 162, Laws of 2013
[95] SSB 5315
[96] DSHS Children's Administration Child Fatality Review, available at: http://www.dshs.wa.gov/pdf/ca/ecfr-powell.pdf.

- When a judge orders a parent to undergo a psychosexual evaluation, DSHS must reassess the duration, supervision, and location of parent/child visits. If the current visitation plan compromises the safety of the child, DSHS, subject to approval by the court, may alter the visitation plan, pending the outcome of the evaluation.
- Caseworkers must receive ongoing domestic violence training and consultation, including how to use the Children's Administration's practice guide to domestic violence.

OFCO testified in support of the intent of this legislation. While many of the facts and circumstances of the Powell case are highly unusual, the recommendations from the fatality review address elements that are common to many dependency cases such as: pending criminal investigations and information relevant to child safety; domestic violence issues; contested custody or placement issues between parents or a parent and a relative; court ordered evaluations of a parent; and child safety and court ordered visits.

STATUS- This legislation was signed into law by Governor Inslee.[97]

IMPROVING THE ADOPTION PROCESS[98]

In response to troubling issues identified by OFCO concerning cases of severe child abuse and neglect of adopted children[99], the Governor requested that Children's Administration (CA) and OFCO convene a workgroup to examine these issues and make recommendations to improve the adoption process and protect children. The workgroup's recommendations addressed the following topics: State Oversight of Child Placing Agencies; Assessing Prospective Adoptive Parents; and Training and Post Adoption Support. In order to learn more about this problem, the workgroup also identified the need to track incidents of failed adoptions.

In order to better assess adoptive parents, this legislation required that both the pre and post-placement reports address the planned approach to child discipline and punishment, in addition to other required areas of inquiry. Pre-placement reports must also include a background check of any prior reports whether these reports were completed or not. All pre-placement reports, whether approved, denied or incomplete must be filed with the court.[100]

The department must establish procedures for identifying, tracking, and reporting failed adoptions and the factors leading to adoption disruption or dissolution. Finally, this legislation required the department to develop a detailed work plan identifying a strategy and time frame to implement these recommendations, and required OFCO to include in its annual report information regarding the progress made by the DSHS in implementing recommendations.

OFCO's testimony emphasized that in many of the cases reviewed, the physical abuse and maltreatment of the child was described by the adoptive parent as a form of discipline or behavior

[97] Chapter 254, Laws of 2013, available at: http://apps.leg.wa.gov/documents/billdocs/2013-14/Pdf/Bills/Session%20Laws/Senate/5315-S.SL.pdf.
[98] ESHB 1675
[99] See *Severe Abuse of Adopted Children Report* at: http://www.governor.wa.gov/ofco/reports/default.asp
[100] RCW 26.33.190(5) requires that all completed preplacement reports must be filed with the court. However, this does not always occur in practice. See *Severe Abuse of Adopted Children Report.*

modification. The initial home study and post-placement reports must therefore specifically address the parents' attitude and philosophies towards child discipline and behavior management. A detailed understanding of the parents' approach to discipline and punishment is essential to match a child's specific circumstances and needs to the appropriate family. *Issues and recommendations regarding improving the adoption process are discussed in section **[X]** of this report.*

STATUS- This bill was not passed by the legislature.

LEGAL REPRESENTATION FOR CHILDREN IN DEPENDENCY CASES[101]

In dependency cases, the court appoints a guardian ad litem (GAL) to represent the "best interest of the child." The court also has the discretion to appoint an attorney to represent a child. If the child is 12 years of age or older, DSHS and the child's GAL must notify the child of the right to request an attorney and must ask the child whether the child wants an attorney.[102] Practice varies from county to county and as a result, whether a child receives a lawyer often depends on where the child lives rather than on the child's needs.

Under this proposed legislation, the court must appoint an attorney for the child within seventy-two hours of granting a petition to terminate the parent and child relationship. The court may appoint an attorney to represent the child's position in any dependency action on its own initiative, or upon the request of a parent, the child, a guardian ad litem, a caregiver, or the department.

OFCO supported the intent of this legislation as appointing an attorney to represent children under certain circumstances is essential to protect the child's rights to services, visitation, permanency and sibling contact. Specifically, legal advocacy for these children can remove barriers to the collaboration and coordination of services between multiple agencies and assure the delivery of services. Legal advocacy can also help a dependent youth address concerns regarding the failure to place a dependent child with available relatives, multiple placements, and sibling separation. The child has the greatest stake in decisions regarding placement and visitation, and an attorney will ensure that the child's interest is heard. When family reunification is not possible, it is paramount that a child to have an attorney to assist in making decisions about permanency. Because attorney-client relationship affords confidentiality, a child can speak freely about conditions in the home. *Issues and recommendations regarding attorney representation for children in dependency proceedings are discussed on pages 55-61 of this report.*

STATUS- These bills were not passed by the legislature.

[101] HB 1285 and SB5461
[102] RCW 13.34.100

STUDY REGARDING THE VALIDITY AND RELIABILITY OF CA'S SAFETY ASSESSMENT TOOL[103]

This legislation directs the Washington State Institute for Public Policy (WSIPP) to study the validity and reliability of the safety assessment tool currently used by Children's Administration to identify impending danger and to identify families who are most likely to experience a future event of child abuse or neglect. The WSIPP must: compare any other empirically based child welfare safety assessment tools to the tool currently being used; determine whether other factors or combination of factors not included in the current tool should be included to help predict real outcomes; and identify unnecessary duplication in the use of the family assessment tool.

OFCO's testimony noted that assessing child safety is a driving factor when making crucial decision such as: whether to remove a child from the home; how to establish an appropriate safety plan; or whether to return a child to the parent's care. It is therefore essential that the assessment tool used by the department is effective and reliable.

STATUS- This bill was not passed by the legislature.

[103] SB 5281

V. APPENDICES

APPENDIX A:
Complaints Received by Region and Office 2012-2013

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 AND OFFICE

	DCFS		DLR	
	2012	2013	2012	2013
Region 1 North	**94**	**87**	**4**	**2**
Clarkston	1	5		
Colfax	1	1		
Colville	14	6		
Moses Lake	14	6		
Newport	2			
Omak	1	2		
Republic				
Spokane	57	59	4	2
Wenatchee	4	8		
Region 1 South	**61**	**44**	**2**	**0**
Ellensburg	3	3		
Goldendale	1			
Richland-Tri-Cities	20	8		
Sunnyside	1	2		
Toppenish	1	2		
Walla Walla	11	11		
White Salmon	2			
Yakima	22	18	2	
Region 2 North	**76**	**70**	**2**	**4**
Alderwood / Lynnwood	8	13		
Arlington / Smokey Point	10	9		
Bellingham	7	12		
Everett	25	17	1	4
Friday Harbor	2			
Monroe / Sky Valley	13	5		
Mount Vernon	11	10	1	
Oak Harbor		4		

	DCFS		DLR	
	2012	2013	2012	2013
Region 2 South	**78**	**93**	**4**	**6**
Centralized Services	12	9	2	4
King Eastside / Bellevue	17	13	1	1
King South / Kent	18	20	1	1
King West	12	21		
Martin Luther King Jr.	8	22		
Office of Indian Child Welfare	11	8		
White Center				
Region 3 North	**95**	**91**	**4**	**4**
Bremerton-Kitsap	22	29	2	
Centralized Services	5	3	2	4
Pierce East	36	26		
Pierce South	12	11		
Pierce West	20	22		
Region 3 South	**82**	**87**	**2**	**1**
Aberdeen	12	15		
Centralia	5	7		1
Forks		2		
Kelso	11	9		
Long Beach	2	1		
Olympia / Lacey	1	3	1	
Port Angeles	5	6		
Port Townsend		2		
Shelton	3	9		
South Bend		1		
Stevenson	2	2		
Tumwater	11	9		
Vancouver	30	21	1	
Other / Statewide	**6**	**7**	**1**	**0**
Central Intake	3	7		
CA Headquarters	3		1	

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 OFCO.

Non-Hispanic	**87.2%**
African American	10.0%
African American & American Indian or Alaska Native	0.7%
African American & American Indian or Alaska Native & Caucasian	0.2%
African American & Some Other Race	0.1%
American Indian or Alaska Native	6.1%
American Indian or Alaska Native & Native Hawaiian Pacific Islander	0.2%
American Indian or Alaska Native & Some Other Race	0.1%
Asian & Native Hawaiian Pacific Islander	0.2%
Caucasian	56.0%
Caucasian & African American	5.4%
Caucasian & American Indian or Alaska Native	2.3%
Caucasian & Asian	0.8%
Caucasian & Native Hawaiian Pacific Islander	0.2%
Caucasian & Some Other Race	0.5%
Native Hawaiian Pacific Islander	0.2%
Native Hawaiian Pacific Islander & Some Other Race	0.1%
Some Other Race	1.2%
Declined to Answer	2.7%

Latino / Hispanic	**12.8%**
African American	0.1%
American Indian or Alaska Native	1.1%
Caucasian	10.4%
Caucasian & African American	0.1%
Caucasian & Some Other Race	0.6%
Some Other Race	0.5%

APPENDIX C: CHILD FATALITIES AND NEAR FATALITIES EXAMINED BY OFCO

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

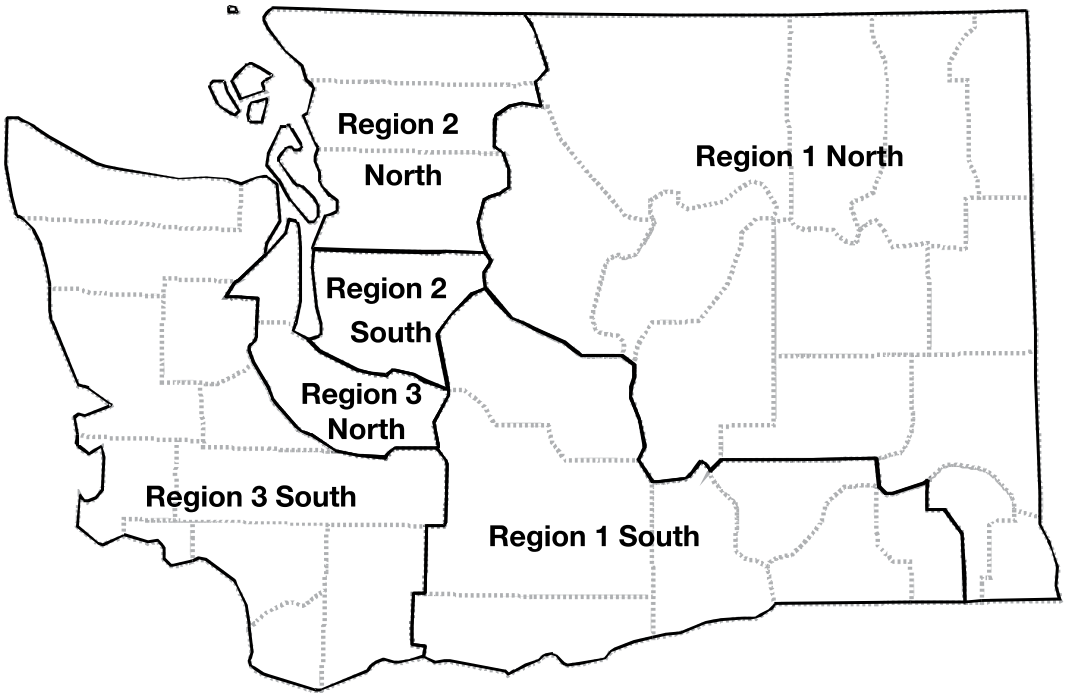

Table 7: **OFCO Child Fatality Reviews by Region**
By Calendar Year (January 1st - December 31st)

	2008	*2009*	*2010*	*2011*	*2012*
Region 1 North	*9*	*13*	*10*	*10*	*6*
Region 1 South	*15*	*2*	*11*	*15*	*3*
Region 2 North	*17*	*15*	*11*	*7*	*7*
Region 2 South	*15*	*17*	*14*	*10*	*7*
Region 3 North	*23*	*11*	*13*	*11*	*8*
Region 3 South	*19*	*6*	*17*	*7*	*11*
Statewide	***98***	***64***	***76***	***60***	***42***

Table 8: **Fatalities by Open Case Program**
By Calendar Year (January 1st - December 31st)

	2008	2009	2010	2011	2012
CWS	18	8	11	6	5
CPS	22	12	20	22	14
DLR	6	4	0	1	1
FRS	2	0	3	1	0
FVS	1	2	4	1	2
ARS	1	4	0	0	0
Statewide	**50**	**30**	**38**	**33**	**22**

Table 9: **Near-Fatalities by Age Group**
By Calendar Year (January 1st - December 31st)

	2009	2010	2011	2012	2013
0 - 2 years	7	14	6	13	20
3 - 7 years	3	5	1	1	5
8 - 12 years	2	0	1	0	0
13 - 17 years	5	6	4	2	5
Statewide	**17**	**25**	**12**	**16**	**30**

Table 10: **Near-Fatalities by Most Recent Case Program**
By Calendar Year (January 1st - December 31st)

	2009	2010	2011	2012	2013
CWS	5	7	1	3	5
CPS	10	14	9	10	24
DLR / DEL	0	1	1	2	0
FRS	0	1	0	0	0
FVS	2	2	1	1	1
ARS	0	0	0	0	0
Statewide	**17**	**25**	**12**	**16**	**30**

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ROSEY THURMAN
Team Child
Spokane

STAFF

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

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

Senior Ombuds
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.

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

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

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

Intake and Referral Specialist
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 services 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.