

OMBUDSMAN IN ACTION

INTERVENTIONS

The Ombudsman takes action when the findings of a complaint investigation indicate that action is necessary to avert or correct a harmful oversight or avoidable mistake by the Department of Social and Health Services (DSHS) or another agency.

After investigating the complaint, if the Ombudsman concludes that the agency's actions are either outside of the agency's authority or clearly unreasonable under the circumstances, and the action could cause foreseeable harm to a child or parent, the Ombudsman intervenes to persuade the agency to correct the problem. The Ombudsman shares the investigation findings and analysis of the problem with supervisors or higher-level agency officials to induce corrective action. In cases in which an agency error is brought to the Ombudsman's attention after-the-fact, and corrective action is no longer possible, the Ombudsman brings it to the attention of high-level agency officials, so they can take steps to prevent such incidents from recurring in the future.

Frequently, a concern is resolved before corrective action is necessary. In these cases, the Ombudsman actively facilitates resolution by ensuring that critical information is obtained and considered by the agency, and by facilitating communication among the people involved. In some cases, the Ombudsman finds that the agency's actions are not in clear violation of law or policy, but rather, represent poor practice. In these cases, if the complaint involves a current action, the Ombudsman intervenes where possible to assure better practice. When it involves a past action, the Ombudsman documents the issue and brings it to the attention of agency officials.

As indicated in the previous section, the Ombudsman's investigation resulted in **an adverse finding in 13% of complaints in 2007, and 21% of complaints in 2008**. As previously noted, sometimes the finding is unrelated to the issue raised by the complainant but was discovered by the Ombudsman in the process of investigating the issues that were raised. For example:

This section of our report contains examples of situations in which the Ombudsman made an adverse finding and took action to address the problem.

A parent complains to OFCO that the agency is failing to reunify the family, without justification. The Ombudsman investigates and finds no basis for this complaint, but finds that there are safety concerns in the home of the relative where the child has been placed, which the agency is not appropriately addressing. The Ombudsman makes a finding regarding the agency's failure to address the safety issues, and intervenes to ensure the child's safety.

Inducing Corrective Action

Examples

Investigative Finding	Ombudsman Action	Outcome
<p>CPS failed to notify a parent of the findings of a CPS investigation into allegations of sexual abuse of a child. The investigation had been completed six weeks prior, and the agency had the parent's correct address. OFCO found this to be clearly unreasonable given the serious nature of the allegations and the potentially harmful impact of the finding on the parent.</p>	<p>The Ombudsman requested that the parent be notified of the finding immediately.</p>	<p>The agency wrote a findings letter to the parent which was delivered 3 days later.</p>
<p>CPS failed to screen in a referral alleging abuse of a 16-year-old non-dependent youth by a sibling. The referral was not screened in for investigation as the information reported did not contain specifics about the alleged abuse. However, there was a clear allegation of abuse, and the named subject of the allegations had been charged with sexual molestation of other children in the past. The family history also indicated that the parents had been unsupportive of the youth's disclosure of abuse.</p>	<p>The Ombudsman requested that the screening decision be reviewed by the CPS intake supervisor. The screening decision was upheld by the supervisor. The Ombudsman requested further review by the Area Administrator, who also upheld the decision.</p>	<p>The Ombudsman took the matter up to the Office of Risk Management at CA Headquarters. Based on their review of the referral and the family's CPS history, CA HQ directed that the screening decision be changed. The report of abuse was investigated and the family received assistance with needed services.</p>
<p>CWS failed to address the need for the appointment of a guardian ad litem in the dependency matter of three siblings, ages 5, 1, and five months respectively. The prior GAL had retired, and a new one had not yet been appointed. Meanwhile, court hearings were being delayed in this complex case, and the children's best interests were not being represented in the legal process. Given that this was a highly contested case, and the case had just been transferred to a new DCFS worker unfamiliar with the case history, OFCO found the gap in representation of the children's best interests to be clearly unreasonable.</p>	<p>The Ombudsman contacted the guardian ad litem program in that county to request that a new GAL be assigned as soon as possible.</p>	<p>A guardian ad litem was appointed by the judge two days later.</p>
<p>CWS delayed permanency with regard to a 3-year-old dependent child who had been in out-of-home care for nearly two years. The parent had not been in compliance with court-ordered services for some time, despite reasonable efforts by the agency, and CWS had not set a trial date for termination of parental rights. The child was in a safe, stable foster home that wanted to adopt the child if she became legally free. Service providers were reporting that the child was exhibiting increased anxiety during visits with the parent. The Ombudsman found that the termination process had been delayed by CWS's failure to provide discovery to the AAG and defense counsel in a timely manner.</p>	<p>The Ombudsman contacted the Area Administrator and requested that discovery protocols in that DCFS office be reviewed and evaluated to curtail delays, and that training and improved oversight be provided to caseworkers on the discovery process and its relationship to the termination process.</p>	<p>The discovery protocols were reviewed and improvements were implemented within three months.</p>

Facilitating Resolution

Examples

Investigative Finding	Ombudsman Action	Outcome
<p>CPS failed to screen in for investigation a referral alleging neglect of a 2-year-old non-dependent child. The report alleged that the parent was using methamphetamines and living in a truck (with the child). The agency screened out the referral based on the parent's exact whereabouts being unknown and due to no specific allegation of harm to the child. The parent had a history of meth use, including during pregnancy with this child, resulting in medical problems for the child.</p>	<p>The Ombudsman verified that the parent was receiving TANF and that DCFS had contact information for the parent and various relatives. OFCO requested that CPS make collateral contacts with relatives.</p>	<p>Further information gathered by CPS indicated that since the referral, the parent had placed the child with a relative voluntarily. The child was now in a safe environment.</p>
<p>CPS delayed in obtaining a pick-up order regarding a non-dependent infant at imminent risk of harm due to the parent's mental illness. The family resided on a military base, and the child's other parent was serving overseas. CPS was seeking assistance from military police in taking the child into protective custody. The MP refused, and CPS believed it had no further authority to intervene. OFCO found that the agency had independent authority under the law to pursue a pick-up order in this case.</p>	<p>The Ombudsman recommended that DCFS staff the situation with an AAG to determine whether a dependency petition should be filed.</p>	<p>The AAG filed a dependency petition and obtained a pick-up order. The child was placed with a relative until the child's other parent returned. CPS assisted the non-offending parent in addressing the family situation to ensure the safety of the child.</p>
<p>CWS failed to respond to requests by the grandparents of a 6-year-old dependent child placed in foster care, for contact with the child. The child had previously lived with the grandparents and they had a close relationship. The grandparents had been granted some visits with the child up until nine months previously, when the foster parent reported increased behavior problems after visits and the agency discontinued them. The grandparents requested phone contact, and had one phone call, but further requests were ignored. The grandparents reported to OFCO that some time later, the child left a phone message for them, stating that he wanted to talk to his grandfather. The grandparents did not have the phone number for the foster home but was able to call the number recorded by her phone's incoming call log. CWS reprimanded the grandparents for calling the foster home. OFCO found the agency's failure to reconsider visits or phone contact to be unreasonable.</p>	<p>The Ombudsman requested that some kind of contact be reconsidered, and that the child's therapist be consulted regarding whether contact would be in the child's best interests.</p>	<p>CWS arranged a visit between the child, the parent, and the grandparents, as part of the parent's process of relinquishing parental rights process. CWS did not consult with the child's therapist regarding the advisability of ongoing contact.</p>
<p>CWS failed to keep its agreement to pay for a couple of months' rent for a room for a parent of a dependent 6-year-old child. The child was in the hospital for treatment of a serious illness, and when the case aide providing 24/7 bedside assistance to manage the child (as required by the hospital) abruptly ended services, the parent stepped in to be with the child daily. The parent rented a room close to the hospital and was unable to work due to caring for the child. However, when the caseworker submitted the funding request for the room rental, the supervisor denied it. The agency still had no case aide and the parent served a vital role in keeping the child calm. The Ombudsman found the denial of the funding request to be clearly unreasonable.</p>	<p>The Ombudsman contacted the supervisor who stated the funding was denied because the supervisor believed it was not an appropriate use of agency funds (despite being present in the meeting during which the agreement was made) as the parent had previously not been in compliance with services and the agency was preparing to terminate parental rights. The Ombudsman went up the chain to the Deputy Regional Administrator to have the funding request reviewed.</p>	<p>The agency agreed to pay two months' rent for the parent's room. However, two months later the agency still had not released the funds due to bureaucratic complications. The Ombudsman intervened again to ensure the funds were provided.</p>

Assisting the Agency in Avoiding Errors and Conducting Better Practice

Examples

Investigative Finding	Ombudsman Action	Outcome
<p>CPS closed a case after making a founded finding of physical abuse of a 15-year-old non-dependent child against a parent. The closure of the case was based on the parent being charged with assault, and the court's ability to order services and monitor the parent. This was poor practice, given that the parent had been investigated by CPS six times for physical abuse in the last two year, and had received two founded and one inconclusive finding in the last 5 months. Community professionals were expressing concerns about the youth's safety and well-being.</p>	<p>The Ombudsman requested review of the case by an Area Administrator.</p>	<p>The AA decided to reopen the case and offer the family voluntary services. Although the parent initially refused, further investigation by CPS revealed that the youth was at ongoing risk of harm by the parent. CPS filed a dependency petition, the prosecutor obtained a protection order, and the agency began working on placing the youth with the non-abusive parent, who was living out-of-state.</p>
<p>CPS planned to return a 19-day-old medically fragile infant on a hospital hold while being treated for methadone withdrawal, to the parent. Medical professionals were concerned because the parent had a history of drug abuse and had 3 other children at home who were ill with an infectious respiratory virus (RSV). Community professionals felt that CPS was not taking their concerns seriously.</p>	<p>The Ombudsman requested that CPS convene a Child Protection Team meeting to allow community professionals involved with the family to share information and make recommendations regarding the case plan.</p>	<p>CPS convened a CPT meeting and the child was sent home with specific recommendations regarding ongoing medical care and other services and a safety plan to ensure the infant's safety. The CPS case remained open for several months, until the parent relapsed and all four children were placed in out-of-home care.</p>
<p>CPS failed to screen in a referral from a mandated reporter alleging physical abuse of an 11-year-old non-dependent child by the parent. The Ombudsman found that the referral was poorly documented (the referent reported providing a good deal more information than was documented), but even so could have been screened in for investigation based on the allegations as well as the chronic history of similar referrals. However, a new referral from a different mandated reporter had just been screened in for investigation, after the child reported being hit with a belt causing a welt on his back. OFCO reviewed the investigation that was in process, and found that the child had only been seen and interviewed four days after the referral had come in. This is a violation of policy; and by that time, the "red 5-inch welt" described by the referent was a faint mark. CPS was preparing to close the investigation. OFCO determined that the agency should gather more information to better assess the child's need for protection, given the family's history of CPS involvement.</p>	<p>The Ombudsman asked CPS to contact the school counselor, the child's health care clinic, and the family court GAL currently assessing both parents (all of whom had made CPS referrals in the last year). The agency did so, and gathered substantially more information. The investigation resulted in a founded finding (all previous investigations had resulted in unfounded or inconclusive findings). OFCO recommended that the agency require the parent to participate in services or take stronger protective action (e.g. filing a dependency to protect the child).</p>	<p>CPS arranged an FTDM, and the parent signed a voluntary service plan agreeing to attend a parenting class, individual and family counseling for parent and child, regular visits to the health care clinic (for monitoring of ADHD medication), and wraparound services in the home. The school counselor agreed to meet with the child monthly as an additional safety net. The case remained open for monitoring and services for over 8 months.</p>
<p>DCFS failed to remove two adopted youths ages 16 and 17 from their adoptive home where they had lived for the past 10 years, after the youths disclosed years of physical, emotional and verbal abuse by their parents. Despite consistent disclosures by these youth, corroboration of the abuse by an older sibling who had since left home, prior removals of other children from these parents, and a recommendation from DLR/CPS who was investigating the current abuse allegations, DCFS believed the abuse did not meet sufficiency for a legal basis for removal of the youths from the parents. Furthermore, the DCFS/CPS worker inappropriately pressured the youths to remain at home and discouraged them from seeking outside assistance from school personnel.</p>	<p>The Ombudsman contacted the Area Administrator to request a review of the case and in particular the decision not to remove the youths.</p>	<p>DCFS asked the parents to sign a voluntary placement agreement, which they did. The agency provided additional training to the CPS worker. DLR and DCFS collaborated on improving their protocols for conducting joint investigations. Neither of these youths returned to the abusive home. The older youth turned 18 while in voluntary placement, and DCFS filed a dependency petition on the younger youth when the voluntary placement agreement expired.</p>

Preventing Future Mistakes

Examples

Investigative Finding	Ombudsman Action	Outcome
<p>CWS planned to terminate the voluntary placement agreement for a non-dependent 17-year-old youth when the youth turned 18, with no assistance or planning for the youth's immediate future. The youth had been severely beaten by her father two years previously, but the agency had not filed a dependency at that time, opting for a voluntary placement with a relative instead. A few months before the youth's 18th birthday, the relative moved out-of-state. The youth wanted to complete high school (where she had a grade point average of 3.8) and attend college, and had requested foster placement in advance of turning 18. OFCO found the agency's failure to explore all options to assist this non-dependent youth in transitioning to adulthood to be unreasonable, based on the youth's lack of parental or other adult support.</p>	<p>The Ombudsman went up the chain of command as far as the Program Manager for Adolescent Programs at Children's Administration Headquarters to request that the agency aggressively explore what could be done to assist this youth.</p>	<p>CA discovered it had erroneously believed that only dependent youth were eligible for the Foster Care to 21 Program (approved by the legislature in 2006 to assist foster youth in remaining in foster care after turning 18 to complete their education). In fact, youth in foster care under voluntary placement agreements are also eligible. The youth signed herself back into care at age 18 and was accepted into the Foster Care to 21 program.</p>
<p>Two dependent siblings, ages 1 and 2, moved with their foster-adopt parents out-of-state after the court authorized the placement pending ICPC approval. The parent's attorney subsequently argued that the placement was illegal, and the court entered a second, ambiguous order stating that the children should return to Washington but should remain in the foster-adopt placement. DCFS received ICPC approval of the placement from the receiving state, but was given conflicting advice from different AAGs, and told the foster parents the children would have to return to Washington. The children had been in foster care since birth, and had been living in this foster home since the ages of 2 months (the younger child) and 6 months (the older child) respectively. The foster parents wanted to adopt the children if they became legally free.</p>	<p>The Ombudsman confirmed that ICPC approval of the placement had been received from the other state, and contacted the AAG to ensure that the court order would be modified to clearly authorize placement of the children with their foster parents.</p>	<p>The court order was amended and the children's placement was not disrupted. They were subsequently adopted by the foster parents.</p> <p>To avoid these types of errors in the future, the AGO provided the court with a bench book covering ICPC law and regulations, and provided additional training for AAGs and DCFS staff on ICPC issues.</p>
<p>In the course of investigating a complaint regarding CWS's failure to place a dependent child with relatives, the Ombudsman found that there had been exceptionally poor communication between the CWS caseworker and various parties involved, that had contributed to the general confusion, inaccurate information, and ill feeling toward the agency by the relatives and other parties, who felt their viewpoints were not being heard or considered due to the caseworker's communication style.</p>	<p>The Ombudsman contacted the worker's supervisor to discuss these concerns.</p>	<p>The supervisor agreed to provide additional training and oversight to the caseworker with the goal of improving the worker's communication skills.</p>
<p>CWS failed to report injuries sustained by an 18-month-old dependent child in foster care, to the foster home licensor. The child sustained numerous injuries including a black eye, a cut on the nose, and other bumps and bruises. While abuse was not suspected, the level of supervision of the toddler was in question, and the recurring accidental injuries should have been investigated as a licensing complaint.</p>	<p>The Ombudsman requested a file review by the foster care licensing supervisor, to assess whether the injuries should have been reported for investigation either by the Office of Foster Care Licensing or DLR/CPS.</p>	<p>The supervisor found that the injuries should have been documented and reported to the licensor. To avoid future errors, the supervisor discussed the importance of making such referrals with the CWS caseworker and supervisor.</p>

CASE SPECIFIC INVESTIGATION

OFCO receives intermittent requests for investigation of specific cases in which there has been a past action resulting in an undesirable outcome. We report here on an in-depth investigation conducted after receiving such a request directly from the Secretary of DSHS. OFCO made specific recommendations to DSHS based on the findings of its investigation.

Investigative Findings Presented to the Secretary of DSHS

Re: Dependency of *CJ*

Dear Ms. Arnold-Williams:

As you know, the Office of the Family and Children's Ombudsman has completed its review of the *CJ* dependency matter. This review was initiated at your request on March 8, 2006 due to concerns that the Department of Social and Health Services (the Department) may not have provided complete and accurate information to the key entities that have authority for decision making in this case.

Summary of Issues Investigated

Did the Department provide complete and accurate information to key entities that have authority for decision making in this case? Specifically:

A) Did the Department provide the X. County Foster Care Citizen Review Board (FCCRB) with complete and accurate information when the FCCRB considered the issue on 1/25/06 of whether to return *CJ* to maternal relatives?

B) Did the Department advocate for the return of *CJ* to maternal relatives at the court hearing on 3/1/06 and present the court with complete and accurate information upon which to base its decision about placement?

Summary of Conclusion

A) No, the Department did not provide complete and accurate information to key entities that had authority to make decisions or recommendations in this case. In particular, 1) there were inaccuracies and omissions in the Child Welfare Services (CWS) social worker's Individual Service and Safety Plan (ISSP) concerning the child's weight and health; 2) the CWS social worker did not provide critical medical information, which contradicted the assertion that the child was possible failure to thrive, to the FCCRB; and 3) it is not clear from the record whether the social worker clearly presented to the FCCRB the Department's rationale for revising the case plan to return the child to maternal relative.

B) OFCO finds that the Department did advocate for return of *CJ* to maternal relatives at the 3/1/06 court hearing. The AAG cited appropriate case law in arguing for return of the child to maternal relatives. Moreover, the AAG pointed out to the court that there was "nothing definitive from the doctors about whether she was failure to thrive or she was just on her own growth chart."

Evidence Relied Upon

Review of case record (hard file and CAMIS/GUI), interviews of various DSHS personnel, medical documentation, minutes of 11/8/05 J/S Family conference, FCCRB 6-month Review Report of 1/25/06, court recordings (via CD) of hearings on 2/21/06 and 3/1/06, ISSP and updates, GAL report, and various letters and other miscellaneous documentation.

Significant Events

- On 8/4/05, CJ was taken into protective custody and placed in foster care.
- On 8/10/05, CJ was placed with maternal aunt in the home of her maternal grandmother (“maternal relatives”).
- On 11/4/05, CJ was removed from maternal relatives and placed in foster care. The Department later conceded to OFCO that it had based its decision to remove CJ, in part, on erroneous information.
- On 11/8/05, the J/S Family Conference took place. The worksheet from this conference stated, “All Family members want CJ removed from foster care and placed back home with aunt.” Eleven maternal and paternal family members signed this. Plan B was to place with paternal relatives.
- On 11/22/05, CJ was placed with paternal relatives (between removal from maternal relatives and placement with paternal relatives, she resided in foster care).
- On 11/30/05 (about 3 months prior to the 6-month FCCRB review meeting and soon after CJ was placed with paternal relatives), the social worker (SW) documented in service episode record (SER) # 9567568 that she had received a phone call from the [paternal] relative placement. “She said that they went to Dr. B. on 11/29 and CJ weighed 20.6 lbs with clothes on and 19.10 lbs [OFCO clarified with the agency (who consulted with the examining physician) that this meant 19 lbs 10 oz.] with just her diaper.”
- On 1/06, Regional Administrator Randy Hart was asked by Senator Val Stevens to review the Department's decision to remove CJ from maternal relatives and place with paternal relatives. Based on his review, the Department altered its previous position and supported return of CJ to maternal relatives.
- On 1/12/06, SW documented in SER # 9744731, after a Dr's appointment reported by the paternal relative placement, that “CJ weighs 19 lbs 10 oz.” This shows that over the seven weeks in which CJ had resided with paternal relatives, there had not been a weight increase.
- On 1/12/06, SW updated her ISSP. This ISSP was provided to the FCCRB for consideration in its decision about placement of CJ. The social worker documented that “CJ is possible failure to thrive. . .[s]ince being placed in paternal relative's home and being placed on a high calorie diet, the child has gained weight at a steady rate and continues to grow.”
- On 1/25/06, the FCCRB conducted a 6-month review of CJ's dependency case to consider whether CJ should be returned to maternal relatives. The FCCRB recommended not moving CJ from paternal relatives, with whom she had resided for approximately 2 months (from 11/22/05). The CWS social worker presented information to the FCCRB. According to the 1/25/06 FCCRB report, the social worker stated, “CJ is doing wonderfully well. Since November 4 she has been put back on Pedia Sure and gained 2 pounds. Her hair is growing and she is filling out. She is taller now. She is appropriately bonded. She is on track and has no delays. An administrative decision has been made to return CJ to the care of her Maternal Aunt and Maternal Grandmother due to the fact that the child resided with them for the first 18 months of her life. The transition will be made over a month. She is bright and happy.” In its recommendation to keep CJ with paternal relatives, the FCCRB stated, in part, “[t]he board is extremely concerned with the plan of the department to return CJ to the care of the maternal relatives. The board does not believe that CJ should be moved again. This move would constitute a 5th placement for the child, which is disruptive and potentially disruptive to CJ's development. CJ needs consistency.”
- On 1/26/06, the dependency case was transferred to a new social worker.

- On 3/1/06, the court held a contested hearing on the issue of CJ's placement. It ruled that CJ should remain with paternal relatives.

Conclusion

The Ombudsman finds that the Department failed to provide complete and accurate information to the decision makers in this case, specifically the FCCRB, with regard to CJ's weight and physical and developmental wellbeing. The social worker's duty and the purpose of an ISSP are to accurately inform the court, other parties, and decision makers about the status and progress of the child.

1) There were inaccuracies, omissions, and misleading information in the ISSP.

The social worker's ISSP was provided to the FCCRB board and to the court in advance of the hearing to determine if placement of CJ should be changed. In the social worker's ISSP update of 1/12/06, she stated, "CJ is possible failure to thrive." This is not a diagnosis that was made by any of the physicians who saw CJ (see discussion below under 2), yet the social worker continued to suggest this diagnosis.

The social worker also stated in the ISSP "[s]ince being placed in paternal relative's home and being placed on a high calorie diet, the child has gained weight at a steady rate and continues to grow." This statement does not accurately reflect medical information that the social worker documented in a 1/12/06 SER (# 9744731), which showed that "CJ weighs 19 lbs 10 oz." This is the same weight as when she was placed with paternal relatives 7 weeks earlier, thus showing no increase in weight.

2) The FCCRB was not provided with information by Dr. B., which contradicted the assertion that CJ was possible failure to thrive. The social worker provided the FCCRB with a copy of her ISSP, which stated CJ was "possible failure to thrive" and had gained weight steadily since being placed with paternal relatives. The assertion of possible failure to thrive was contradicted by the medical documentation of Dr. B. (CJ's primary pediatrician) who examined CJ on 11/29/05. In a letter on this same date, Dr. B. summarized her findings from medical visits with CJ and noted that the child was small for her age, but she had stayed fairly consistently between the third and fifth percentile for weight, based on her length. Dr. B. stated, "[w]e find that many infants who are born small for gestational age [CJ was born premature] never catch up and continue to be very small and below the 'normal parameters' that have been established." She was thoroughly tested by Dr. B. and was not found to have any abnormalities based on the screening tests. She also did not appear to have any delays, physically, emotionally, or socially. This information was not provided to the FCCRB.

3) Although the caseworker articulated the Department's revised case plan to return the child to maternal relatives, it is not clear that the agency's rationale for doing so was clearly presented to the FCCRB. It is unclear whether the FCCRB conveyed to the social worker the agency administration's rationale for placing CJ back with maternal relatives, other than that she had lived with them for the first 18 months of her life. If the social worker elaborated further on the merits of this placement, the FCCRB report does not reflect this. The report documents that the social worker presented CJ's adjustment to the paternal relatives home in positive terms, stating she is "doing wonderfully well. . . is appropriately bonded. She is on track and has no delays. . . She is bright and happy."

Recommendations

It is unclear to what extent the FCCRB relied on representations by the CWS social worker that CJ had improved physically and developmentally to make its decision. However, when the agency does not provide accurate information or omits information that contradicts other information presented, it undermines the ability of decision makers to make the best decisions for children. It also undermines public confidence in the child welfare process. Based on our review of the case file and investigation of this matter, we are recommending three practice changes:

1) The Department should inform the FCCRB and other entities staffing cases, such as Child Protection Teams, of which issues are in dispute and provide these entities with original source documents related to such issues. Information that is verbally presented, which relies on one person's interpretation of written documentation, is susceptible to mischaracterization. Critical information may be accidentally or intentionally omitted or simply presented in such a way that the information is skewed. Participants in decision making or advisory entities should have access to the source documents to review themselves so that they may ask critical and appropriate questions.

2) Policies should be reviewed to ensure that Department records (SERS) and documents (ISSPs) are corrected when inaccurate information has been documented. There needs to be a clear and consistent mechanism for correcting inaccuracies in the record. If the record goes uncorrected, then the misinformation is repeated and is more likely to be relied upon by the court and other entities in making decisions about the child's welfare. Examples of erroneous or incomplete information: 1) the agency persisted in suggesting that CJ was "failure to thrive" even though this had never been medically diagnosed. In fact, there was medical information that contradicted such a conclusion, which was not presented to decision makers; 2) although the Department conceded that the maternal aunt's boyfriend submitted information for a background check (after initially insisting that necessary information had not been submitted to the Department and relying on this as one of the reasons for removing CJ from maternal aunt) there is no evidence that the record was corrected to reflect this.

3) When Children's Administration changes its case plan as a result of review of a case by upper management, management need to attend the subsequent FCCRB meeting or court hearing to present the change in position. It is less effective to rely on the line social worker or even the supervisor to present a significant change in case plan, particularly when that worker/supervisor was responsible for making and/or advocating the prior case plan.

Once again, thank you for contacting our office, and please do not hesitate to contact us again if we can be of assistance to you.

Sincerely,

Mary Meinig
Director Ombudsman

Children's Administration Summary Response

OFCO received a response to its recommendations from the Assistant Secretary for Children's Administration, Cheryl Stephani, in October 2006. The response is summarized here:

Recommendation 1): The Department agreed with the recommendation to inform staffing entities about which issues are in dispute and provide related source documents. The agency reported that this requirement was communicated to all staff in the region in which this case was handled, and CA developed new statewide Child Protection Team policy requiring that source documents be provided to the CPT.

Recommendation 2): The Department agreed with the recommendation to review policies regarding corrections to departmental records, but provided no information as to whether they were reviewed or any changes made.

Recommendation 3): The Department agreed to follow the recommendation to have a representative from upper management present any significant changes in the case plan directed by upper management, directly to the FCCRB or the court.

CHILD FATALITY REVIEW

The Ombudsman reviews all fatalities and near-fatalities of children whose family had an open case with DSHS at the time of death, or within a year prior to death. OFCO released its first child fatality review report in 2005, which described child fatalities that occurred during the 2004 calendar year. Since then, the number of fatalities that OFCO reviews has increased. During its 2007 and 2008 reporting years¹¹, OFCO reviewed over 158 of child fatalities. An in-depth child fatality review report is forthcoming.

2SSB 6206 IMPLEMENTATION

The Ombudsman's reporting duties expanded with the enactment of S22B 6206 which became effective June 2008.

2SSB 6206 requires the Ombudsman to:

Analyze a random sampling of child abuse and neglect referrals made by mandated reporters to the DSHS/CA during 2006 and 2007.

The Ombudsman must report to the Legislature no later than June 30, 2009, on the number and type of referrals, the disposition of the referrals by category of mandated reporter, any patterns established by DSHS in how it handled the referrals, whether the history of fatalities in 2006 and 2007 showed referrals by mandated reporters, and any other information OFCO deems relevant. The Ombudsman may contract to have all or some of the tasks completed by an outside entity.

Issue an annual report to the Legislature on the implementation of child fatality recommendations.

Ombudsman progress:

OFCO entered into an interagency agreement with the Washington State Institute for Public Policy (WSIPP) to utilize its expertise to analyze patterns in mandated reporter referrals. The Ombudsman has facilitated a data sharing agreement between WSIPP and DSHS/CA.

The Ombudsman is in the process of identifying the presence of mandated reporter referrals in the history of child fatalities that occurred during 2006 and 2007 and met DSHS and OFCO's review criteria.

Ombudsman progress:

OFCO is in the preliminary stages of tracking child fatality review recommendations, and plans to issue a report on the status of implementation prior to the 2010 legislative session.

2SSB 6206 requires DSHS to:

Promptly notify the Ombudsman when a report of child abuse or neglect constitutes the third founded report on the same child or family within a twelve-month period. DSHS must also notify OFCO of the disposition of the report.

Promptly notify the Ombudsman in the event of a near-fatality of a child who is in the care of or receiving services from DSHS within the last 12 months

Ombudsman update: The Ombudsman began receiving notification of chronic maltreatment cases in June 2008. DSHS/CA informed OFCO that it would continue to send notification on a monthly basis until an automatic notifier system can be arranged via Famlink. The Ombudsman will provide the Children's Legislative Oversight Committee with an update on findings of the Ombudsman's preliminary review of these cases.

Ombudsman update:

The Ombudsman began receiving automatic notifiers from DSHS/CA regarding critical incidents, near-fatalities, and child fatalities prior to the enactment of 2SSB 6206. The Ombudsman reviews each incident.

¹¹ The Ombudsman's reporting year is September 1 to August 31.