

APPENDIX B

OFCO IN THE NEWS

“Woman pleads guilty in starvation deaths of young sons.” – *KOMO TV, Aired October 25, 2007*

- “An independent investigation [by the Office of the Family and Children’s Ombudsman] into the boys’ deaths found state child protection workers ignored or mishandled complaints about Robinson.”

“Mom Who Starved Sons to Death Pleads Guilty to New Charges.” - *Associated Press and Kitsap Sun Staff, Kitsap Sun, October 25, 2007*

- “The children’s deaths caused a furor at the time, as the Child Protective Services Caseworkers in Bremerton were accused of mishandling the Robinson case in a report issued by the state Office of the Family and Children’s Ombudsman, according to Sun archives. ... Charges against Robinson were dropped in January and she was referred to Western State Hospital for civil commitment.”

“Union Head Calls for Withdrawal of Human Services Appointee.” -*Ann E. Marimon, Washington Post, February 8, 2007*

- “...At the time, Mary Meinig, Washington state’s ombudsman for families and children, told the Seattle Post-Intelligencer that the ‘ramifications were pretty hard-hitting.’ In an interview last week, Meinig described Ahluwalia as ‘very smart, focused and committed to children’s issues.’”

“Statistics on abuse are difficult to pin down.” –*Shawn Vestal, Spokesman Review, April 1, 2007*

- “...often the circumstances surrounding a neglected child’s death are murky. The Washington Office of the Family and Children’s Ombudsman produced a report that noted in 2004, 87 children died who were ‘in the care of, or receiving child welfare services ... within one year of their death or who died while in state licensed care.’”

“Abused by drugs.” – *Benjamin Shors, Spokesman Review, April 2, 2007*

- “In a review of 87 child fatalities published last year, Washington’s children and families ombudsman found that two-thirds of the children who died came from homes with histories of drug and alcohol abuse.”

“Child welfare system biased, experts claim, disproportionate number of minorities affected.” -*Kevin Groman, Spokesman Review, April 4, 2007*

- “...Fuentes filed a complaint with the Office of the Family and Children’s Ombudsman against the Division of Foster Care Licensing. She said she had been trying since January to gain custody of Lorenzo without success despite passing several background checks and a home study. She also complained of the foster family’s interference in violation of her civil rights and the rules for state licensed foster care.”

“System under scrutiny, Summer’s death may eventually affect Washington law.” –*JoNel Aleccia, Spokesman Review, April 4, 2007*

- “The Spokane 4-year-old, who died March 10 of severe abuse, allegedly at the hands of her father and stepmother, likely, will be the subject of a full fatality report by the Office of the Family and Children’s Ombudsman.”
- In 2004 and 2005, Meinig’s office conducted full reviews of the deaths of Justice and Raiden Robinson, a toddler and an infant found starved and dehydrated in their home, and Siritia Sotelo, a 4-year-old beaten to death by her stepmother. Those reviews led to changes in laws governing Washington’s child welfare system, including the Justice and Raiden Act, which allowed greater ability to intervene in cases of neglect.”
- “We look at where the system had an opportunity, where it missed an opportunity and how do we make sure it doesn’t happen again,’ Meinig said.”

“Deaths often unreviewed.” –*JoNel Aleccia, Spokesman Review, April 13, 2007*

- “In Washington, budget cuts, inconsistent reporting and the lack of statewide coordination have eroded what once was a robust program for monitoring about 750 child deaths each year.”
- “It was a very good system and we could have confidence in what we were looking at,’ said Mary Meinig, director of the Office of the Family and Children’s Ombudsman, which conducts its own reviews. ‘Now we just don’t have that confidence’... ‘We’re missing kids,’ said Meinig.”

“Standard review in Phelps case.” –*JoNel Aleccia, Spokesman Review, April 19, 2007*

- “An executive review is not required to fully understand every child death analyzed by the Children’s Administration, said Mary Meinig, director of the Office of the Family and Children’s Ombudsman. Executive reviews often are high-profile events that include legislators and range of agency representatives.”
- “Still, Meinig said she plans to conduct a separate investigation of Summer Phelps’ death and to come to Spokane as an independent observer of the other agency’s process.
- “How many other eyes were on this child?’ Meinig said Tuesday. ‘Did we know enough to be involved enough to make a referral?’”

“Who speaks for the kids in dependency court?” –*Maureen O’Hagan, Seattle Times, April 25, 2007*

- “Studies have indicated that cases take longer when the child goes unrepresented, according to the state Office of the Family and Children’s Ombudsman.”

“Sirta’s Law’ may help avert future tragedies” –*Diana Hefley, Daily Herald, May 12, 2007*

- “I think this is going to make a difference,” Meinig said. ‘We can’t predict who is capable of hurting a child, but we can look at the system and where there are opportunities to make improvements.”
- “Meinig said the new law may have helped Shayne Abegg. The boy, 4, was found nearly starved to death in March in his father’s south Everett apartment.”

“Helpless at helping our kids.” –*Diane Carman, Denver Post, May 13, 2007*

- “In Washington State, if a doctor notices a child is not thriving, calls social services and sees no action being taken, he or she can call children’s ombudsman Mary Meinig and get results.”
- “Meinig and Alston do not work for state departments of social services, the courts, the schools or the cops. They work for the children and they accept no excuses.”
- In Washington, Meinig’s office acts as ‘neutral fact-finders,’ she said. With no butts to protect except those of the kids, ‘we can identify clearly where the gap in response has occurred, which department failed to make collateral calls and determine what needs to be done right away.’”

“Review delayed in Summer’s Death.” –*JoNel Aleccia, Spokesman Review, May 16, 2007*

- “Mary Meinig is among advocates who worry that such delays dilute the momentum for action that follows egregious deaths such as Summer’s.”
- “‘People want to know what happened and what we need to fix,’ Meinig said. But she and others also acknowledged that balancing the interests of prompt disclosure with the interests of justice is difficult. ‘We want to be timely – and we want to do it right,’ said Meinig.”

“Our Kids: Native American Children” –*Live chat with community expert, Toni Lodge, Spokesman Review, May 17, 2007*

- Q: “Can you discuss obstacle/problems/issues discovered in the Indian Child Welfare system when an Indian Child is killed while in this system? And of the children killed while in foster care; do you have data depicting which minority suffers the greatest losses?”

A: “Indian children had the highest percentage of child deaths of any ethnic group in Washington State. Native people are 2% of the total population and suffered 17% of the child fatalities in 2006, according to [the Office of the Family and Children’s Ombudsman]. Unbelievable and unacceptable. As we are continually exposed to death, trauma, grief and loss, we perpetuate the concept of intergenerational trauma.”

“Report finds similar problems in foster care system” –*Susannah Frame, King 5 News, November 29, 2007*

- “The Ombudsman has dealt with a significant number of complaints involving children with special needs who have been adopted through the foster care system. Parents who have adopted these children... report great difficulty accessing needed services.”
- “The Ombudsman is urging the state to put together a task force to develop an effective response to requests for service from adoptive parents.”

“Report finds complaints growing against DSHS.” –*John Langelier, KXLY4, Aired December 3, 2007*

- “More complaints, more areas of concern and way too much work: In a nutshell that describes the latest report on Washington’s child welfare system.”

“State didn’t do enough to protect starved boy, report says.” –*Diana Hefley, Daily Herald, December 18, 2007*

- “First his parents failed him. Then state social workers let him down. Shayne Abegg, 5 nearly starved to death before someone noticed.”

- “Based on the history of medical and physical neglect, the state should have gone to court to begin the process of removing the children from their parents, according to the DSHS review.... The review team included staff from the Children’s Administration, a pediatrician, sheriff’s detectives and the director of the Family and Children’s Ombudsman.”

“Zarelli targets foster care ills.” *-Kathie Durbin, Columbian, January 10, 2008*

- “Senate Bill 6209 would require DSHS to notify the state Office of the Family and Children’s Ombudsman when it has received a third report of abuse/neglect involving a child, and to inform the ombudsman office of how it dealt with the report.”
- “‘The 2004-05 ombudsman report found 63% of the children who died from abuse or neglect while under state supervision had at least three prior reports in their files,’ Zarelli said. ‘Instead of letting DSHS choose not to investigate a complaint, or deem the complaint unfounded, we need this legislation to put a spotlight on cases where the evidence says a child is at high risk.’”
- “‘Presently, the agency is not required to investigate reports made by these ‘mandatory reporters,’ and Zarelli said the ombudsman has noted that it’s common for them to be disregarded. ‘What’s the point of requiring someone to make a report if we can’t be sure it will be investigated?’ he asked.
- “‘Senate Bill 6206 would expand state law to require investigations of near-fatalities of children under the state’s supervision. It would require legislators to hold public hearings on the finding of fatality and near fatality investigations; require DSHS to post its investigations on a public website; and require the Family and Children’s Ombudsman to issue annual reports on the agency’s progress in implementing recommendations to reduce child fatalities and near-fatalities.’”
- “‘By raising the profile and legislative awareness of near-fatalities as well as deaths, we can increase the chance that corrective action will be taken, and that the agency will be held accountable,’ Zarrelli said.”

“A glut of near-death experiences.” *–Adam Wilson, Olympian Blog, January 18, 2008*

- “File this under sad but true: Asking the Legislature to hold hearings every time a child under state supervision nearly dies would be asking too much. ...Sen. Joe Zarelli, R-Ridgefield, proposed requiring the Department of Social and Health Services to conduct in-depth reviews each [time] there is an unexpected ‘near fatality’ incident with a child under state watch, such as foster care or in-home supervision.”
- “Mary Meinig, the ombudsman in the Office of the Family and Children’s Ombudsman, supported the concept, for rather depressing reasons. ‘Most of these kids are not a fatality because of highly sophisticated medical intervention that saves their lives,’ she said. “We can learn a lot from looking at the system and where the systems had an opportunity to intervene with these families.”

“Foster care bills met with skepticism.” *–Kathie Durbin, Columbian, January 19, 2008*

- “A package of bills introduced by Sen. Joe Zarelli that would hold the state more accountable when it receives reports of abuse or neglect of foster children got an openly skeptical reception from the chairman of the Senate Human Services and Corrections Committee on Friday. ...But the Office of the Family and Children’s Ombudsman, which exercises independent oversight of the Department of

Social and Health Services, said the reforms could provide valuable information to the social workers and even save lives.”

- “...Mary Meinig, director of the ombudsman’s office, said the recommendations resulting from those fatality reviews often get lost. They don’t always get implemented.’ She said Zarelli’s legislation would allow her office to monitor more closely how DSHS acts on the lessons learned when children die or experience life-threatening injuries in state custody.”
- “On the bill requiring notification of the state ombudsman when the state receives the third public complaint of abuse or neglect about an individual child, Hargrove said that could create an overwhelming workload for state workers. ...Receiving that many complaints ‘would be daunting,’ Meinig agreed. ‘But it would also give us some pretty useful information,’ she added. ‘A neighbor calls three times and, bingo, a fatality occurs and it turns out the neighbor was right. We might learn a lot from this. ...One solution to the volume of calls, she said, would be to look at a random selection of calls DSHS receives but chooses not to act on.”

“Bill seeks to keep watch on child abuse.” –*Adam Wilson, Olympian, January 21, 2007*

- “State Sen. Joe Zarelli, R-Ridgefield, proposed three bills last week that would require more reporting by the agency, which needs 1,500 more social workers to keep up with current workload according to a recent report.”
- “The additional reports, many of them to the independent Office of the Family and Children’s Ombudsman, are intended to reduce the worst of the worst cases of abuse and neglect. ‘There’s a lot of proposed demand on our office, but they are all good. They are coming from our recommendations,’ said Mary Meinig, director of the ombudsman’s office.
- “Zarelli also proposed requiring the agency to notify the ombudsman’s office of cases involving multiple reports of child abuse or neglect. An ombudsman’s report found at least three previous reports of abuse where made to the state in 63 percent of the cases that ultimately led to the death of a child. ‘The goal here again is to have the ombudsman have a different set of eyes on it... to try to bring additional oversight into what might be chronic cases,’ Zarelli said.”
- “The ombudsman’s office checks in on thousands of cases each year, but nowhere near 22,000, said Meinig. “That would be daunting. That’s a lot. But it would also give us some valuable information, what do these 22,000 families look like?”

“Deaths of kids raise oversight questions, Relatives are among those seeking independent reviews of DCS cases.” – *Tim Evans, Indianapolis Star, February 18, 2008*

- “In Washington State, lawmakers established an ombudsman office in the mid-1990s after the death of a 3-year-old girl who had just been returned to her parents despite the concerns of some social services workers. Mary Meinig, the state ombudsman, said she is appointed by the governor but is independent and can only be removed for malfeasance. Her post is a Cabinet level position, outranking the head of the child welfare program. Like most ombudsman programs, the office investigates all fatalities or near-fatalities of children who have had any contact with the system within the year before their deaths – in Washington that’s about 110 deaths and near-deaths a year. The office also reviews complaints about the child protection system leveled by children, parents, and others in the community. ‘I think, over the years, we have really created credibility everywhere,’ she said.

- “Having a watchdog is huge . . .,” said Meinig. “There is no doubt that we have intervened in cases where a bias existed” because of conflicts between agency workers and family members.”

“Senate approves Zarelli’s foster care bill.” –*Kathie Durbin, Columbian, February 19, 2008.*

- “Legislation sponsored by state Sen. Joe Zarelli that would require more oversight of children in state-supervised foster care passed the Senate unanimously Monday.”
- “The independent Office of the Family and Children’s Ombudsman would be required to issue an annual report to the legislature describing how recommendations in the fatality and near-fatality reports are being implemented by DSHS caseworkers.”
- “The bill also requires DSHS to promptly notify the ombudsman’s office when a report of child abuse or neglect constitutes the third founded report on the same child or family within a year, and to promptly notify a dependent child’s guardian ad litem when it receives a report that the child being abused or neglected.”
- “Finally, Zarelli’s bill would require the ombudsman’s office to review all child abuse and neglect referrals made in 2006 and 2007 to DSHS by “mandatory reporters – doctors, nurses, child care providers, and professional school personnel, who are required by law to report suspected child abuse or neglect. The ombudsman would have to report to the Legislature by July 2009 on the number and type of referrals, how they were handled, and any apparent patterns in how the department handles referrals.”

“Law requires near-death reviews for children.” –*Kevin Graman, Spokesman Review, March 12, 2008*

- “Senate Bill 6206, which passed unanimously by both houses of the legislature, also requires the Department of Social and Health Services to tell a child’s court-appointed guardian, or guardian ad litem, when a child under state care is reported to have been abused or neglected.”
- “That is an important change in current policy, according to Mary Meinig, director of the Office of the Family and Children’s Ombudsman, who said the policy should already have been in place. . . .The GALs need to know. They are responsible for the child,’ Meinig said. ‘It’s too bad we have to have it legislated.’”
- “The bill also directs Meinig’s office to report annually on how DSHS is implementing recommendations from the child death and near death reviews and requires the ombudsman’s office to analyze reports of child abuse and neglect made by “mandatory reporters.”
- “The ombudsman’s office will look at a random sampling of mandatory reporting and look the “screening decisions” made by the child welfare professionals as to whether the reports were referred for further investigation. ‘The reason for this is DSHS kept having incidents of mandated reporter referrals that had been screened and not investigated,’ Meinig said.”

“Lawmakers take up the fight.” –*Richard Roesler, Spokesman Review, March 30, 2008*

- “Child abuse, neglect and foster care were much on the minds of Washington lawmakers this year, and they approved several changes that advocates long have urged.”
- “Senate Bill 6206 is an attempt to eliminate some ‘blind spots’ in child welfare cases, particularly those involving the death of a child. Under current law, the state must launch a public “child fatality

review” if a state-monitored child dies unexpectedly. SB 6206 tightens up the procedure, banning people involved with the case from being on the review committee and requiring that the reports be published on the internet. It would also require annual reports to the Legislature on whether social workers are making the changes recommended in previous child fatality reviews. The bill is awaiting Gregoire's signature.”

“Making strides, it has been a year of progress since a month long focus on child welfare, yet much work remains.” –Kevin Graman, *Spokesman Review*, March 30, 2008

- “In its most recent annual report, released late last year, the ombudsman’s office found shortcomings in three areas: compliance with the federal Indian Child Welfare Act; long-term treatment for children with mental illnesses; and reducing the workload of caseworkers and supervisors in the Washington Children’s Administration.”
- “In the [reporting] year ending Aug. 31, 2006 the ombudsman’s office, which is charged with overseeing child protection and child welfare services investigated a record 477 complaints. Most of these complaints fell under two categories, ‘failure to protect’ and ‘unnecessary removal’ of children, reflecting the tightrope the Children’s Administration walks in performing its duties.”
- “Since recommending a reduction in caseloads in 2005, the ombudsman’s office has conducted periodic random reviews of the Children’s Administration, consistently finding much higher caseloads in both Child Protective Services and Child Welfare Services units than recommended by the national Council on Accreditation.”
- “Mary Meinig, director of the Office of the Family and Children’s Ombudsman, said these high caseloads are responsible for the ‘severity of morale in the agency and a sense of its staff being overwhelmed and afraid. Meinig’s concerns were confirmed in a study contracted by DSHS that was completed late last year by Walter R. McDonald and Associates in collaboration with American Humane Association.”
- “In its report, the ombudsman’s office also recommended that the state Division of Children and Family Services, the Division of Developmental Disabilities and the Mental Health Division come together to help families with children who can no longer be managed at home... exacerbating these issues, the ombudsman finds that a culture has developed within the agency that frequently shames families who cannot manage special needs children at home,” the report states.

“Foster-care system still struggling.” –Maureen O’Hagan, *Seattle Times*, August 10, 2008

- “Earlier this year, the Office of the Family and Children’s Ombudsman had so many concerns that its director, Mary Meinig, gave her first closed-door legislative briefing. Among other things, she told lawmakers that child fatalities were on the rise and complaint-ridden foster homes were allowed to remain open. Meinig, a neutral, nonpartisan investigator into complaints about the Children’s Administration, later wrote in a memo that it was “imperative” the problems be addressed immediately.”
- “Last February, Meinig, the ombudsman, told key legislators that the number of complaints to her office was ballooning. Some involved children in foster care, and thus came under Braam, but her concerns were broader than that. Most troubling, she said, was that child fatalities were increasing. Eighteen children who were the subject of open child-abuse or –neglect complaints had died in the previous six months. Twelve died in the same period a year earlier.”

- “There were also numerous worrisome incidents that didn’t result in death. One of those, Meinig later said, involved a 12-year-old Pierce County boy who lived with his grandparents. They were suspected of abusing him. Using Stephani’s philosophy of engaging families, workers and relatives came up with a plan: The boy would stay with grandparents, but head to live out back, in a travel trailer with no running water. Police, who arrested the grandparents last summer after the boy said he suffered further abuse, were appalled. ...The agency acknowledged it made an error. But Meinig and others worried that the family –focused policy wasn’t properly understood by workers. In her memo, Meinig wrote that the alleged perpetrators were invited to help decide where abused children should live, and that relatives weren’t being properly scrutinized.”

“Colville’s child and family services under investigation.” *KXLY, Aired August 11, 2008*

- “...complaints are similar, but wide-ranging. State Children and Family Ombudsman Mary Meinig has seen them all. “Safety of children in foster care is one. Removal is another. Removal from parents. Reunification issues. It is a number of issues...”

“This is just the tip of the iceberg.” *–Sophia Aldous, Statesman Examiner, August 13, 2008*

- “A state ombudsman will be in Colville this week as part of a state investigation into the Washington Division of Children and Family Service’s Colville office. The investigation follows a high number of complaints connected to the department.”
- “At the request of the Department of Social and Health Services Secretary Robin Arnold-Williams, ombudsman Mary Meinig will be in Colville meeting with WDCFS staff as well as area groups and individuals concerned about the division practices in Stevens and Ferry counties.”