

# RESPONDING TO COMPLAINTS

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The Ombudsman investigates every complaint received.<sup>8</sup> Through impartial investigation and analysis, the Ombudsman determines an appropriate response. In cases where the Ombudsman finds that the agency has properly carried out its duties, no further action is taken. In cases in which an adverse finding is made, the Ombudsman may work to change a decision or course of action by the Department of Social and Health Services (DSHS) or another state agency.

## ANALYZING COMPLAINTS

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

After initial investigation, the lead Ombudsman presents a report for review by the team, or a senior Ombudsman. Staff may pose questions, test assumptions, identify information gaps, identify problematic policy or practice issues, raise additional issues for investigation or analysis, or offer an alternative analysis by playing “devil’s advocate”. The investigation continues until it can be determined whether the allegations in the complaint meet one or more of the criteria for intervention by the Ombudsman (see sidebar). If these criteria are not met, no further action is taken and the complainant is notified by telephone or in writing. If the criteria are met, the Ombudsman decides what action to take to address the concerns raised by the specific complaint or any additional concerns uncovered during the course of the investigation. The complainant is informed of the progress and final resolution of the investigation.

### Criteria for Analysis

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

- The alleged agency action (or inaction) is within the Ombudsman’s jurisdiction.
- The action did occur.
- The action violated law, policy or procedure, or was clearly inappropriate or unreasonable under the circumstances.
- 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.

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<sup>8</sup> The Ombudsman may also initiate an investigation without a complaint. During the 2007-08 reporting period, OFCO initiated 17 investigations and monitored the cases of three families as a result of information obtained by means other than a formal complaint, for example, by way of news reports. Three of these investigations/case monitors were closed without Ombudsman intervention after the concerns were resolved, and are not included in the data in this section. One investigation was closed after the Ombudsman intervened to resolve the concerns. Thirteen of the OFCO-initiated investigations remained open at the end of the reporting period.

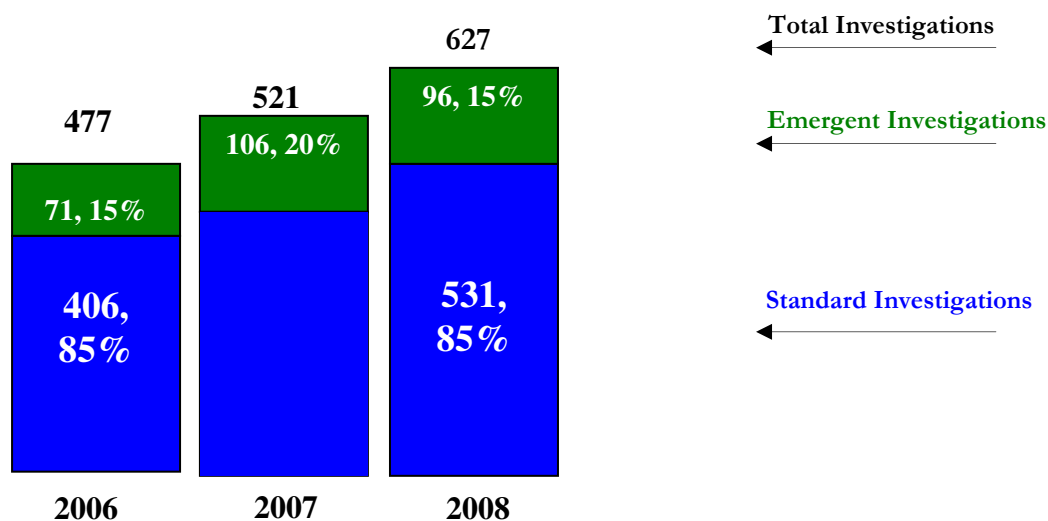
## INVESTIGATION OUTCOMES

### Completed Investigations

The Ombudsman completed 521 complaint investigations in 2007<sup>2</sup>, representing a **9% increase over the previous year**; in 2008, investigations **increased another 20%**, to reach an all-time high of 627. This increase is attributable to the sharp increase in the number of complaints received by OFCO over this period, as well as OFCO's increased productivity resulting from the addition of staff (three FTEs over the two-year period) to meet both the demand for our services as well as to carry out new responsibilities assigned by the legislature. As in previous years, the majority of these investigations were **standard non-emergent investigations** (80% in 2007, and 85% in 2008). In 2007, one out of every five investigations met the Ombudsman's criteria for initiating an **emergent investigation**, i.e. when the allegations in the complaint involve either a child's immediate safety or an urgent situation where timely intervention by the Ombudsman could significantly ease a child or family's distress. In 2008, emergent investigations decreased to slightly less than one out of five.

### Type of Investigations Completed

September 1 to August 31



<sup>2</sup> Of the 2007 complaints, 83% were investigations of complaints received during that reporting year, while 17% were of complaints received in a previous year. At the end of 2007, 25% of complaint investigations remained open. For the purposes of this section, investigations of complaints raising identical issues involving the same child/family are counted only once. The actual number of complaints closed in 2007, including these identical complaints from more than one complainant, was 556; for 2008, it was 681.

## Ombudsman’s Findings

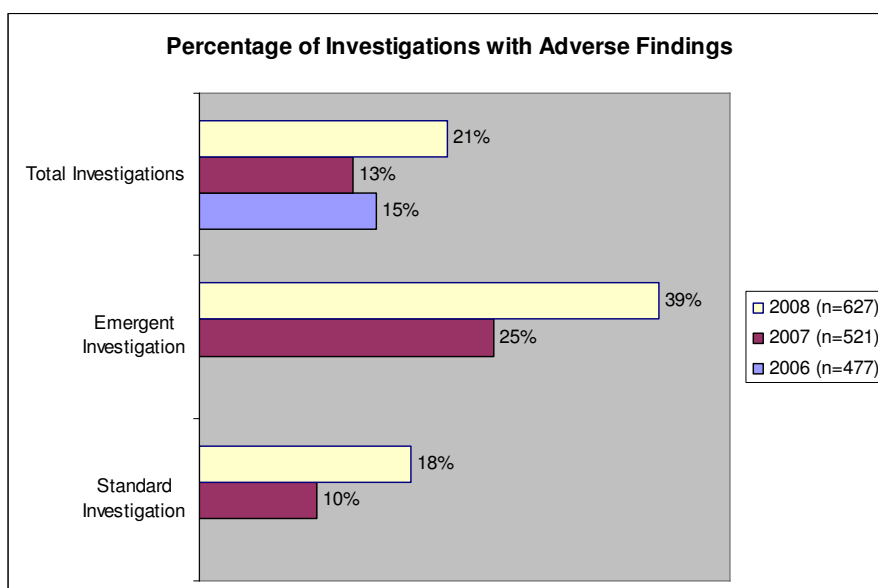
As shown in the graph below, the majority of complaint investigations resulted in **no adverse findings** (452, or **87% in 2007**, and 496, or **79% in 2008**). However, the number of adverse findings decreased slightly from 2006 (15% of complaints) to 2007 (13%), but increased significantly in 2008, to 21% of complaints. This was partly due to OFCO’s improved data capturing resulting in more accurate reflection of agency violations of policy and poor practice; other reasons for the increase in the number of adverse findings as well as the number of interventions by the Ombudsman are discussed in the next section of this chapter (see “Investigation Results, page [currently 7]).

**Approximately one in eight investigations (13%) resulted in an adverse finding in 2007**; this number went up to **about one in five (21%) in 2008**. It should be noted that a finding by the Ombudsman may or may not be related to the complaint issue/s raised by the complainant, but rather to other violations or unreasonable actions found by the Ombudsman in the course of investigating the complainant’s concerns. The number of adverse findings was also significantly higher in emergent complaints than in standard complaints.

Adverse findings fell into three broad categories:

- the agency violated a law, policy or procedure;
- the agency’s action or inaction was clearly unreasonable under the circumstances;
- no violation or clearly unreasonable action was found, but harm to the child or family had occurred as a result of poor practice on the part of the agency.

The Ombudsman intervened in some way to resolve the situation in 54% (37) of the 69 complaints with findings in 2007, and in just over one-third (45) of 131 in 2008. In the remaining complaints, the action had either already occurred or did not require or allow for intervention for other reasons.



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

| FINDINGS BY ISSUE                                                                                                                                                                                                 |           | Number of Findings |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|--------------------|--|
| Issue                                                                                                                                                                                                             | 2007      | 2008               |  |
| <b>Child Safety</b>                                                                                                                                                                                               | <b>29</b> | <b>68</b>          |  |
| Failure by CWS to ensure/monitor dependent child's safety (examples: failure to conduct Health & Safety visits; inadequate monitoring of supervised parent-child visits; failure to report child injuries to CPS) | 11        | 28                 |  |
| Failure by CPS to ensure/monitor non-dependent child's safety                                                                                                                                                     | 5         | 16                 |  |
| Inadequate CPS investigation/case management                                                                                                                                                                      | 4         | 11                 |  |
| Failure to screen in CPS referral for investigation/other screening errors                                                                                                                                        | 5         | 8                  |  |
| Inappropriate CPS finding                                                                                                                                                                                         | --        | 3                  |  |
| Failure by DLR to ensure safety of foster home/facility                                                                                                                                                           | 4         | 2                  |  |
| <b>Family Separation and Reunification</b>                                                                                                                                                                        | <b>3</b>  | <b>20</b>          |  |
| Failure to/delay in placing child with relative                                                                                                                                                                   | --        | 9                  |  |
| Failure to provide appropriate contact between parent and child                                                                                                                                                   | 2         | 4                  |  |
| Delay in reunification                                                                                                                                                                                            | 1         | 3                  |  |
| Failure to provide visits with siblings                                                                                                                                                                           | --        | 2                  |  |
| Failure to provide contact with other relative                                                                                                                                                                    | --        | 2                  |  |
| <b>Dependent Child Permanency</b>                                                                                                                                                                                 | <b>10</b> | <b>19</b>          |  |
| Delay in permanency                                                                                                                                                                                               | 9         | 15                 |  |
| Inadequate permanency planning                                                                                                                                                                                    | 1         | 3                  |  |
| Inadequate preparation of youth aging out of foster care                                                                                                                                                          | --        | 1                  |  |
| <b>Parents' Rights</b>                                                                                                                                                                                            | <b>6</b>  | <b>18</b>          |  |
| Failures of notification, public disclosure, or breach of confidentiality                                                                                                                                         | 4         | 8                  |  |
| Delay in completing CPS investigation                                                                                                                                                                             | 1         | 6                  |  |
| Failure to provide services to parent                                                                                                                                                                             | --        | 2                  |  |
| Other violations of parent's rights                                                                                                                                                                               | 1         | 2                  |  |
| <b>Foster parent/foster care issues</b>                                                                                                                                                                           | <b>5</b>  | <b>16</b>          |  |
| Poor communication by agency, unreasonable treatment                                                                                                                                                              | --        | 7                  |  |
| Violation of foster parent rights                                                                                                                                                                                 | 3         | 2                  |  |
| Overly lengthy DLR/CPS investigation, inappropriate findings                                                                                                                                                      | 1         | 2                  |  |
| Failure to provide foster parent with support services                                                                                                                                                            | --        | 2                  |  |
| Retaliation by agency                                                                                                                                                                                             | --        | 2                  |  |
| Unreasonable licensing delays/other licensing errors                                                                                                                                                              | 1         | 1                  |  |
| <b>Dependent Child Health and Well-being</b>                                                                                                                                                                      | <b>16</b> | <b>13</b>          |  |
| Failure to provide adequate medical care                                                                                                                                                                          | 4         | 5                  |  |
| Failure to provide appropriate services to meet special needs                                                                                                                                                     | 1         | 3                  |  |
| Placement issues (unnecessary moves, delays in placement, lack of availability, inappropriate placement type)                                                                                                     | 7         | 3                  |  |
| Failure to meet basic physical needs                                                                                                                                                                              | 1         | 1                  |  |

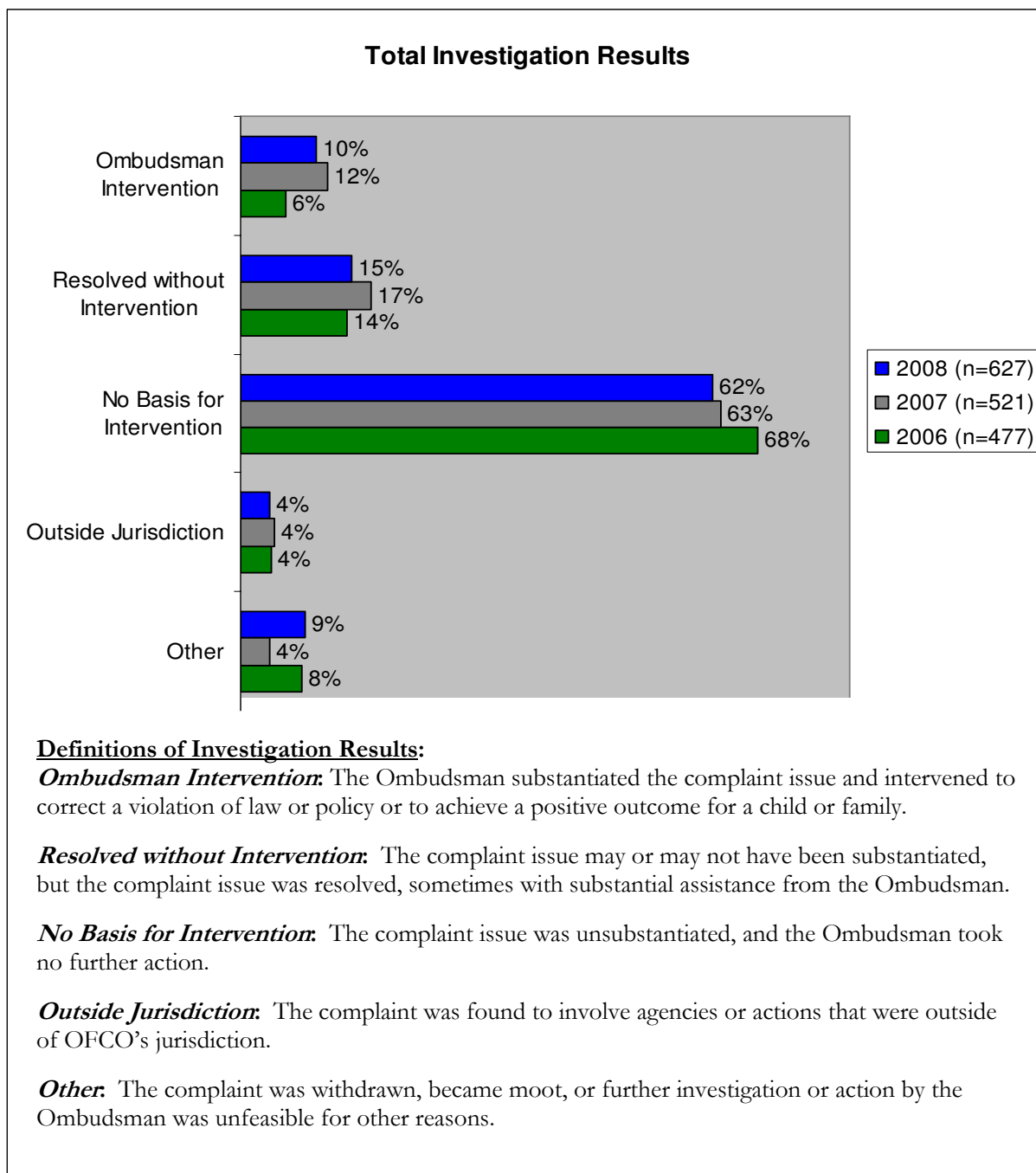
|                                                                                  |           |            |
|----------------------------------------------------------------------------------|-----------|------------|
| Unreasonable delay in providing Children's Long-Term In-Patient treatment (CLIP) | 3         | 1          |
| <b>Legal Issues</b>                                                              | <b>6</b>  | <b>3</b>   |
| Lack of attorney or guardian ad litem for dependent child                        | 2         | 2          |
| Violations of Indian Child Welfare Act                                           | 4         | 1          |
| <b>Poor casework practice resulting in harm to child or family</b>               | <b>11</b> | <b>10</b>  |
| Other poor practice                                                              | 6         | 9          |
| Communication failures                                                           | 4         | 1          |
| Unprofessional conduct by agency staff                                           | 1         | --         |
| <b>Relative caregiver issues</b>                                                 | <b>--</b> | <b>4</b>   |
| Poor communication, poor treatment, lack of support                              | --        | 4          |
| <b>Adoptive parent/adopted children's issues</b>                                 | <b>4</b>  | <b>2</b>   |
| Inadequate services for adopted children with special needs                      | 3         | 2          |
| Inadequate pre-adoption services                                                 | 1         | --         |
| <b>Other findings</b>                                                            | <b>1</b>  | <b>--</b>  |
| Failure to conduct child death review                                            | 1         | --         |
| <b>TOTAL # OF FINDINGS<sup>9</sup></b>                                           | <b>91</b> | <b>171</b> |
| Total # of Complaints with one or more finding                                   | 69        | 131        |

Of note in the above table is that the number of adverse findings made by the Ombudsman increased significantly (sometimes more than doubled) in almost every category from 2007 to 2008. Findings related to child safety under CWS or CPS supervision, increased sharply, as did the agency's failure to place or delay in placing a child with a relative, and delays in achieving permanency for dependent children. Violations of parents' rights tripled, as did foster parent issues; and in 2008, OFCO paid close attention to documenting relative care issues as a distinct category. A cautionary note regarding the above data is that OFCO gathered data regarding adverse findings more meticulously in these last two years, and we only have two years of comparison data showing findings in this kind of detail. The large swings in some of the numbers from one year to the next may even out once several years of data have been reported.

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<sup>9</sup> Note that several complaints raised more than one issue and resulted in more than one finding.

## Investigation Results



**In 2007, complaint investigations requiring direct intervention by the Ombudsman doubled, jumping from 6% to 12% of all investigations. In 2008, interventions decreased slightly to 10%, which still represents a significant increase over the 2006 rate of intervention. This sharp increase in interventions is attributable to several factors:**

- Administrative changes in the way OFCO gathers complaint data has greatly improved our ability to capture a more accurate reflection of the Ombudsman's efforts to resolve substantiated complaints;

- Institutional experience garnered by OFCO over its 11 years of operation has taught us to quickly recognize the types of situations in which the Ombudsman can best utilize its unique role to prompt Children’s Administration in achieving positive outcomes for families and children, resulting in more decisive and timely interventions; and
- Correspondingly, we have observed that our outreach and educational efforts as well as the reputation OFCO has gained over the years as an entity that can negotiate the child welfare system to achieve more positive outcomes, has resulted in greater awareness within the child welfare community as well as the general public regarding this unique resource and the types of problems it can effectively resolve. We speculate that OFCO has been able to effectively intervene on behalf of many more families and children each year, in part due to our stakeholders becoming more astute and timely in bringing complaints to our attention.

**The vast majority of complaints requiring intervention by the Ombudsman resulted in the complaint issue being resolved (83%).<sup>10</sup>** In the remaining 17% of complaints in which the Ombudsman intervened, the agency did not change its position and the issue became moot or remained unresolved.

For example, the former foster parent of a dependent youth with severe behavior problems contacted the Ombudsman with concerns about DCFS placing the youth in a group care facility close to the foster home. The youth had repeatedly broken into the foster parent’s home since being moved, and the foster parent was concerned that she would be forced to defend herself, with potentially tragic results. The Ombudsman contacted the CA Regional Administrator (RA) regarding these safety concerns. Regional management explained that the agency recognized the risk, but its efforts to find another suitable placement for this youth had been unsuccessful. The RA agreed to staff the case with CA Headquarters. Ultimately, Headquarters agreed that DCFS had done all that it could at that point. A couple of months later, DCFS was able to move the youth to another group home that was further away from the foster home.

**In 2007-08 an average of 16% of investigations were resolved without intervention.** Resolution of the complaint sometimes occurred as a result of the Ombudsman’s assistance, for example by ensuring that critical information was obtained and considered by the agency, or by facilitating timely communication among the people involved in order to resolve the problem.

In one example, the Ombudsman found that CWS failed to notify the CASA and other parties of a scheduled CPT meeting in which important decisions were being made regarding the child’s placement. The Ombudsman requested that the CPT be reconvened to include these parties, but the agency was unsuccessful. OFCO monitored the situation for several months as the case moved forward to ensure this did not recur. The CASA and other parties were notified in advance of subsequent decision making meetings.

**Since 2006, just under two-thirds of complaint investigations were closed after the Ombudsman either found no basis for the complaint, or found no unauthorized or unreasonable actions** by the agency warranting intervention. In some of these cases, the Ombudsman may have made an adverse finding regarding a violation of law or policy or an unreasonable action that was not raised by the complainant but that was discovered by the Ombudsman in the course of investigating the complaint. However, the adverse finding did not require further action or could not be remedied.

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<sup>10</sup> See the following chapter, Ombudsman in Action, for examples of interventions.

For example, the Ombudsman found that CWS failed to place a two-year-old dependent child with relatives. In discussing this with the agency, CWS admitted that policy and procedures were not followed in this case, partly due to the caseworker’s high caseload, and that the relatives were not fairly considered in a timely manner as a result. Meanwhile, enough time had passed that the child had developed a strong attachment to the foster parents, who wished to adopt him, and the court ordered the agency to pursue a plan of adoption by the foster parents. The Area Administrator reported that staffing changes were being made to ameliorate heavy caseloads.

### Emergent vs. Standard Complaint Investigations

Investigation results differ quite significantly in complaints that are investigated on an emergent basis compared to our standard investigation process. The following charts depict the various outcomes for these categories of complaints. The largest increase in interventions was seen in **emergent** complaints (a 9% increase over two years). Correspondingly, in the last three years, complaints that were not substantiated and did not require Ombudsman action decreased steadily (68%, 63%, and 62% from 2006 to 2008; see “Total Investigations” table).

