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

Loss of Trust:
A Crisis of Confidence in the Child Welfare System in Colville

Colville Investigation May 2009

Mary Meinig, Director Ombudsman
Linda Mason Wilgis, Ombudsman

www.governor.wa.gov/ofco

Acknowledgment

We wish to acknowledge and thank the communities of Stevens, Pend Oreille, and Ferry County and Spokane for the considerable time and effort put into meeting and talking with the Office of the Family and Children's Ombudsman. We respect your commitment and desire to improve child welfare practice in the tri-county area. It is never comfortable to have the things near and dear to your heart—your community, your family, your children, your profession – scrutinized, particularly by individuals from outside of your community. We appreciate this is difficult and thank you for treating us with respect, cooperation, and patience over many long hours of conversation. We wish we could tell everyone's story. But we have done our best to fairly represent the problems we identified based on the concerns you expressed to us and provided recommendations that we believe can provide a framework for improvement.

We also want to thank the other members of our staff who did a marvelous job of assembling data, crunching numbers, and providing another set of eyes to the report, which resulted in valuable input.

Thanks too to the vigilance of state legislators in helping to shine a light on a community in need of help.

Mary Meinig
Director Ombudsman

Linda Mason Wilgis
Ombudsman

Office of the Family and Children's Ombudsman

May 2009

Table of Contents

EXECUTIVE SUMMARY

The Office of the Family and Children's Ombudsman (OFCO) is an independent office within the Office of the Governor that serves as a watchdog over government agencies with responsibility over the child welfare system. OFCO works independently on behalf of children and families and the citizens of the State of Washington to protect them against harmful acts or failure to act by state agencies, identifies areas of concern, and recommends improvements to the system.

In June 2008, the Ombudsman was asked by the Department of Social and Health Services (DSHS), in response to concerns expressed by Representative Joel Kretz, to examine child welfare practice in Colville, Washington, in the northeastern corner of the State. Between June 2008 and May 2009, OFCO spent hundreds of hours personally meeting with child welfare participants and interviewing others by phone. We talked to frustrated parents, overworked DSHS social workers, administrators, and CASA volunteers; disillusioned foster parents and relative care givers, service providers, attorneys court administrators, and others about their experience with the child welfare system in the Colville area. We also launched investigations into case specific complaints and continued our work on complaints pending prior to this formal request for a regionally focused systemic investigation.

Between January 1, 2007 and March 31, 2009 we received 62 complaints regarding child welfare practice in the Colville, Republic, and Newport DSHS, Division of Children and Family Services (DCFS) offices. We have completed and closed investigations on 44 out of the 62 complaints and 18 complaints remain open, with active investigations still pending. The Ombudsman made 16 adverse findings during the course of investigating these complaints in the Tri-County area since January 1, 2007, thus far. These adverse findings include violations of law, policy, procedure; clearly unreasonable actions; or simply poor social work practice.

- 11 of the complaints with adverse findings resulted in intervention by the Ombudsman.
- 5 of the complaints with adverse findings either did not present a basis for further action by the Ombudsman, or further action was not feasible.

As a result of our investigative work, the Ombudsman found child welfare cases in which DCFS did not comply with law or policy—but perhaps even more challenging to address, our investigation revealed a culture of pervasive distrust between parties and stakeholders, poor communication, and a lack of collaboration among professionals which infects day to day decision-making and case planning for dependent children. This culture leads to unnecessary placement changes, delays in permanence for children, and ultimately, actions or inaction that put children and families at risk of harm.

At the conclusion of our review and investigation, we understand with certainty that the Colville community cares deeply about its children and desires to improve the child welfare system. The community recognizes that as the system currently functions, it is putting children at risk of harm because of the contentious atmosphere surrounding decision-making. The relationship between Colville DCFS and community professionals is sorely strained and this has an adverse impact on the quality of social work being delivered to families and children.

Colville DCFS and the Stevens County Court Appointed Special Advocate (CASA) program have an unhealthy relationship that needs work. The relationship between DCFS and the medical and mental health community in Stevens County is also in need of repair. These entities openly acknowledged these problems in their conversations with OFCO and were candid and cooperative with the Ombudsman in pinpointing specific areas of concern.

SUMMARY OF OFCO RECOMMENDATIONS

Impartial advice and consultation from outside the local child welfare community is needed:

a. Use an **outside professional mediation service** that is mutually agreed upon by DCFS, the CASA program, and the medical community to help rebuild trust, encourage dialogue, and address specific issues needing repair.

b. Create a diverse **community advisory board** including members who are not connected to the child welfare community to provide advice to DCFS.

c. Improve collaboration by requiring significant stakeholders to continue to participate in the **Table of 10 court improvement project** and other opportunities for multidisciplinary training.

Judicial Leadership can assist in restoring trust and accountability:

d. **Encourage the judiciary to take a leadership role in addressing accountability** and information sharing by creating a culture of compliance, encouraging a dialogue about mutual accountability as a shared responsibility, and spearheading training on conflict of interest considerations among parties. Provide specific training to judiciary on availability of sanctions under the law to enforce court orders and compliance with other law, policy, and procedure.

e. Encourage judiciary to conduct **monthly operations meetings** between significant stakeholders to encourage regular communication and help set a tone of civility and respect among stakeholders.

f. Judiciary should enforce requirement under the law that parties select a **"mutually agreed upon provider"** and if a provider cannot be agreed upon, the judge selects the provider so that parties in a dependency action have a level field. This will encourage parents to comply with services and help neutralize allegations that DCFS is "shopping" for providers who are supportive of their objectives.

Roles, rights, and responsibilities must be clarified:

g. **Provide improved and ongoing training to DCFS** workers and supervisors, including at Academy, and **to CASA on respective roles, rights, and responsibilities** of parties and other stakeholders to a dependency.

h. **Clarify the investigative power of CASA** to ensure CASA is not interpreting its investigative powers beyond statutory intent and standards established by the Washington State CASA program. DCFS and CASA should develop a mutually agreed upon and legally permissible protocol on the scope of CASA's independent investigatory power.

i. **Create clear standards** by mutual agreement between local CASA and DCFS offices with input from state-wide CASA program, and Attorney General's office **on what information CASA is entitled to** from the DCFS case record and establish clear protocol for DCFS to provide clear and timely notice to CASA and other parties if certain information will not be released, the basis for that decision, and the agreed upon process for parties to further seek such information.

The power imbalance between DCFS and parents must be addressed through effective and compassionate social work and meaningful services:

j. DCFS must communicate clearly and consistently with parents and providers not only the services which are court ordered, but the concerns which they are designed to address.

k. The judiciary and parties must ensure that services ordered are specifically designed to address the parental deficiencies which led to the need for removal of the child from the home.

Adequate notice and other aspects of due process must be followed and parents, relatives and foster parents must be treated fairly and with dignity:

l. **Provide all care providers (foster and relative) with a minimum of 5 days written notice of DCFS intent to remove child** from home unless there is imminent risk of harm. Notice should include a clear explanation as to the reasons for the agency's decision to remove a child.

m. Require DCFS to convene a sit down, **face-to-face meeting with a care provider, who is the subject of a child abuse or neglect referral** that could lead to removal of the child, to explain the nature of the allegations and give care provider a reasonable opportunity to respond to the allegations.

n. **Prohibit DCFS from removing children from relative care providers unless CPS has made a finding that the relative has abused or neglected the child** or clearly violated a court order, or the child is at imminent risk of harm.

o. Provide relatives with the right to an administrative review of agency decision to remove a dependent child when child has been in their care for 6 months or longer.

p. Require DCFS to inform parent both verbally and in writing what relatives the agency has considered for placement and the outcome of that consideration. Also require DCFS

to consistently inform relatives with a written explanation as to why a child will not be placed with them.

q. Require DCFS and enforce duty of agency to adhere faithfully to notice requirements, ensure parents are represented by an attorney, treat families with dignity and respect even when it may take more time to do so, and address parents' concerns by communicating with them in a clear, compassionate manner.

The importance of relatives must be recognized:

r. **Encourage DCFS to promote visitation between relatives and dependent children** by incorporating into Academy training research-based teaching on current best practice for decision-making regarding contact between relatives and dependent children and facilitating regular and beneficial contact. Incorporating relative and child testimonials on this subject could be a powerful teaching tool.

s. Allow relatives who have an established relationship with a dependent child in out of home placement to petition the court for visitation when visits are mutually agreed to by the child and relative.

Community professionals must be treated with respect and receive accurate information:

t. Amend DCFS policy and procedure to **require Colville DCFS to use local community resources** unless a mutually agreed upon provider agrees in writing that there is a compelling reason for use of resources outside the local community. If local resources are consistently found not to be sufficient, efforts should be made to identify funding sources to augment local resources so they can be developed sufficiently over time to meet the capacity and needs of the community.

u. Require DCFS to **provide CPT members with source documentation** from service providers on cases subject to consultation and provide legal basis for withholding information if it is not being shared.

v. Office of the Attorney General should collaborate with defense bar and statewide CASA program to **conduct improved and ongoing training of DCFS on confidentiality requirements** under the law as they relate to dependency process. Encourage DCFS workers and supervisors to staff issues of confidentiality with AGO if uncertain whether information may be shared.

Resources and DCFS leadership must be sufficient to do the job:

w. Colville demands **full-time local leadership** to address problems. Require DCFS to appoint a full-time area administrator.

x. **Provide resources** to increase judicial officers, attorneys, and CASAs so that an added perspective can be brought to dependency and termination cases, cases can be heard on

a timely basis and contested issues can be more effectively addressed. Also ensure that sufficient resources are available to allow parents to engage in services without delay.

y. Establish **weighted case loads** for DCFS caseworkers to account for long distances travelled in rural areas.

z. When funds become available, require DCFS to provide **additional support staff** in local offices to assist caseworkers in ensuring that parties and care providers receive timely and consistent notice of hearings and meetings, copies of ISSPs, and timely discovery to parties that is updated on a regular basis.

Background to Colville Investigation

In June 2008, Robin Arnold-Williams, then Secretary of the State of Washington Department of Social and Health Services (DSHS), contacted Mary Meinig, Director Ombudsman of the Office of the Family and Children's Ombudsman, to request that OFCO conduct a review of the child welfare and protection practices and procedures at the Colville Division of Children and Family Services (DCFS).[1] DSHS requested OFCO's independent review after being contacted by State Representative Joel Kretz, of the 7th legislative district,[2] who had concerns about agency practice in the Colville office.[3] In a June 5, 2008 letter to DSHS, Representative Kretz expressed that, "After several years of involvement in multiple CPS cases, I have developed concerns about the office in Colville. There is a very negative view of the department, both with individuals involved, as well as the general public. It is my opinion that these views are legitimate and warrant a deeper look into CPS and their practices and processes." Representative Kretz raised specific concerns: the failure of the agency to follow legal requirements, including a lack of clarity about what objective standards and protocols DCFS must follow when determining whether to remove a child from a home or place a child in foster care; and a lack of accountability by the agency.[4]

In July 2008, OFCO initiated the Colville investigation after identifying significant stakeholders, gathering documents, and compiling an investigative team. In August 2008, the

[1] The Division of Children and Family Services (DCFS) is a division of the Children's Administration, the agency within the Department of Social and Health Services (DSHS) that is mainly responsible for providing child protection and child welfare services. This report will refer to both CA and DCFS to mean the agency that provides child protection and child welfare services. Within DCFS is Child Protective Services (CPS) whose role, in part, is to investigate reports of child abuse or neglect. Also within DCFS is Child and Family Welfare Services (CFWS, commonly called CWS), the arm of DCFS that provides ongoing casework services to children and families subject to state oversight through the dependency process set forth in chapter 13.34 RCW. The Division of Licensed Resources (DLR) is the division within DSHS that licenses foster and group homes and investigates reports of abuse or neglect in licensed facilities.

[2] The 7th legislative district includes all or parts of Ferry, Lincoln, Okanagan, Pend Oreille, Stevens, and Spokane counties.

[3] Colville is located in Stevens County, Washington in the northeastern corner of the State..

[4] Representative Kretz also wrote a June 19, 2008 letter to Attorney General Rob McKenna addressing the same concerns he stated in his letter to DSHS and asking for assistance from the Attorney General's Office "in researching these issues in greater detail in order to determine what legislation your Office may wish to propose in order to ensure more clear, just, and enforceable laws in this regard that will better protect families and children."

Ombudsman conducted a two-day site visit to begin interviewing citizens, DCFS employees, and child welfare professionals about the situation in Colville.

Following the Ombudsman's August site visit, OFCO experienced a significant spike in complaints received from the Colville community. To illustrate, between April 2008 and June 2008, OFCO received one complaint related to Colville DCFS; in contrast between July 2008 and September 2008, this increased more than ten-fold, with 11 complaints coming in.[5] Between August 2008 and March 2009, the investigative team spent a significant amount of time investigating these complaints and intervening with the agency in cases where OFCO found a violation of law, policy, or procedure or that the agency's action or inaction was clearly unreasonable or harmful.[6]

Additionally, OFCO conducted extensive interviews of community members working in the child welfare field or directly affected by dependency/termination cases involving a family or child involved with DSHS/DCFS. In October 2008, the Ombudsman had further contact with Area Administrator (AA), Kris Randall, to discuss practice concerns. The AA acknowledged there were areas of practice needing improvement, stated that efforts would be made to involve relatives in Family Team Decision Meetings (FTDMs)[7] to a greater degree, and improve the operation of Child Protection Teams (CPTs)[8] by putting into place a CPT coordinator who was a DCFS supervisor from outside the local office. She also stated that a stakeholder survey would be conducted so that the agency could gauge the community's perception of the agency[9]. OFCO monitored these promised improvements, but found that complaints continued to flow to the Ombudsman alleging a host of concerns, including concerns about how CPTs were conducted.

On March 18, 2009, Stevens County Prosecuting Attorney, Tim Rasmussen, sent a letter[11] to Governor Christine Gregoire; Attorney General Rob McKenna; Kelly Stockman Reid, Executive Director of the Washington State CASA program; Mary Meinig, Director Ombudsman of OFCO; Representative Joel Kretz and other legislators; and Children's Administration staff addressing his concerns about child welfare practice in Stevens County.

---

[5] See chart on p. 71 of this report on complaints OFCO received between 2007 and 2009 related to DCFS offices in Colville, Newport, and Republic. It should be noted that there was an overall corresponding rise in complaints throughout Region 1 between June 2008 and September 2008.

[6] WAC 112-10-070 provides that "OFCO interventions may be initiated when, upon investigation, the ombudsman determines that an administrative act is harming or has placed at risk of harm a particular child or parent. OFCO may not intervene until the ombudsman has made such a determination." See also RCW 43.06A.030; WAC 112-10-040

[7] Family Team Decision Meetings (FTDM) convene family members, relatives and foster parents caseworkers, other service providers at critical decision points (prior to removal, placement changes, and exit from care) to identify the best course of action, and ensure child and the adults who care for them have necessary support.

[8] Child Protection Teams (CPTs) are mandated by RCW 74.14B.030 and Governor's Executive Order 94-04. CPTs consist of at least four persons, selected by the department which provided services to abused and neglected children, and/or their parents. "The teams shall be available for consultation on all cases where a risk exists of serious harm to the child and where there is dispute over whether out-of-home placement is appropriate."

[9] It is OFCO's understanding that DCFS is in the process of developing this survey and it may be completed by Fall 2009.

[11] Letter from Rasmussen in Appendix F of this report.

Mr. Rasmussen stated "I solicited information from the public and received responses to my request from many people. Many provided documents to me which substantiate serious concerns." He acknowledged, however, that "Some people have shared concerns with me, but I am unable to obtain documents which might support those concerns because of the confidential nature of the documents and the rule preventing access to court files except by parties to the actions." He further stated that, based on "solicit[ing] information from the public and receiv[ing] responses to [his] request from many people", he believes that:

- A pattern of misconduct exists that has resulted in corruption of the meaning of the statutes;

- CPS workers have apparently developed a pattern of 'shopping' for health care providers and counselors who are supportive of their objectives;

- The department occasionally attempts to keep children from contact with the CASA;

- The department regularly does not abide by regulations requiring advance notification to foster parents of removal of a child from a foster placement; and

- Relatives are not notified or considered [for placement], and when they do request contact with the child, the department resists or creates obstacles to the contact.

On March 30 - April 2, 2009, the Ombudsman returned to Stevens County over four days to conduct additional interviews of community members and DCFS staff. During this timeframe, Director Mary Meinig apprised the Governor of the status of the investigation.

On March 31, 2009, Attorney General Rob McKenna responded to Mr. Rasmussen by letter.[12] Attorney General McKenna, noted that OFCO had initiated an investigation and was in a "unique position to investigate complaints related to agency action or inaction and has the power to intervene in cases where an agency may have acted in an unauthorized or unreasonable manner. The OFCO also can identify system-wide issues and make appropriate recommendations for change."

On April 1, 2009, the Governor responded to Mr. Rasmussen's letter.[13] She too made it clear that OFCO was conducting an investigation and noted that OFCO is authorized to access confidential case records and to interview state staff and clients. She also stated that DSHS had "dispatched three staff from across the state to Colville to take a deeper look into the specific issues that you have raised."

[12] McKenna letter attached in Appendix F to report.
[13] Gregoire letter attached in Appendix F to report.

On April 6, Randy Hart, interim Assistant Secretary of Children's Administration issued a press release on behalf of DSHS addressing Mr. Rasmussen's letter.[14] Mr. Hart stated that: "The safety and well being of children is the Department's core mission and overarching concern. We take very seriously allegations that Children's Administration leadership and employees are not taking steps to protect children or are disregarding their safety and needs." He went on to say that DSHS had asked OFCO to undertake an independent review and that the Ombudsman had "been in ongoing communication with the Department regarding specific cases." He sought to reassure the public that "Children's Administration headquarters and Region 1 management have been working with the Colville office, legislators' offices and the community regarding concerns previously expressed about individual cases. In October 2007, the Colville office underwent management changes. We appointed a new area manager to cover Colville, Newport and Republic. This change reduced the span of control for that manager, allowing more focus on the area. We have been actively engaged with this office through case reviews, office and community visits and ongoing case reviews by staff teams for more than a year and a half."

Throughout April 2009, the Ombudsman met with Attorney General McKenna and Representative Kretz, Representative Short, Senator Morton and Senator Stevens regarding concerns about the Colville area.

Purpose

Consistent with its statutory role and mission,[16] OFCO conducted this investigation to:

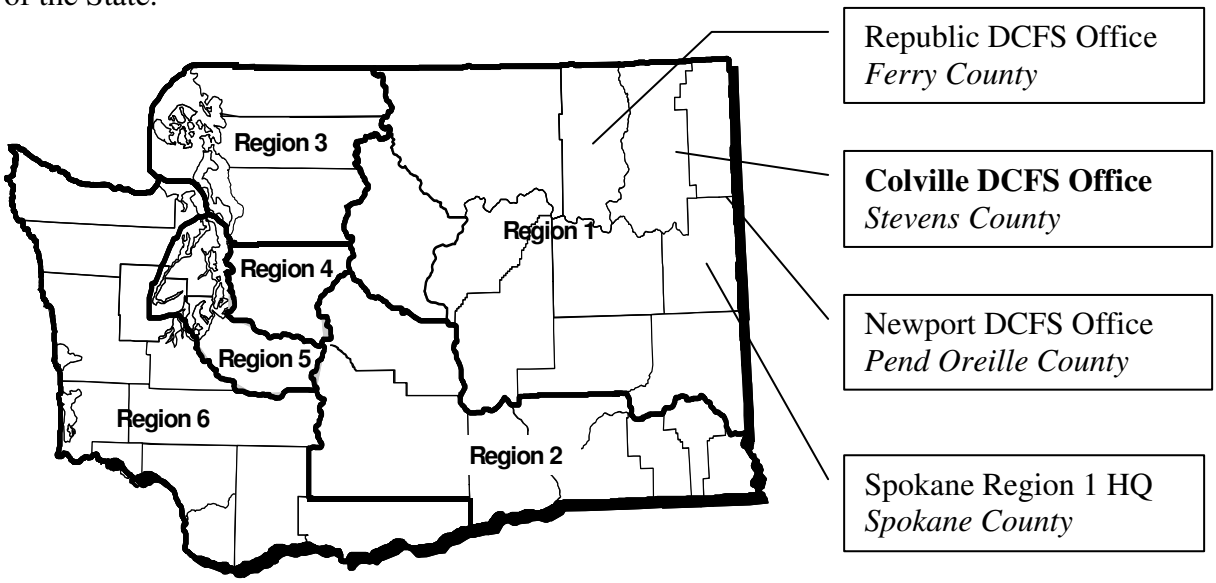
- Determine whether DSHS/ DCFS is following law, policy, and procedure in decisions affecting children alleged or determined to be abused, neglected, or abandoned.
- Identify specific areas of systemic deficiencies.
- Formulate recommendations for DSHS, the Legislature & the Governor to improve child welfare practice.

[14] See April 6, 2009 DSHS Press Release by Randy Hart, interim Assistant Secretary of Children's Administration. Available at http://www.dshs.wa.gov/mediareleases/2009/pr09052.shtml. A copy of the full text is included in Appendix F of this report.

[16] In 1996, the Office of the Family and Children's Ombudsman (OFCO) was established by the Washington State Legislature as an independent office within the Office of the Governor under Chapter 43.06A RCW. OFCO's mission is to ensure that government agencies respond appropriately to families and children involved in the child welfare system, by: 1) promoting public awareness and understanding of family and children services, 2) intervening in cases in which we have determined that an agency's action or inaction is unauthorized or unreasonable, and 3) identifying system-wide issues and recommending appropriate changes in public reports to the Governor, the Legislature and agency officials.

Scope of Investigation

The Department of Social and Health Services (DSHS) is the state's largest provider of child protection and child welfare services.[17] The work of DSHS is administered across six regions of the State.



This investigative report focuses on child welfare practice and systemic issues across three counties, known as the tri-county area, within Region 1:[18] Stevens, Pend Oreille and Ferry counties. It also provides data and findings on case specific complaints the Ombudsman received and completed investigating from approximately January 1, 2007 to May 1, 2009 related to cases originating out of DCFS offices located in Colville (Stevens County), Newport (Pend Oreille County), and Republic (Ferry County). OFCO completed and closed investigations on 44 out of the 62 complaints. The Ombudsman made 16 adverse findings during the course of investigating these complaints. Currently, there are 18 complaints still open and being actively investigated by OFCO.[19]

Based on Representative Kretz's initial request for investigation and a review of OFCO complaints, OFCO addresses three broad areas of concern: 1) A negative view of Colville DCFS by the surrounding community; 2) the alleged failure of DCFS to follow legal requirements; and 3) alleged lack of accountability in the system.[20] In addressing these concerns, OFCO outlines applicable law, policy, or procedure; includes excerpts from the

[17] As the state agency that administers child protection and child welfare programs, DSHS CA, Division of Children and Family Services (DCFS) is the primary agency over which OFCO provides oversight.
[18] Each region has a regional office. Spokane is the regional office of Region 1. The other seven offices that fall within Region 1 are Colfax, Colville, Moses Lake, Newport, Omak, Republic, and Wenatchee.
[19] OFCO anticipates issuing a supplementary document in 2009 setting forth the results of those investigations.
[20] These last two areas of concerns involve case specific complaints or issues relevant to all three counties: Stevens, Pend Oreille, and Ferry.

results of our interviews of numerous community members;[21] provides data on the number of complaints in which citizens identified these issues as areas of concern; and provides examples of case specific complaints and the results of interventions[22] by the Ombudsman. Additionally, OFCO makes findings and recommendations to improve practice.

Community

Child welfare practice in a community reflects a complex set of factors: the demographics of the community served and its physical setting, the availability of resources, the quality of child welfare agency practice, service providers, legal representation and leadership from the bench and the culture and history of the community. The tri-county area, which encompasses Stevens, Pend Oreille, and Ferry counties, is located in the Northeastern part of Washington State. This is primarily a rural area.

Geographic & Economic Factors

- Eastern Washington has roughly twice the land area and one-third the population of the Western side of the state.

- These three counties, although sparsely populated, cover approximately 6,000 square miles. Ferry County is Washington's least densely populated county.

- The tri-county area relies primarily on timber, agriculture, mining, tourism, and recreation. The timber and mining industries has experienced significant declines over the past several years, resulting in fewer jobs available. This combined with the country-wide economic slump has created financial hardship for many families.

- Many families subject to DCFS oversight are geographically isolated—they reside in remote settings that are not easily accessible.

- The distance required to travel to, from, and between DCFS offices, medical providers, schools, and other services can be substantial. Cell phone reception is poor.

[21] In determining how much weight to give interviews, we considered the credibility of the person being interviewed; whether information provided was corroborated by other sources; and possible bias in the opinions provided.

[22] OFCO intervenes to induce DCFS to take corrective action if OFCO concludes that DCFS has clearly violated law, policy, or practice, or otherwise engaged in "bad practice" that harms a child or family.

- The rural topography affects travel time. This area is comprised primarily of rural two lane roads that cannot be traveled safely at a high rate of speed. Harsh weather conditions during the winter months can also be a factor that can make traveling difficult.

Approximate Distance & Travel Time Between DCFS Offices

	Colville	Republic	Newport
Colville	-	-	-
Republic	52 miles 1.4 hours	-	-
Newport	79 miles 1.6 hours	131 miles 3 hours	-
Spokan*e Region 1 HQ*	71 miles 1.5 hours	123 miles 3 hours	47 miles 1 hour

Demographic Factors

To understand the complexity of the systemic problems in the child welfare system, it is necessary to consider the composition of the community being served by DCFS. Law, policy, and procedure alone, while providing a necessary framework for analysis, provides a too narrow prism though which to examine child welfare practice. Our interviews of stakeholders brought to life the importance of geographic, social, and economic factors on the child welfare system. It shapes not only resources available in the community, but the vulnerabilities people may be susceptible to, biases they may have and the choices they make. **In comparison to the rest of the state, the tri-county area is a mostly rural community with a significantly lower median family income.**[23] These factors influence how people interact with one another and their communication style – their willingness to share information, to trust in other professionals, to recognize the limitations of ones' knowledge, the ability to cede control in certain instances, and the readiness to collaborate and cooperate with others who may present a difference of opinion.

Additionally, because these counties are less sparsely populated, it increases the likelihood that parties and other stakeholders on a particular child welfare case know each other in some capacity. They may be related to one another, be a friend, neighbor, or colleague, or even married to one another. This creates a greater likelihood of conflict of interest, and a perception of bias. It may even shift the boundaries of confidentiality.

DCFS, Judiciary, Legal Representation, CASA & Law Enforcement

There is certain overlap in professionals that service the tri-county area, such as the same two superior court judges who preside over most of the dependency and termination fact-findings for all three counties and the same Children's Administration Area Administrator (AA) who supervises child welfare cases in this area. Other roles are distinct to each county. For example, each county has a different CASA/GAL program manager. Please see the chart entitled "Select

[23] Please see chart on page 76.

Tri-County Child Welfare Resources" on p. 70 of this report for a county-by-county description.

Historical Factors

The history of child welfare practice within a particular community influences current practice, especially those cases which sit in the collective conscience as reminders of where the system failed. These are the ghosts of children past--children who have died or were significantly injured while under the care and supervision of the child welfare agency charged with protecting them. Other times the system's failing may not result in the death of a child, but results in significant trauma to children and families who are the subject of state oversight and to the professional providing services to them. For a discussion of three cases that have a bearing on child welfare practice today please see the section "History Influences Current Child Welfare Practice" on page 68 of this report.

I. DISCUSSION OF AREAS OF CONCERN

Negative Perception of Colville DCFS by the Community

There is a serious crisis of confidence in the child welfare system in Colville – this much is clear after ten months of talking to the Colville community and investigating case specific complaints. In its most elemental form it is ***a loss of trust.*** This lack of trust has led to an erosion of confidence that permeates all aspects of the child welfare community in Colville. This is not to say that stakeholders did not praise some DCFS workers and supervisors or compliment certain case work practices – they did. However, criticism of Colville DCFS came from every significant sector of the child welfare community, including from within the agency itself.

Our conversations with the community took many forms – informal, formal, in-person, over the phone, one-on-one, small groups, private offices, public spaces, emotional and tear filled, angry and passionate, cool and detached, hope-filled, and resigned. Our goal was to try to connect with as many people as possible within our purview and resources. This ran the gamut from those who were identified by stakeholders as significant players in the child welfare system, such as parties to dependency proceedings: parents, DCFS, and CASA; to representatives of parties: the Office of the Attorney General, local prosecutors and defense attorneys; care providers for children placed out of the home: foster parents and relatives; professionals providing necessary services to families: the medical and mental health community, child advocates, and other agency contracted providers; other professionals intrinsic to the system: law enforcement and court administrators; to personally affected family members, and ordinary citizens concerned about a family they know or perhaps had heard about on the news.

Participants and stakeholders describe a child welfare agency that is arrogant, unyielding, unpredictable, and irrational. Professionals criticize DCFS decisions as being overly secretive and they cite the agency as using the confidentiality laws that govern dependency cases as a shield to hide flawed decision-making. This undermines the community's trust and leads to its perception that the agency is not accountable for its actions. It has also led to growing disrespect for DCFS. The community expressed very little faith that things would improve in the near term,[24] but expressed a shared priority of wanting to protect children and provide them with positive outcomes. Most agreed this meant ensuring children are in permanent homes that are safe, stable, and nurturing.

Some of the most critical comments about DCFS came from within the ranks of the agency itself. DCFS workers expressed a lack of confidence in the management team at Colville DCFS: their lack of experience, lack of credibility and veracity, and their alienation of the medical community in particular.

[24]Both the community's harshest critics and supporters recognize the difficult work of DCFS: *"Unfortunately, CPS is a very unloved job here. Quite often [the agency]. . . if they react too fast before putting a case together, they are "damned" as guns blazing without having a case; if too slow and the child gets injured, then they are damned as not acting fast enough. It is pretty much a thankless job. . . ."*

OFCO Systemic Findings:

1. The **community identified child safety as its # 1 priority and shares the goals** of reducing the length of time that children are in out-of-home care and implementing case plans that serve the best interest of children subject to state oversight.

2. There is a **lack of trust** between parties and among stakeholders in the Stevens County/Colville area[26] that **undermines decision making** in dependency cases and **puts children at risk of harm.**

3. **Poor communication, an absence of collaboration and cooperation, and a lack of transparency in the decision-making of DCFS has eroded trust.**

4. The **community does not believe that DCFS is held accountable for its actions.**

5. The community is **not confident in leadership within the Colville DCFS office**. The current Area Administrator is stretched too thin – covering 3 counties over a large, mostly rural, geographic area with significant travel times.

6. **Community professionals do not feel respected and the relationship between Colville DCFS and professionals is severely strained.** The input professionals provide to the agency is not adequately considered and this contributes to their distrust of the system. There is **significant friction in the relationship between Colville DCFS and the Stevens County CASA program.** DSHS/CA and the CASA/GAL program are perceived by the other as being inflexible, unreasonable, and dishonest. **DCFS Colville has alienated the medical and mental health community in Stevens County** by bypassing available medical and community mental health professionals in Colville to rely on medical care in Spokane or private mental health contractors.

7. **Parties are not clear on the roles and responsibilities of other entities**. This blurring of roles creates unreasonable expectations which fuels conflict and leads to potential conflicts of interest which can result in actual or perceived bias in decision making.

8. The Stevens County CASA program oversteps its role at times by attempting to exercise duties of DCFS. CASA has the legal authority to independently gather information about the child to make an informed recommendation to the court, but should not conduct investigations into child abuse or neglect that run parallel to agency investigations.

9. DCFS has created barriers to CASA's ability to formulate independent recommendations to the court as to the best interest of children by unreasonably interfering with CASA's contact with children.

[26] Interview subjects did not identify this as a significant factor in Ferry or Pend Oreille counties.

10. Although parties may take issue with certain decisions, the judiciary is respected by all parties.

11. There is a natural power imbalance between parents and DCFS which leaves many parents feeling vulnerable, angry, fearful, and intimidated about the dependency process.

12. The anger and emotion within the Colville community exposes DCFS workers and supervisors to an increased risk of physical harm.

13. **DCFS does not consistently provide foster and relative care providers with notice of hearings and shared planning meetings or explain clearly why** a child is being removed from their care.

14. DCFS has removed children from relative caregivers even in cases when they have not been abused or neglected.

15. **Limited judicial officers** restrict the capacity to hear contested cases and move cases toward permanence on a timely basis.

16. **The rural nature of the tri-county area adds to the difficulty** of serving this community. Although OFCO did not find, on average, excessively high caseloads, the travel time required for agency caseworkers to conduct health and safety checks, and to take children to visits and other services can be significant and adds to the workload.

Discussion of Systemic Findings

Loss of Trust

Members of the Colville community do not trust each other or "the system" to make decisions that are in the best interest of children and they fear it is putting children at risk of harm. Participants communicate poorly, and show little civility and respect in their interaction with each other. The problems identified here are exemplified by the rapidly deteriorating relationship between the Stevens county CASA program and the Colville DCFS program represented by the Office of the Attorney General.[27]

The relationship between DCFS and community professionals, especially medical and mental health providers in Colville, is also greatly strained. This too has an adverse impact on child safety and well-being. As one medical professional noted: *"[T]he level of trust has deteriorated to a level that I hesitate to even get involved with the child welfare system but certainly if the lines of communication were open and more productive, cooperation could certainly begin to happen again."*

In OFCO's interviews of DCFS, the CASA program, AGO, and medical and mental health providers, they were quick to acknowledge that their relationship is in disrepair and that trust

[27] Dependency cases are handled primarily by AAG, Kelly Kronkight.

must be restored to improve the system. They recognize that trust is essential to a well functioning system in which different segments of the child welfare community draw on each others' expertise and collaborate to make decisions. What is less clear is the solution.

Eight (8) of the 62 complaints that OFCO received raised "trust" issues about the agency's practice. For example, complaints alleged the agency had unreasonable expectations of families, inaccurately reported information to police, based its decisions and/or findings on information from unreliable sources, and lacked professional boundaries such as releasing unredacted case files.

The lack of transparency in the agency's decision-making contributes to the lack of trust. *"[A] Lack of trust in our situation stems from a combination of secrecy, lack of respect, bypassing physicians in Colville, and not listening to our input when it is given . . .it also relates to a direct breakdown in the function of the CPT team . . . ." [medical professional]* Greater transparency is needed to help restore trust in the system or point the way to where improvements must be made.

Community members point to the **agency's refusal or inability to explain the basis of its decisions as evidence of the agency's lack of transparency.** They also cite DCFS's **intentional withholding of information** the agency deems confidential as contributing to an air of secrecy. OFCO found this assertion to be corroborated by our investigations and such agency action to be problematic. The agency seldom provides professionals outside of the agency with all relevant data, so it makes it difficult for them to provide meaningful input to the agency. It also leads non-agency stakeholders, based on the more limited information they have before them, to conclude that the agency's recommendations may not be in the best interest of a particular child.[28] Professionals had this impression even in a number of cases where OFCO found the agency decision to be legitimately based on reasonable concerns. Until professionals from outside the agency have the benefit of more information, they will likely continue to conclude that the agency's decisions are flawed. The lack of transparency has undermined their overall confidence in the agency's decision-making.

Mandated reporters are reluctant to make referrals of possible child abuse or neglect because they lack confidence in Child Protective Services's handling of the referral. In short, they fear that the agency's response will not be targeted to help families, but instead will be heavy handed and result in the removal of children from families who instead could have benefited from voluntary services in the home that could keep the family together.

The lack of open communication leaves professionals and families with the feeling that there is little logic behind decisions. Reflecting a common sentiment expressed to OFCO, one

[28] In some cases that OFCO reviewed, we found the agency decision was legitimately based on reasonable concerns, but perhaps because outsiders were not given the benefit of certain information, they concluded that the decision was flawed.

professional stated: *"[The agency's] chaotic, inappropriate, and unpredictable irrational decision making"* undermines our confidence in the system. This element of unpredictability is reinforced by the opinion of many in the community that the agency is inconsistent in applying confidentiality restrictions: *"Things can get so tied up in confidentiality – staff then extrapolate restrictions"* in a way that results in very inconsistent interpretations about what information is restricted.

The community repeatedly painted a picture of a closed, insular environment in Colville. Non-agency professionals find it difficult to be integrated and made a point of contrasting this to other jurisdictions where this is not a problem. One DCFS contracted service provider commented that: "*It is more difficult for me to get direct answers and to access information [in Stevens County] that I have no problem getting in other areas."* A DCFS employee remarked that: "[*In Colville I am not invited to unit meetings within the Department unless it is specific to what I do. It is hard to work into acceptance here. In other offices I am totally welcomed."*

Reinforcing OFCO's finding that information is unreasonably withheld in Stevens County, OFCO experienced its own difficulty in obtaining information to which it is entitled. This, however, was not from DCFS, but from Stevens County Superior Court. OFCO requested a transcript of court hearings on a dependency matter. OFCO is entitled to this information under its authorizing statute[29] which empowers OFCO to gather information to investigate actions by a government agency related to a dependent child and as a "juvenile justice or care agency" which gives it access to files and records retained by juvenile court.[30] This is the first time in its 13 year history that the Ombudsman can recall having a request for such records denied. Although OFCO was ultimately successful in acquiring the records from other channels, it caused unnecessary delay and added work and reinforced our concerns about information being inappropriately withheld.[31]

OFCO finds that the agency's application of confidentiality restrictions is frequently cast too broadly and it undermines the ability of outside professionals to provide valuable input in areas of shared decision making when they are not given the whole picture. WAC 388-15-029 provides that: "(1) CPS in the conduct of ongoing case planning and consultation with those persons or agencies required to report alleged child abuse or neglect under RCW 26.44.030[32] and with consultants designated by CPS, may share otherwise confidential information with such persons, agencies, and consultants if the confidential information is pertinent to cases currently receiving child protective services."[33] Yet, despite the legal

[29] Chapter 43.06A RCW.
[30] RCW 13.50.100.
[31] OFCO letters requesting transcript and the Steven's County court's response is Appendix F to this report. Identifying information has been redacted.
[32] RCW 26.44.030 designates as mandated reporters of child abuse or neglect "any practitioner, county coroner or medical examiner, law enforcement officer, professional school personnel, registered or licensed nurse, social service counselor, psychologist, pharmacist, employee of the department of early learning, licensed or certified child care providers or their employees, employee of the department, juvenile probation officer, placement and liaison specialist, responsible living skills program staff, HOPE center staff, or state family and children's ombudsman or any volunteer in the ombudsman's office."
[33] See also RCW 74.13.031, 74.04.050, and chapter 26.44 RCW.

authority granted to DCFS to share information with other professionals to aid in its decision-making, OFCO was provided with many examples where the agency failed to do so.

Child Protection Team (CPT) staffings in particular were identified as one arena in which information is inappropriately withheld:

> A professional from outside DCFS who is a Child Protection Team (CPT) member was asked to attend a CPT to help determine placement of a dependent child. The child was in a long time foster care placement and the issue before the CPT was whether to remove the child from the foster home. The CPT member described their discomfort when agency employees were exchanging furtive glances and it became clear there was information relevant to the issue that was not being provided. The CPT member inquired and was finally told that a referral had been received on the foster home. When the CPT member asked what it was about, the agency informed the CPT member that it was "confidential" information and could not be disclosed. The CPT member pondered to themselves how they could make an informed recommendation if they did not understand the nature of the allegations. The CPT member asked if they could at least know if it related to child safety concerns. After much pushing and prodding, the agency conceded that it did not. The CPT member did their best to weigh in on the situation without knowing the specific allegations, but believed they were hampered in their ability to make a recommendation.

The purpose of CPTs is to "provide consultation and recommendations on all cases where there is a risk of serious harm to the child and/or where there is dispute over whether out-of home placement is appropriate."[34] The goal is to reach the best possible decision for the child. "Each CPT consists of at least four persons, selected by the Regional Administrator, from professions that provide services to abused and neglected children and/or the parents of such children. Participants include law enforcement officers, physicians, mental health and substance abuse counselors, or other mandated reporters of child abuse and neglect."[35]

[34] See DSHS, Children's Administration Volunteer Handbook—Child Protection Teams, February 2003. http://ca.dshs.wa.gov/intranet/manuals/CPT%20Manual.pdf; RCW 74.14B.030 and Governor's Executive Order 94-04

[35] See DSHS, Children's Administration Volunteer Handbook—Child Protection Teams, February 2003. http://ca.dshs.wa.gov/intranet/manuals/CPT%20Manual.pdf

OFCO Recommends:

- Require DCFS to **provide CPT members with source documentation** from service providers on cases subject to consultation and provide legal basis for withholding information if it is not being shared.

- Office of the Attorney General should collaborate with defense bar and state wide CASA program to **conduct improved and ongoing training of DCFS on confidentiality requirements** under the law as they relate to dependency process. Encourage DCFS workers and supervisors to staff issues of confidentiality with AGO if uncertain whether information may be shared.

Professionals criticize the CPT in Colville as not being fairly comprised of a cross section of community professionals. Instead of bringing in the objective opinions of professionals who do not have a direct, vested interest in the case, they state that the agency routinely stacks the composition of CPTs with agency workers and supervisors to pre-determine the outcome. As one frustrated professional succinctly stated, *"CPTs are a farce . . . the agency makes the decision and not the CPT members."* Management within Colville DCFS acknowledged that it was aware of this criticism and in Fall 2008 stated to OFCO that it was taking steps to address this by prohibiting caseworkers from participating in CPTs and putting into place a DCFS supervisor from outside the office to serve as the CPT facilitator. OFCO is not confident that this has resolved the problem based on ongoing complaints by community CPT participants.

CPT participants also expressed disillusionment about the lack of respect the agency showed for the opinions of other professionals:

> *"One area the lack of trust stems from [are] the comments CPS workers make in the CPT meeting. The CPS workers will make critical/negative remarks about judges, physicians and supports of the family, during the time when facts should be presented. Those comments made get back to the individuals that are talked about."[medical professional]*

Community professionals do not believe that CPTs involve a deliberative, thoughtful process as intended. Many expressed the opinion that **the agency had its mind made up even before the CPT commenced,** thus undermining its purpose. One provider pleaded with the agency *"to wait one day until the staffing could be done and the opinions of all of the team members could be heard."* They report that the agency ignored this request despite having before it issues of critical importance to the child's future. Yet another professional stated, *"It's a stare down by the department and some people are not wanting to come anymore."*

A provider who had spent years participating on CPTs finally stopped when the exercise seemed pointless. They stated, *"the policy is not followed. I think that reviewing and actually*

following and using the policy, which provides for team decision making that ***is real and not nominal****, would go a long way in improving the situation.*"[36] Ultimately this provider resigned from the CPT because they did not wish to sign their name to the roster indicating they had been at the meeting, when they felt that the meetings were not the venue for decision-making as they should be. They expressed a willingness to re-engage in the process if the meetings were once again used for their intended purpose. As illustrated in this example, the skewed CPT process causes professionals to question the usefulness of participating in CPTs and many regard it as a waste of their time. One medical provider summed it up by stating that important decisions are made "*in the hallways of CPS, . . .and behind closed doors [which is] acceptable and customary."*

Parties complained about the delay in receiving timely discovery from the agency. Defense attorneys representing parents and the CASA program in Stevens County described ongoing problems with obtaining access to agency case records. RCW 13.50.100 (10) provides that "Subject to the rules of discovery in civil cases, any party to a proceeding seeking a declaration of dependency or a termination of the parent-child relationship and any party's counsel and the guardian ad litem of any party, shall have access to the records of any natural or adoptive child of the parent, subject to the limitations in subsection (7)[37] of this section. A party denied access to records may request judicial review of the denial. If the party prevails, he or she shall be awarded attorneys' fees, costs, and an amount not less than five dollars and not more than one hundred dollars for each day the records were wrongfully denied." On the other hand, DCFS and the Attorney General's office complain about what they regard as unreasonable demands by CASA to have unfettered access to these files.

Court personnel stressed that to the extent information can be shared between different child serving agencies, this helps put people on a level playing field, makes them better informed, and results in improved decision-making. As one defense attorney noted*, "I don't play to win, I just want a level playing field."* The community emphasized that to rebuild trust, DCFS needs to exhibit a true desire to work with local providers and acknowledge that it has undermined trust by showing a lack of respect for families and professionals outside the agency. **Trust requires honest answers to difficult questions:** "*We need honest communication and open responses to the concerned individuals and the public. And then promotion of the good work done for children and families."* One long time child advocacy professional talked about past efforts that can give present guidance to improving the system: "*It took time to develop trust but first we had to understand the language. Every entity had an opportunity to list their*

[36]OFCO has had concerns about the authenticity of CPTs and prognostic staffings in other jurisdictions based on Ombudsman participation. Just as this medical provider describes, we have come away from some of these meetings feeling that the agency had made up its mind before the meeting and that the meeting was not a true airing and consideration of professional opinions, as it was intended to be. The agency appeared to go through the motions by following the letter, but not the spirit of the law.

[37] RCW 13.50.100(7)(a) provides that "If it is determined by the agency that release of this information is likely to cause severe psychological or physical harm to the juvenile or his or her parents the agency may withhold the information subject to other order of the court: PROVIDED, That if the court determines that limited release of the information is appropriate, the court may specify terms and conditions for the release of the information." Subsection (7) also sets forth informed consent requirements for disclosing information to a juvenile's parents when the juvenile has voluntarily sought counseling, psychological, psychiatric or medical services. It also authorizes DSHS to delete the name and identifying information of reporters of abuse or neglect.

frustrations but first they had to understand the principle that 85% of the problem is in the system. . . and 15% is in the people working in any system. After understanding the facts then and only then can effective change be made."

Poor communication is a problem

An overriding problem identified by almost all sectors of the community[38] is **poor communication.** Communication is especially strained between DCFS and the CASA program and between DCFS and other service providers, particularly the medical community. Professionals and families describe a communication style by DCFS employees that is dismissive, shows a **lack of respect toward those outside the** agency. They characterize agency workers and supervisors as being typically unresponsive to their **concerns**.

> A parent complained to OFCO that DCFS was not taking seriously the parent's concerns about repeated allergic reactions her two-year-old child was experiencing in foster care. The parent had informed the agency of the child's allergies to certain foods, but the child had undergone preliminary tests while in foster care indicating no allergic reaction to those foods. The foster home was continuing to provide the foods to the child.
>
> OFCO found that the agency made questionable practice decisions regarding the standard of care for this child. The child had already been in foster care for 7 months, yet the allergic reactions had not been resolved. The precipitating event for the parent's complaint to OFCO was that the child had been taken to the ER in respiratory distress. An evaluation by a specialist had been sought but not yet obtained, and the agency had been asking the parent to furnish medical records documenting these allergies for some time, but had not sought the records itself. The agency could not tell OFCO whether the alleged allergy-inducing foods were still being fed to the child by the foster parent.
>
> OFCO intervened by requesting that the agency direct the foster parent to refrain from feeding the child these foods, and independently obtain the child's past medical records.

[38]Law enforcement did not generally identify communication problems with the agency and described DCFS as professional and responsive, collaborative and good about helping people.

As one medical professional observed:

> *"[Communication] involves listening with respect, acknowledging that no one party has the one right answer, but that together the various professionals that are interested in the welfare of the child can come up with a plan that will work. Clearly, without sitting at the same table, communication cannot occur. If physicians, counselors, etc. are bypassed, communication cannot occur. If one party feels that they must be secretive about their reasons for doing things, communication is not occurring."* [medical professional]

Furthermore, they describe multiple case scenarios in which they write, call, or e mail the agency and do not get a response back. Some professionals state that even when they have been concerned enough about a family to write a letter to DCFS, they have never received a response back. This **lack of responsiveness** leads to a feeling among professionals of frustration, dismay and futility in dealing with Colville DCFS:

> *"The biggest barrier to improvement is that I just can't get anywhere. . . I have tried for years to talk to CPS, I have written letters. I have put my neck on the line and I cannot find a forum whereby we can talk about issues of concern within the system. . . Any communication from CPS would be good. I have not received anything in writing, though I have written to them on more than one occasion and I have met with [supervisors and top administrators]. . . I will continue to write letters and I would be happy to talk to individuals and to the group. I would be happy to meet and I have offered to meet with CPS workers, as a group of providers, but I have not received a response these last three years."* [medical professional]

Moreover, **problems with communication are not limited to professionals who may have a different agenda than DCFS.** At least one attorney representing DSHS wished for more of a dialogue between the agency and their office. This was not solely blamed on the agency but seemed to stem, in part, from the perception that the workload is so high that it makes it difficult to carve out time to talk. The good news is DCFS and its attorney have talked and are scheduling regular sit down sessions with each other in the near future to strategize about cases and to keep each other mutually apprised about issues of concern.

Agency workers also expressed frustration about communication with their supervisors. They described receiving mixed directives and being instructed more recently not to staff cases outside of their unit. Some workers did not understand the rationale for this policy and expressed the view that this makes the decision-making more insular, they have fewer colleagues with whom to staff cases, and it limits the pool of seasoned colleagues whose expertise they can draw upon.

OFCO finds that **the agency is not as responsive as it needs to be. The agency needs to make improvements in its communication both within and outside of DCFS and this needs to be a priority.**

Challenges with communication were expressed by the CASA community as well. The CASA program complained of not being notified by the agency when children on their caseload are the subject of a CPS investigation. RCW 26.44.030 was amended in 2008 to require: "Upon receiving a report of alleged abuse or neglect involving a child under the court's jurisdiction under chapter 13.34 RCW, the department shall promptly notify the child's guardian ad litem of the report's contents. The department shall also notify the guardian ad litem of the disposition of the report...." **OFCO testified in support of notifying GALs when a child on their caseload is the subject of a CPS referral or residing in a foster or relative placement subject to investigation.**

There continues to be significant conflict between CASA and DCFS over information sharing. OFCO finds there is a lack of clarity about what details DCFS is obligated to share with the CASA. This issue arose specifically in the context of a pending DLR/CPS investigation into allegations of abuse/neglect in a foster home. As part of that investigation, OFCO asked the agency about information sharing. The agency responded that "[t]here is no specific reference regarding the sharing of information with CASAs, or practice specific to CASAs, in the current Child Abuse and Neglect Section Practice Guide Investigating Abuse in State-Regulated Care."[39] This needs to be clarified.

In the meantime, CASA believes the agency is unfairly restricting its ability to independently investigate cases to make an informed recommendation to the court about the child's best interest. DCFS believes that CASA is overstepping its bounds and attempting to conduct a parallel investigation into allegations of abuse or neglect. OFCO finds this is neither the CASA's role, nor do CASAs have the expertise to conduct forensic interviews.

At the core of each entities' perspective is a lack of confidence in the other to do its job. DCFS complained that in one case affecting several families, the CASA lacked professional objectivity over a person who was the subject of agency investigation. The agency believed strongly that what it viewed as a "conflict of interest" arising from the CASA's pre-existing relationship with a foster parent clouded the CASA's judgment. The agency was also concerned that the CASA would inappropriately communicate confidential information. In turn, the CASA had significant doubts about the integrity of the DLR/CPS' investigation. They were offended by the accusation of conflict of interest and believe they took scrupulous steps to avoid this despite personally knowing the subject of the agency's investigation. This situation came to a head and resulted in delayed permanence for children. It also required court intervention because the parties could not figure out how to amicably navigate the case with each other. These problems will not be remedied without mediation from the outside and clarification about information sharing, and roles and responsibilities.

Families and professionals alike complain that the agency focuses excessively on the deficits of a family rather than on focusing on how individuals can use their strengths to overcome problems. Parents often feel that because they are struggling in caring for their children, the agency discredits what they have to say:

[39] Darcey Hancock, Office of Foster Care Licensing, Administrator of Division of Licensed Resources, provided OFCO a description of the agency's understanding of information between DLR/CPS and CASA. This is in the Appendix C of this report.

> *"They wouldn't listen to me because they thought it was a custody battle. . . The caseworker told me I was a bad mother for not having a parenting plan in place. . . CPS refused to protect my children from my spouse's abuse."*

They also cited many instances in which information was misconstrued by the agency by being taken out of context and used to advance the agency's position. The following case example illustrates this as a recurring theme in the agency's decision-making on the case.

The grandparents of a 3-year-old non-dependent child contacted DCFS requesting assistance with protecting the child from her drug-involved mother, and with day care. The grandparents had cared for the child for 2 ½ years at the request of their daughter, a young mother who was not ready to parent her baby. The mother would show up periodically and disrupt the child's stability. The agency accepted the grandparents' request for services for day care and gradually added other services to assist them in managing the child's difficult behaviors, including in-home parenting coaching, counseling for grandparents and child, and a bonding assessment. When the in-home counselor recommended a physical restraint technique that seemed overly restrictive in relation to the child's behavior, the grandparents refused to continue services with this provider. This service refusal, coupled with the agency's perception that one of the grandparents was behaving erratically and possibly experiencing mental health problems, led to the agency staffing the case with the Child Protection Team (CPT). The CPT recommended removing the child. The agency filed a dependency petition based upon abandonment of the child by her mother, and the grandparent's "escalating potential for catastrophic harm to the child". The child was placed in foster care and psychological evaluations on the grandparents were ordered.

The grandparent's psychological evaluation found no evidence of clear mental health concerns. However, the in-home counselor had reported that the grandparent was taking multiple medications. The agency consulted with their regional medical consultant who reported that many of these drugs could have interactions that affect thinking and functioning. The evaluating psychologist recommended further assessment of the grandparent's medication regimen. CWS therefore contacted the family physician for further information. The physician informed that there was no basis for the agency's concerns about overuse of medications and possible drug-seeking behavior.

Within 3 months of the child's removal, visits with the grandparents had been reduced to 2 hours a month, despite CPS's finding that the allegations of neglect by the grandparents, as well as abandonment by the mother, were inconclusive. Within another month, visits were stopped altogether, after the child's therapist recommended no contact based on concerns about the grandparent's ability to maintain appropriate boundaries and about emotionality during visits. The grandparents did not have any contact with the child for a year-and-a-half. By then, the child had been placed in three different foster homes. The grandparents filed three motions to intervene in the dependency matter, denied each time by the court. They were therefore unable to respond to the allegations made against them in court.

The Ombudsman's investigation revealed much contradictory and incomplete information. OFCO made several requests at various decision points in the case that the agency seek clarifying or further information. The Ombudsman ultimately found that the child's removal and prohibition of contact had been clearly unreasonable, given that there had been no founded finding of abuse or neglect by the relatives, nor evidence of clear risk of maltreatment. The Ombudsman requested a full review of the case by CA Headquarters, with a view to reestablishing visits and reconsidering returning the child to the grandparents. After an extensive case review, the agency changed its position. Visits were granted by the court, but the CASA recommended against returning the child. Although the court initially concurred with the CASA, over the course of the next 9 months, the court agreed to transition the child to their care. The transition is in process.

The size of the agency can make effective communication difficult:

> *"The agency is too big, it is just too huge and has too many levels between the folks providing services [caseworkers and service providers] and those directing at the top – it's like the old parlor game of those whispering down the chain and how [the message] changes. It really complicates everything they do. They try to break it down in a way people understand, but then they over-simplify. It is just a mess. I know a lot of good people who work for the organization, but it is too hard to effect change in something this big." [community professional]*

Court personnel stressed the importance of effective communication, stating, *"It depends a lot on the individuals involved. [The system] is cyclical. . . it goes* up *and down. . . It revolves around communication or the lack of it." C*ourt personnel expressed some optimism, however, and noted that things appeared to be on an "upswing" and that discussion and interest among stakeholders has been generated largely as a result of the Table of 10[40] workshop held in August 2008 by the Court Improvement Training Academy.

> *"Improving communication means listening, learning and taking risk to go where it is uncomfortable – with respect."*

Lack of collaboration in decision making

There is a significant lack of collaboration between DCFS and outside professionals in decision making. **Professionals complain that** DCFS supervisors and some workers are arrogant. They state that they either do not ask for their opinion or when professionals do provide input, it is ignored or misconstrued.

> "*The attitude of DCFS leadership appears to be one of superiority, [it is] confrontational and unwilling to cooperate with outside providers. The supervisor out of the Spokane Office/Region 1 seems to encourage this attitude. Internal audits completed by her support actions of local supervisors. These attitudes flow down from the top to the Social Workers. 'Power' is the focus of the DCFS office instead of communication."* [medical professional]

> *"The agency doesn't listen to us… [they] bypass us… [they] whisk kids off to Spokane thinking we are biased. . . they have done this for years."* [CASA program]

[40] In August 2008, Tim Jaasko-Fisher, Director of the Court Improvement Training Academy (CITA)[40] conducted a "Table of 10" two day training session bringing together significant players in Stevens and Ferry counties. CITA's mission is to: "create a learning community comprised of judges, lawyer, and other professionals involved in the juvenile court dependency process. This learning community will bring together innovative research and practical solutions to improve the operations and decision making in courts deciding actions under RCW 13.34." http://www.uwcita.org/CITAv1008/tablesoften.html.

A community professional alleged that DCFS unreasonably refused the CASA's request to reschedule a Child Protection Team (CPT) meeting that they were unable to attend. The goal of the meeting was to obtain the CPT's recommendation and input regarding the agency's plan to return three dependent children to their parent. The agency was aware that the CASA disagreed with this plan.

OFCO investigated and found that DCFS was aware that the scheduling of the CPT conflicted with a long-standing work commitment of the CASA and intended to proceed with the meeting despite the CASA's direct request that it be rescheduled.

OFCO intervened to request that the agency reschedule the meeting to ensure the CASA's views could be presented in person to the CPT for their consideration. The agency rescheduled the meeting to ensure the CASA could participate.

Families also complained about the agency's attitude and what they perceived as the agency's abuse of authority. One citizen who reported to OFCO that they were having a neighborhood dispute with a DCFS employee stated:

> *"Our concern is that [the social worker] is abusing her authority at CPS. We believe she obtained information about my family by using her connections with CPS. . . Her coworker said to us that he was doing this 'as a favor for a co-worker.'"*

A parent complained to OFCO that highly personal information was disclosed by CPS to law enforcement: *"Private and personal papers were provided to persons who never should have received them."* Although OFCO was unable to establish whether actual harm to the individuals involved occurred following this disclosure, in a small community this kind of violation of confidentiality, even in error, can have personally devastating consequences.

Lack of collaboration can lead to insularity and polarization of opinions: *"I worked in Chelan County during the Wenatchee sex abuse scandal. It was the most bizarre thing I'd ever seen. It became the focal point of our training of what happens when we get insular. Collaboration is important."* Law enforcement also emphasized the need for a multi-jurisdictional approach in sparsely populated communities with scarce resources.

Medical providers consistently complained of agency workers bypassing the physicians in Colville to seek the same level of medical care in Spokane. Short of this, they state that their input is often ignored or marginalized: *"I think it is safe to say that most of the physicians in Colville feel powerless to be heard or enact any change in the child welfare system or the cases involving our patients. Even when I have called to talk to CPS or met with workers, decisions have been made seemingly ignoring my input."* At a minimum, medical providers would like a reasonable explanation from the agency when it departs from the provider's recommendation:

"I think we need to be intimately involved in the cases and management that involve our identified pediatric patients. We often know these patients and families very well and can offer valuable input. I feel when I have talked to workers in the past regarding a patient I have been met with resistance. It would be helpful to me to know that they have heard my concerns, considered them, and be able to offer me an explanation if their course of action differs from what I feel would be appropriate." [medical professional]

Professionals recognize that there are many committed people who want to help children and families, but noted that it requires collaboration to best accomplish this. "*The more parties looking at a situation the better. It forces us to take a step back and look at the evidence and consider what we have. Emotions can go off the planet" and it helps to keep this in check if you are working in collaboration. [law enforcement]*. **Improved communication** will lead to more collaboration among participants and better outcomes.

Resources are not sufficient

Resources are not sufficient to adequately meet the needs of the community and provide effective delivery of services to families.

There is inadequate court time and judicial officers to hear contested cases

A shortage of judicial officers and courtroom space lead to delays in hearing cases. In Stevens County, parties reported significant delays in shelter care hearings. Shelter care status has been extended in some cases to as long as 14 months.[41] According to the Office of the Attorney General, there is only one trial slot available every two months for contested fact finding dependency or termination hearings. At least one attorney stated that they are forced to make concessions on cases that they would not otherwise make due to the unavailability of a judge or courtroom to hear a contested matter. This calls into question whether dependent children and their families are being served as well as they could be by the court process.

The system would benefit from an additional AAG assigned to the dependency/termination rotation in Stevens County. Practice will likely be improved by providing the current AAG with another colleague who can provide another communication style and perspective. A system of checks and balances can by helpful.

CASA representation would also be improved by diversifying management responsibilities and having the local CASA program seek more guidance from the State CASA program, particularly in the areas OFCO identified as especially contested: information sharing, access to children, and the scope of CASA's investigative powers.

There is inadequate line and management staff within the agency

Both professionals outside of the agency and DCFS employees themselves cited **poor management by DCFS** as **a significant factor that negatively impacts social work practice**. Caseworkers expressed feeling overwhelmed, not getting the support they need from management, and receiving mixed messages from supervisors about what their priorities should

[41] Under RCW 13.34.070 the fact-finding hearing on a dependency petition must be held no later than seventy-five days after the petition is filed. Courts are directed to hold fact-finding hearings on a expedited basis to ensure this timeline is met.

be. They also criticized management as being overwhelmed, lacking experience, and being out of touch with the unique needs of local communities.

Caseworkers also feel that they are trying to do a job that is too big for the resources available. This factor coupled with their lack of confidence in management, and criticism from the community at large leads to a high rate of job dissatisfaction, burnout among workers, and high turnover of staff. Supervisors as well express the difficulty of working in a community in which they don't feel supported:

> *"It is hard to live in a community where the truth isn't out there . . . making workers a target in our community."*

As law enforcement observed, "*The situation is the most hazardous we deal with. It is full of raw emotion. We are coming to someone else's castle and threatening to take kids."*

The difficulty the agency has in retaining experienced workers adds to the stress of young caseworkers new to the job. It also results in lack of continuity on cases: *"The caseworker is changed every few months."*

Organizational and operational changes need to occur within the agency to improve delivery of services and facilitate teamwork: *"Working as a team with CPS makes all the difference. It cuts down all the stereotyping. You are dealing with a person not a bureaucracy. The more you can support [workers and supervisors] so [they] can do the job, the better job we can do together."*

The majority of DCFS employees (both line workers and staff working in a supervisory capacity) stressed the **need to have more peer support and a full time Area Administrator located in Colville**, rather than having one that straddles the tri-county area. They believe there is value in having an AA who lives in the local community and can develop relationships so that collaboration with outside groups is more likely to occur and have a chance at success. They also cited the benefits of having a full-time AA available to staff cases with on a daily basis.

Additional support staff are needed to provide increased support to case workers,[42] to provide assistance in meeting notice requirements and providing discovery on a timely basis and to free up caseworkers so they are able to collaborate more and team up on cases. These measures will strengthen decision- making and provide more safety when workers are going into remote areas to conduct health and safety checks on children.

[42]More staff would be helpful to provide paralegal support to review and distribute discovery to parties and to ensure parties and care providers receive timely and consistent notice of hearings and meetings.

Lack of sufficient foster homes

A lack of available foster homes limits the agency's options for placing children in out-of-home care. In interviews with OFCO, the agency, professionals and the public identified this as a concern in the tri-county area and expressed fears that a lack of available homes could result in compromising the quality of care for children. People also stated that placements are frequently too far removed from parents, services, and the child's school, or that the child is not placed with a sibling. The problem was identified as being particularly acute for adolescents needing placement:

> *"I was hopeful that with [the enactment of the] neglect [law] we would see more placements of teens, but we are still not seeing this. We hear that there are no foster homes. This is a chronic complaint in all three counties. My answer is 'I'm sorry, go make [a foster home].' The upper echelon has never wanted to acknowledge that this is a problem."*

When there are not enough homes to meet an area's need for out-of-home placement, pressure is created on the agency to grant administrative approvals to allow foster homes to accept more children than their license provides (thus overloading otherwise good homes), or to maintain marginal placements. An example of an OFCO investigation:

> The Division of Licensing Resources (DLR) received multiple referrals over several years reporting poor hygienic conditions in a foster home and lack of nurture of the foster children by the foster parent. OFCO investigated and found that DLR had been aware of a persistent strong odor of cat urine and excessive pet hair in the foster home. DLR failed to successfully address these issues with the foster parent, yet the license was maintained and children continued to be placed in the home. When a new referral reported that a foster child had experienced an allergic reaction to the conditions in the home and the foster parent had blamed the child for allowing cat hair to accumulate on their clothing, DLR began yet another investigation. At that point, the foster parent asked that the children be moved and the foster care license closed. OFCO found that DLR had failed to adequately monitor and respond to poor hygienic conditions and lack of nurturing of foster children in this foster home.

Also concerning are reports that sometimes, even when a home is licensed, the agency will not place children in the home due to concerns about that home. There needs to be consistency across DCFS and DLR – if there are sufficient concerns about a particular home to justify not placing children in the home, than the home should not be licensed.

According to CAMIS data[43] from January 2009, there were 73 state-licensed homes in Steven's County, 15 privately-licensed homes, and 3 group homes; in Ferry County, there are 5 state-licensed homes; in Pend Oreille County, there are 11 state-licensed homes and 4 privately-licensed homes.

The regional licensing office reported to OFCO that the availability of foster homes relative to the need in Stevens County has improved in recent months. It appears that more homes are becoming licensed, and the local offices continue in their efforts to recruit new homes. This is a positive development. As is the case throughout the state, more homes are always needed to accommodate adolescents, children with behavioral or special needs, and sibling groups.

More local services are needed

The majority of community members interviewed stated that there is very good medical care available in Stevens County. However, some community professionals stated there is a void in other local services. This can make it more difficult for parents to comply with services as they have to travel greater distances to participate in them or to see their children because there are limited visitation supervisors. Public transportation is not always available and the agency has imposed limits on gas vouchers to assist parents travelling by car. Defense attorneys report that these are often not adequate to provide the gasoline necessary for a parent to attend services and visitation.

According to the community, some of the services that need to be developed or expanded locally are domestic violence treatment; psychologists/counseling services by well qualified therapists, and in-patient drug/alcohol treatment programs recognized by DCFS.

In the course of OFCO's Colville investigation, OFCO also asked the agency to look into information regarding contracted providers. DCFS discovered that in at least one case, the contracted provider did not have a current contract with DSHS to provide services and had not had a contract for approximately two years. This is not permissible under existing agency policy. The Region 1 administrator is conducting a 100% review of contract providers to ensure contracts are up to date and current.[44]

[43] CAMIS is a CA computerized data base, which was developed in 1989 to document the services the agency delivers to children and families. It was replaced in January 2009 by FAMLINK. OFCO had access to CAMIS to aid in its investigations and has access to FAMLINK.

[44] April 2009 communication between OFCO Director Ombudsman Mary Meinig and Acting Assistant Secretary of Children's Administration, Randy Hart.

[47] As already noted, a number of complaints remain open and are being actively investigated. .

OFCO Recommends:

- Colville demands **full-time local leadership** to address problems. Require DCFS to appoint a full-time area administrator.

- Establish **weighted case loads** for DCFS caseworkers to account for long distances travelled in rural areas.

II. ALLEGED FAILURE OF DCFS TO FOLLOW LEGAL REQUIREMENTS

This section of our report addresses allegations in case specific complaints arising from child welfare practice in the tri-county area. These complaints were brought to OFCO's attention by a variety of citizens including family, foster parents, and community professionals.

Adverse findings and interventions by the Ombudsman

The Ombudsman made 16 adverse findings out of 44 completed complaint investigations since January 1, 2007.[47] These adverse findings may include violations of law, policy, procedure; clearly unreasonable actions; or simply poor social work practice.

- 11 of the complaints with adverse findings resulted in intervention by the Ombudsman.
- 5 of the complaints with adverse findings either did not present a basis for further action by the Ombudsman, or further action was not feasible.

The following table summarizes each adverse finding and intervention by the Ombudsman in specific complaint investigations. This table includes closed and open investigation at time of this report.

Adverse Findings Resulting in Ombudsman Intervention

I. Intervention involving Colville DCFS

Investigative Finding	Ombudsman Action	Outcome
CWS removed a 3 1/2 –year-old non-dependent child from the care of relative caregivers without evidence of abuse or neglect. This decision, as well as a decision to prohibit contact between them for a year and a half, was clearly unreasonable.	The Ombudsman requested a full review of the case by Headquarters, and asked that the agency reconsider visits between the child and relatives, and reconsider the relatives as a permanent placement.	Visitation between the child and relatives was reestablished. The child is being transitioned back to the care of the relatives. OFCO continues to monitor the case.
CWS failed to provide sibling visitation between dependent and non-dependent siblings, stating that the dependent children's service providers had recommended against this contact.	The Ombudsman requested multiple times over a seven-month period for the agency to provide written documentation of professionals' recommendations to limit	The agency agreed to provide written documentation, but never did so. Although the agency reported that the dependent children's foster parent began facilitating communication between the

	contact between the siblings.	sibling groups, later follow-up by the Ombudsman indicated that this did not occur.
CWS was unsuccessful in preventing moderate to severe allergic reactions in a 2-year-old dependent child who had been reported by the parent to be allergic to certain foods. The allergic reactions continued for several months while the child was in foster care. The agency had requested allergy testing by the child's current pediatrician and asked the parent to provide the medical records diagnosing the allergies.	Since initial test results showed no evidence the child was allergic to the reported foods, the foster mother was continuing to provide them. The Ombudsman requested that the agency ensure the suspected foods were no longer provided, seek an evaluation by a specialist (already in process) and obtain the child's past medical records directly from past providers.	The agency directed the foster parent to refrain from giving the child the potential allergy-inducing food, arranged for specialty care, and obtained the missing medical records. The child was found to have complex medical issues causing these symptoms, and received treatment.
DCFS failed to provide a 5-day written notice to the foster parents prior to removing their foster children. The Ombudsman found no sufficient evidence of a safety risk to the children to support CWS's decision to remove them from the home on an emergent basis.	The Ombudsman included this finding as an issue of concern in our request to Headquarters for a full review of the case (see related finding regarding unreasonable DLR/CPS findings on a foster parent).	A review of the case by Headquarters is in process.
DCFS failed to conduct a full relative search when an 8-year-old now-dependent child was placed in foster care. As a result, the agency excluded an interested relative, who was unaware the child had been removed from the parent, from participating in case-planning and being considered for placement of the child. The relative had contacted the	The Ombudsman requested that the agency involve the relative in case planning, and screen the relative for consideration of visits and possible placement.	The agency invited the relative to a shared planning meeting, and arranged for supervised visits with the child.

agency upon discovery of the child's situation, and was told the child was already placed with another relative.		
CWS unreasonably refused the Court Appointed Special Advocate's (CASA) request to reschedule a Child Protection Team meeting to assess the reunification plan for 3 dependent children. The CASA was in disagreement with the agency's plan to return the children to the parent, and wanted to present his assessment of the plan to the CPT, but was unable to attend the meeting as scheduled.	The Ombudsman requested that the agency reschedule the meeting to ensure the CASA's views could be personally presented at the meeting.	The agency rescheduled the meeting to ensure the CASA could participate.
OFCO found that the high level of conflict between the CASA program and the agency had interfered with timely case planning and resulted in a clear delay in permanence for these children.	The Ombudsman contacted the Attorney General's office and requested that a meeting be arranged to formally address the ongoing conflict between the CASA program and the agency.	The Ombudsman continues to monitor action taken by DCFS to address the professional conflict. To the Ombudsman's knowledge, no meeting has been arranged with the CASA program.
II. Interventions Involving Newport DCFS		
Investigative Finding	**Ombudsman Action**	**Outcome**
CWS failed to conduct health and safety checks on a 12-year-old dependent child in the child's foster home during a 7-month period. The Ombudsman did not find this violation of policy to be clearly unreasonable, as weather conditions prohibited reasonable access to the foster home throughout the winter, and the child was seen by the social worker on at least four	The Ombudsman requested that a health and safety visit be conducted at the foster home immediately.	The agency conducted a health and safety visit in the child's foster home within a week.

occasions in other settings during that period. However, the child was not seen at all for about 3 months, and the agency had still not been out to the home by mid-spring.		
A state-licensed group home failed to provide a 15-year-old dependent youth residing in group care with basic necessities (hygiene products and clothing).	The Ombudsman contacted the CWS caseworker for the youth inform her of the youth's need for personal care items. The issue had already been reported to DLR by several youth in the group home.	The youth was provided with hygiene products and clothing. DLR launched an investigation into the group home's failure to provide basic necessities to several youth.
DCFS removed two dependent children ages 8 and 7 from their relative caregiver with insufficient evidence that the children were being neglected.	The Ombudsman requested a review of the case by CA Headquarters, to consider returning the children to the care of the relatives.	The agency returned the children to the care of the relative.
III. Interventions involving Region 1 DLR (serving the tri-county area)		
Investigative Finding	**Ombudsman Action**	**Outcome**
DLR/CPS made four founded findings of abuse/neglect against a foster parent, without sufficient evidence.	The Ombudsman requested that DLR Headquarters review the basis for all of the founded findings. DLR changed two of the findings but upheld the other two.	The Acting CA Assistant Secretary agreed to review the decision-making leading to the problematic findings against the foster parent. The outcome of the agency's review is pending.

Adverse Findings Not Requiring Intervention

I. Failure by DLR to adequately protect children in foster homes

Subject of Complaint	Investigative Finding	Ombudsman Action	Outcome
Region 1 DLR	DLR failed to adequately monitor and correct poor hygienic conditions and lack of nurturing in a foster home over several years.	By the time this complaint was made to the Ombudsman, the foster parent had already requested that the agency move the foster children, and close the foster care license.	The foster home is no longer licensed. The Ombudsman investigated the subject children's current placements to ensure they were receiving suitable care.
Region 1 DLR	DLR failed to fully investigate previous allegations of abuse and neglect of foster children by a foster parent, by failing to interview the referent who could have provided additional details that would have yielded stronger evidence of maltreatment.	By the time the Ombudsman received the complaint, there had been a subsequent investigation resulting in founded findings of maltreatment. The foster home had been closed by DLR.	The children identified in the complaint had been placed in safe alternative placements.

II. Failures of communication and/or cooperation with CASA

Subject of Complaint	Investigative Finding	Ombudsman Action	Outcome
Colville DCFS	The Ombudsman was unable to find evidence to support the allegation that CWS failed to communicate details of two legally free children's adoption plan with the children's CASA. The Ombudsman found that a clear lack of trust and general lack of communication between DCFS and the CASA had hindered case planning and resolution in this case.	Since the court had halted the adoption proceedings to allow the CASA and children an opportunity to discuss the adoption plan, intervention by the Ombudsman was not necessary.	Further disagreement between professionals involved in the case hindered the outcome intended by the court. The adoption plan is now moving forward. The Ombudsman continues to monitor the case.
Colville DCFS	CWS limited CASA access to children they represented, diminishing the CASA's ability to effectively participate in case-planning for the children.	The Ombudsman was unable to intervene as this action occurred in the past and is now moot.	The Ombudsman continues to monitor action taken by DCFS to address ongoing professional conflict between DCFS and the CASA program.

III. Unprofessional Conduct by Agency Staff

Subject of Complaint	Investigative Finding	Ombudsman Action	Outcome
Region 1 DLR	A DLR licensor behaved unprofessionally in a meeting with a foster parent (to a clearly unreasonable degree).	The Ombudsman contacted the supervisor and found that appropriate action had already been taken. The supervisor had given the licensor a written reprimand, and was monitoring the licensor's performance more closely.	Upon the Ombudsman's follow-up, the licensor's interactions with clients was reported to be improved since the reprimand.

Allegation 1: Unlawful Removal of Child from Parents

Parent: *"My daughter should never have been removed from the home as there was no abuse or neglect of her. The incident reported was about rodents in the heat ducts and no smoke alarms. The caseworker interrogated my two sons…."*

> *Thirty-one out of 62 complaints received related to family separation and reunification. Six (6) out of 31 of these complaints alleged inappropriate removal of children from parents/legal guardians.*

Law: There are clear standards and protocols that DCFS and other authorized entities must follow to remove a child from his or her home and place in shelter care. Shelter care is temporary physical care of a child in a licensed facility, such as foster care, or in a facility not required to be licensed, such as relative care.[48] A shelter care hearing determines the need for ongoing out of home placement.[49]

Who can remove a child?

- **DCFS, with a court order.** RCW 13.34.050.

  DCFS may obtain a court order to take a child into temporary custody if the court finds reasonable grounds to believe that the child's health, safety, and welfare will be seriously endangered if not taken into custody. This must be supported by a petition filed by the agency[50] in juvenile court alleging that the child is dependent[51]; and a declaration or affidavit setting forth the factual basis for why the child is at risk of imminent harm.[52] A court order for removal of the child may be obtained ex parte, which means that the order is obtained without notice or the presence of affected parties. The petition and supporting documentation must be served on the parent or whomever has custody.[53]

---

[48] RCW 13.34.060.
[49] RCW 13.34.065.
[50] RCW 13.34.040 provides that **any person** may file a petition showing that there is a "dependent child".
[51] A dependent child is any child who is (a) abandoned, (b) has been abused or neglected as defined in chapter 26.44 RCW; or (c) has no parent, guardian, or custodian capable of adequately caring for the child, such that the child is in circumstances which constitute a danger of substantial damage to the child's psychological or physical development. RCW 13.34.030.
[52] "Imminent harm" includes, but is not limited to, circumstances of sexual abuse, sexual exploitation as defined in RCW 26.44.020, and a parent's failure to perform basic parental functions, obligations, and duties as the result of substance abuse. RCW 13.34.050(1).
[53] RCW 13.34.050(3).

- **Law enforcement.** RCW 26.44.050 and RCW 13.32A.050. [54]

  Law enforcement may take a child into custody without a court order if the officer or his or her designee has probable cause[55] to believe that the child is abused or neglected[56] and probable cause to believe that the child would be injured if it were necessary to first obtain a court order.[57] Alternatively, law enforcement may take a child into custody without a court order if the officer has probable cause to believe that the child could not be taken into custody if it were necessary to first obtain a court order pursuant to RCW 13.34.050 (this may be the case in situations where there is a reasonable concern that the child would be a flight risk or that the care taker might hide the child); or if a child is the victim of custodial interference, such as the non-custodial parent has taken the child without the consent of the custodial parent.[58] A written statement must be left with the parent or in the residence providing the reasons for removal of the child and the telephone number of Child Protective Services.[59]

- **A licensed physician or osteopath**. RCW 26.44.056.

  Hospitals and health care workers can hold a child against the wishes of the parent if they think the child has been abused or neglected. This provision is commonly relied upon in cases where an infant is born drug addicted and the parent has a concerning history – such as lack of pre-natal care, and possibly other children that have been removed from the parent's care.

What are Alternatives to DCFS removing a Child?

There are several alternatives to removing a child from a parent's home. DSHS must demonstrate, prior to removing a child from its home, that reasonable efforts were made to provide necessary services to the child in the home, unless out of home placement was unavoidable due to the child's safety being at risk.[60] In situations where a family may be experiencing difficulty in adequately caring for a child, but presents a low risk of child abuse or serious neglect, DCFS may put "alternative response systems" in place to offer the family voluntary services, such as intensive family preservation services designed to bolster the family's parenting and household organizational skills.[61] Another alternative to removing a child from the home is to remove an alleged offender from the home.[62] A party can obtain a

[54] Additionally, under RCW 26.44.050 a child may be taken into custody by any person law enforcement authorizes to take a child into custody. Under certain circumstances, probation counselors may take a child into custody with a court order. RCW 13.34.050.
[55] Probable cause means reasonable cause, having more evidence for than against.
[56] RCW 26.44.050.
[57] RCW 26.44.050.
[58] RCW 13.34.055.
[59] RCW 26.44.050.
[60] RCW 13.34.020 & 130.
[61] RCW 74.14D.010.
[62] RCW 26.44.063.

temporary restraining order from the court upon demonstrating reasonable grounds that an incident of sexual or physical abuse has occurred.[63]

What are the Notice Requirements and Steps after a Child is Removed?

DCFS must make reasonable efforts to inform parents that their child has been taken into custody and the reasons for this. The law requires that: "Notice must be provided in an understandable manner and take into consideration the parent's, guardian's, or legal custodian's primary language, level of education, and cultural issues."[64]

A shelter care hearing determines the need for ongoing custody and out-of-home placement of the child. A shelter care hearing must be held within 72 hours.[65] Parents must be informed of their right to a shelter care hearing and parents and other parties have the right to present testimony as to the need or lack of need for continued shelter care.[66] At the shelter care hearing, **the court must make an inquiry into several factors, including the terms and conditions for parental, sibling, and family visitation.**[67] The child must be returned to the parents unless the court finds reasonable cause to believe that "after consideration of the specific services that have been provided, reasonable efforts have been made to prevent or eliminate the need for removal of the child from the child's home and to make it possible for the child to return home" and, the child has no one to provide supervision and care; or release of the child would present a serious threat of substantial harm to the child; or the parent to whom the child could be released has been charged with the crime of custodial interference.[68]

Who is Entitled to Legal Representation?

A child has the right to a guardian ad litem or independent legal counsel to represent the child's interests, unless the court, for "good cause," finds the appointment unnecessary.[69] **A parent has the right to an attorney**, and counsel will be appointed if the parent is indigent.[70] DSHS is represented by the Spokane Office of the Attorney General in Stevens County, and in Pend Oreille County. In the less populated county of Ferry, this role is contracted out to the local county prosecutor's office.

Finding: OFCO finds there is a natural power imbalance between parents and DCFS which leaves many parents feeling vulnerable, angry, fearful, and intimidated about the dependency process.

---

[63] RCW 26.44.130.
[64] RCW 13.34.062.
[65] RCW 13.34.060. This time frame does not include weekends and holidays.
[66] RCW 13.34.062.
[67] RCW 13.34.065(4)(k).
[68] RCW 13.34.065(5)(a).
[69] RCW 13.34.100.
[70] RCW 13.34.090. An affidavit of indigency is filed with the court demonstrating that the parent cannot afford an attorney.

OFCO Recommends:

- DCFS adhere faithfully to notice requirements, ensure parents are represented by an attorney, treat families with dignity and respect even when it may take more time to do so, and address parents' concerns by communicating with them in a clear, compassionate manner.

Allegation 2: Failure of DCFS to Reunify Children with Parents

Parent: "*There are strong reasons to believe the Department is trying to aggressively terminate my parent rights and adopt my child into a foster home that cannot have children of their own. I've been in full compliance with court orders for over 6 months, and have been denied any contact for over 9 months with my child."*

"[DCFS] threatened [me] that if the judge didn't take away my rights CPS would be in my life forever."

Thirty-one out of 62 complaints received related to family separation and reunification. Four (4) out of these 31 complaints alleged failure of DCFS to reunify despite the parents' compliance with services and/or inappropriate termination of parental rights.

Law: RCW 13.34.138(2) provides that a child may not be returned home until the court finds that the reason for removal no longer exists. DCFS has a duty to make reasonable efforts to provide services to the family which are designed to eliminate the need for out-of-home placement of the child.[71] To meet that duty, RCW 13.34.136 requires that DCFS establish a written plan which specifies "what services the parents will be offered to enable them to resume custody, what requirements the parents must meet to resume custody, and a time limit for each service plan and parental requirement."

Finding: While OFCO did not find a specific instance where DCFS failed to follow the law and their policies governing reunification of children and parents, the systemic failures identified in other areas of this report have undoubtedly had a negative impact on the timely resolution of dependency cases. The inability of parties and professionals to communicate and

[71] RCW 13.34.138(2)(c)(i).

collaborate to serve families leads to unreasonable delays, changes of placements, and an inability to access timely services.

OFCO Recommends:

- DCFS must communicate clearly and consistently with parents and providers not only the services which are court ordered, but the concerns which they are designed to address.
- The judiciary and parties must ensure that services ordered are specifically designed to address the parental deficiencies which led to the need for removal of the child from the home.
- **Provide resources** to increase judicial officers, attorneys, and CASAs so that an added perspective can be brought to dependency and termination cases, cases can be heard on a timely basis and contested issues can be more effectively addressed. Also ensure that sufficient resources are available to allow parents to engage in services without delay.

Allegation 3: DCFS Efforts to keep children from having contact with the CASA

Community Professional: *"The foster parents, in concert with the agency, were limiting CASA access to the children…"*

Family Member: *"The [family] does not trust CASA will accurately represent their home or statements."*

CASA: "*Because of limited interaction between the caseworker, foster parent, and myself, I cannot determine what is truly and fully in the best interest [of the children]."*

Two out of 62 complaints received alleged that the agency was attempting to keep children from having contact with the CASA.

Law: Under RCW 13.34.105, the CASA/GAL has a duty to investigate, collect relevant information about the child's situation, and report to the court findings and recommendation as to the best interests of the child. The CASA/GAL has the right to make its recommendations

based upon an independent investigation,[72] not merely based on information provided to the CASA/GAL by DCFS. The CASA/GAL must have regular in person contact with the child sufficient to have in depth knowledge of the case, the child's progress, well being and appropriateness of placement and to make fact based recommendations to the court unless the child is placed out of the jurisdiction.

Finding: DCFS intentionally limited access between the CASA and dependent children subject to representation by the CASA in one case investigated by the Ombudsman. This stemmed from DCFS' concern that the CASA would engage the children in inappropriate conversations, seeking to influence the children's opinion about where they would like to live. Due to concerns about DCFS interfering with the CASA's contact, the court entered an order stating, in part: "CASA shall be allowed to visit with the children privately. Department is to make arrangements for CASA to have random visits with the children in the [foster] home (or at the children's activities).The [foster parents] shall not be prevented from having a 3rd party present with the [foster parents] if feasible." The court should not have to dictate the terms of contact between a CASA and child, but unfortunately it appears that it was necessary in this particular case due to the contentious relationship between DCFS and CASA.

A community professional alleged that DCFS limited the CASA's access to children they were representing, diminishing the CASA's ability to effectively participate in case-planning for the children. OFCO investigated and found that the agency had thwarted the CASA's contact with the children, as alleged. The following is an excerpt of an e-mail between the DCFS caseworker, supervisor and area administrator found by OFCO:

> *"With regards to the appointed CASAs on this case. . .everyone is aware of the ethical issues concerning these CASAs and the foster parent – [the CASA] called me this morning with regards to appts* [sic]. *She was going to attend regarding the children and I have told her those are rescheduled, but am not giving her any more information. I have instructed [the placement facility] not to give any information to the CASAs nor allow any contact with the children. I am looking for some clear guidelines here as we are suppose to share info with the CASAs and they have open access to our files and I don't want to break any policies or procedures, but am hesitant to give them any information, please advise."*

This case was remarkable not only because of the agency's clearly documented efforts to prevent contact between the CASA and the children whose best interest the CASA was appointed to represent, but because the worker clearly sought guidance from supervisors about how to handle this situation and OFCO was unable to find any evidence that the caseworker received the education and input she was seeking.

[72] RCW 13.34.105(d).

OFCO Recommends:

- **Provide ongoing training to DCFS** workers and supervisors, including at Academy, and **to CASA on respective roles, rights, and responsibilities** of parties and other stakeholders to a dependency.

- Parties need to clarify the investigative power of CASA to ensure CASA is not interpreting its investigative powers beyond statutory intent and standards established by the Washington State CASA program. DCFS and CASA should develop a mutually agreed upon and legally permissible protocol on the scope of CASA's independent investigatory power.

- **Create clear standards** by mutual agreement between local DCFS and CASA offices with input from state-wide CASA program, and Attorney General's office **on what information CASA is entitled to from DCFS case record** and establish clear protocol for DCFS to provide clear and timely notice to CASA and other parties if certain information will not be released, the basis for that decision, and the agreed upon process for parties to further seek such information.

Allegation 4: Failure of DSHS to consider relatives for placement of dependent child

Relatives: *"We just want what is best for the children, which is living with family members not someone they don't know."*

"My grandchildren were taken into custody by child protection and I was never contacted."

"I attempted to contact the caseworker and my calls were never returned."

"My grandchildren were placed in foster care and I was never contacted or given the opportunity to provide for their care."

Thirty-one out of 62 complaints received related to family separation and reunification. Ten (10) out of these 31 complaints alleged inappropriate placement of the child, with 6 raising specific concerns about the failure of DCFS to place the child with a relative.

Law: The law mandates that DCFS give priority to placing dependent children with relatives. RCW 13.34.130(1)(b); RCW 13.34.060(2). Under RCW 13.34.260(1), "the department, absent good cause, shall follow the wishes of the natural parent regarding the placement of the child."

Policy: DCFS policy provides that the social worker will work with the family to identify possible placement options and absent good cause, will follow the wishes of the parent regarding placement of the child. The social worker is to consider both in-state and if appropriate, out-of-state placement options.[73]

Finding: OFCO found two cases in which policies regarding relative placement was not followed. In one case, a relative had not been identified or contacted at all, and in another case, placement with relatives was delayed.

A grandparent contacted OFCO after discovering that her grandchild had been placed in foster care three months previously following the arrest of the parent. The grandparent heard about this via a news report about the parent's long-term prison sentence. The child's other parent was no longer alive, and the grandparent had since been cut off from contact with the family. The grandparent immediately contacted DCFS upon hearing the news, and was told that the child had been placed with a distant relative on the other side of the family. The grandparent wanted to have contact with the child and be considered for placement, but the agency did not offer either of those options. Upon contacting the agency, OFCO found no clear rationale as to why the grandparent had not been contacted when the child came into care (other relatives who had the grandparent's contact information had been contacted) and why this relative was not now being included in planning for this child's future. Following OFCO intervention, the agency arranged for the grandparent to attend a Family Team Decision Making meeting, and began the process of considering the grandparent for permanent placement of the child.

[73] See Case Services Policy Manual, Section 4400; Practices and Procedures Guide, Section 4527.

A relative contacted OFCO alleging that CPS was failing to place two children in shelter care status with their grandparents out-of-state, despite a court order allowing the placement. The grandparents had passed background checks and their home had been approved by DCFS. Meanwhile the children were in their third foster home placement in the 6 weeks since they had been removed from their parents. The agency wanted to ensure that the grandparents understood their legal options for assuming care for the children. Soon after OFCO began investigating, the agency placed the children with the grandparents for a 30-day placement while options such as third party custody were explored.

OFCO Recommends:

- Require DCFS to inform parent both verbally and in writing what relatives the agency has considered for placement and the outcome of that consideration.
- Require DCFS to consistently inform relatives in writing as to the reason the agency is not recommending the child be placed with the relative.

Allegation 5: Failure of DSHS to notify relatives and foster parents of important meetings or hearings

OFCO did not specifically quantify the number of complaints in which foster parents or relatives raised concerns about the failure of DCFS to notify them of important meetings or hearings because although OFCO heard from complainants that they were not notified, specific data is not available as this issue is not formally captured through OFCO's routine data-collection process.

.

Law: The Adoption and Safe Families Act (ASFA) of 1997 provides that caregivers (relatives and foster parents) must be provided notice of, and the opportunity to be heard in, any review or hearing to be held with respect to the child.[74]

[74] The Adoption and Safe Families Act of 1997, Pub.L.No. 105-89, 111 Stat. 2115, amending 42 U.S.C §§671-675.

Finding: DCFS does not provide care providers with consistent notice of meetings and hearings related to children in their care. This results in the court not having the benefit of a care giver's report to court, which makes the court less informed. It also alienates care providers from the decision-making process.

OFCO Recommends:

- When funds become available, require DCFS to provide **additional support staff** in local offices to ensure that parties and care providers receive timely and consistent notice of hearings and meetings, copies of ISSPs, and timely discovery to parties that is updated on a regular basis.

Allegation 6: DSHS Removal of Child from a Relative or Foster Parent without Sufficient Cause or Adequate Notification

Out of 62 complaints received, 4 raised issues about inappropriate removal of a child from a relative; 6 alleged an unnecessary change of placement from a foster home.

Relatives*: "The biggest reason they moved the kids was because I told the caseworker to do her job and quit expecting me to do it. They moved the kids two days later. This meant that [one of the children] changed schools, they both were seeing a counselor, now that's changed. [One child] had quit wetting the bed while in my care, now is back to wetting her bed. . . . "*

"CPS removed my granddaughters from placement with me for what I felt were a whole list of unfounded excuses. The best interest of the kids were not considered."

"DSHS has demonstrated they are willing to be dishonest to achieve their agenda."

A grandparent contacted OFCO after her two dependent grandchildren, ages 7 and 8, were removed from the grandparents' care. The children had lived with the grandparents or with their parents on the grandparents' property, much of their lives, but were officially placed with the grandparents by CPS ten months previously due to concerns of abuse and neglect by one of the parents. The precipitating event for the children's removal from the grandparents was a CPS referral alleging that the 7year old had ridden a motorized dirt bike on the family farm unsupervised, and that the children were having unsupervised contact with the other parent, who lived on the property. The grandparent had recently been told by CWS to supervise the children on their bikes at all times, as the older child had had an accident a year previously.

The agency removed the children from the grandparent and placed them in a 20bed group receiving home two hours' drive away from the grandparents' home while CPS investigated the allegations of neglect. In the course of the investigation, the grandparent sought to reassure CPS that the child was wearing a helmet while riding the motorbike and that the grandparent accompanied the child in the car when the child was riding the motorbike outside of the yard. The agency conceded that it could not substantiate the claims that the children were having unsupervised contact with one of the parents and, in fact, there was evidence to refute this. The findings were inconclusive for neglect (lack of supervision).

Despite the inconclusive finding, the agency did not return the children to the grandparent's care. OFCO's investigation concluded that the neglect allegations were insufficient to warrant the children's removal. There were no credible, immediate safety concerns to justify the trauma to the children caused by removing them from their primary caregivers and there was not sufficient justification for continuing to keep them out of the home of their grandparent. OFCO intervened by requesting review of this decision by CA Headquarters. Headquarters reached the same conclusion and almost two months later, the children were returned to their grandparent's care.

Foster parent: *"An 18-month- old child was placed with us at birth. . . [and] will be placed elsewhere against a CASA and DSHS-contracted [early childhood development] expert's [advice]. These independent experts maintain this will cause great harm to the child."*

"Caseworker went to court and heard the tape and agreed we were right but they still moved [the child from the foster home]."

A foster parent complained to OFCO that 5 foster children, ages 6 through 13, were removed from their foster home on an emergent basis when there was no imminent risk of harm to the children. The foster parents were not provided with the required 5-day written notice. The foster children consisted of two sibling groups, and one of the sibling groups had been living in the home for 10 months, while the other group had been living there for over two years. Another two children had been in a guardianship with the foster parents for several years, and all 7 children were reported to be thriving by their DCFS social worker, medical providers, their schools, and therapists. The agency had received a referral alleging negligent treatment of the children. The foster home had been licensed for 7 years with no prior referrals for abuse or neglect. The Ombudsman found that DCFS had insufficient basis (i.e. no imminent safety risks to the children) to warrant an abrupt disruption in the children's long term placement.

The DLR/CPS investigation of the referral leading to the children's removal and several subsequent referrals made during the course if the investigation, resulted in founded findings of negligent treatment. The Ombudsman found that DLR/CPS failed to conduct collateral interviews which would have provided a fuller picture of the children's care in the home. The Ombudsman requested a review of the findings by DLR Headquarters. Two of the findings were changed following this review, but two were upheld. The Ombudsman contacted the CA Acting Assistant Secretary and requested further review of the decision-making leading to the problematic findings against the foster parent. The outcome of this review is pending.

Law: RCW 13.34.130(6) provides that any placement with relatives is contingent upon cooperation by the relative with the agency case plan, compliance with court orders and any other conditions imposed by the court related to the care and supervision of the child including contact between the parent and child and sibling. Failure to comply with case plan or court order is a basis for the agency to remove the child.

Law: RCW 74.13.300(1) requires that: "Whenever a child has been placed in a foster family home by the department or a child-placing agency and the child has thereafter resided in the home for at least ninety consecutive days, the department or child-placing agency shall notify the foster family at least five days prior to moving the child to another placement . . . ." The goal of this provision is to minimize disruption to the child in changing foster care placements.[77] The only exception to this requirement is if: (a) A court order has been entered requiring an immediate change in placement; (b) The child is being returned home; (c) The child's safety is in jeopardy; or (d) The child is residing in a receiving home or a group home. [75]

[75] RCW 74.13.300(1)(a) – (d).

The 5-day notice law does not currently apply to removal of a dependent child from relatives. OFCO has testified before the state Legislature recommending that this notice be extended to relatives.

Finding: DCFS does not consistently apply this provision and the consequences of not complying with a case plan or court order vary case by case. If the agency perceives the care provider is not cooperating with the agency, advocating too strongly for the child (especially if this runs counter to the agency's plan), or initiating complaints (by contacting other high profile entities—the legislature, the media) it appears more likely that this will result in abrupt removal of the child.

OFCO Recommends:

- **Provide all care providers (foster and relative) with a minimum of 5 days written notice of DCFS intent to remove child from home unless there is imminent risk of harm.** Notice should include a clear explanation as to the reasons for the agency's decision to remove a child.

- Require DCFS to convene a sit down, **face-to-face meeting with a care provider, who is the subject of a child abuse or neglect referral** that could lead to removal of the child, to explain the nature of the allegations and give care provider a reasonable opportunity to respond to the allegations.

- **Prohibit DCFS from removing children from relative care providers unless CPS has made a finding that the relative has abused or neglected the child** or clearly violated a court order, or the child is at imminent risk of harm.

- Provide relatives with the right to an administrative review when children who have been in their care for 6 months or longer are removed from their care.

Allegation 7: Failure of DCFS to provide relatives with adequate contact with dependent children

Relatives: *"It has been 4 years since I've seen or had any contact with my [grandchildren]."*

"I just want [my grandchildren] to know that [their grandparent] does still think about them a lot and still loves them."

"[I]f [visitation is not] possible, could I at least have a yearly picture of each one?"

> *Of the 31 complaints received regarding family separation and reunification, 7 alleged DCFS failed to provide appropriate contact between a family and child.*

Law: In 2008, RCW 13.34.385 was enacted to provide relatives with the right to petition juvenile court for reasonable visitation with a child whose parents' rights have been terminated. This law became effective in June 2008. However, existing law, even with these changes, does not clearly require DCFS to provide contact between children and relatives (unless placed with that relative). Although relative visitation is left to the discretion of the child welfare agency and the court, at the shelter care hearing, the court must inquire into the "terms and conditions for parental, sibling, *and family* visitation," RCW 13.34.065(4)(k) (emphasis added). It is left to the discretion of the child welfare agency and court.[76]

Policy: See August 2006 DSHS Guide "The Relative Framework: A Guide for Social Workers" whose stated purpose is to "assist staff in the search for extended family, to foster connections for children, engage family in planning for the child, and support caregivers of children involved with our child welfare system." This is available at http://ca.dshs.wa.gov/intranet/pdf/manuals/RelativeFramework.pdf

Finding: Relatives can be a source of love, strength, and support to children in the dependency system. DCFS should do more to encourage and maintain relationships between dependent children and appropriate relatives. Parties should consider asking for appropriate relative and family visitation as part of the initial shelter care order.

[76] Only weeks ago, the Governor signed into law HB 1938 which provides for post-adoption visits between siblings.

OFCO Recommends:

- Encourage DCFS to promote visitation between relatives and dependent children by incorporating into Academy training research-based teaching on current best practice for decision-making regarding contact between relatives and dependent children and facilitating regular and beneficial contact. Incorporating relative and child testimonials on this subject could be a powerful teaching tool.

- Allow relatives who have an established relationship with a dependent child in out of home placement to petition the court for visitation when visits are mutually agreed to by the child and relative.

Allegation 8: CPS workers "shop" for health care providers and counselors who are supportive of their objectives

Law: RCW 13.34.370 provides that the "court may order expert evaluations of parties to obtain information regarding visitation issues or other issues in a case. These evaluations shall be performed by appointed evaluators **who are mutually agreed upon by the court, the state, and the parents' counsel, and, if the child is to be evaluated, by the representative for the child.** If no agreement can be reached, the court shall select the expert evaluator." RCW 13.34.370 (emphasis added).

Finding: Colville DCFS routinely seeks medical attention and diagnostic tests in Spokane rather than in Colville for children whose dependencies are based in Colville. This leads to a perception that DCFS is "shopping" for providers that support their objectives. Many medical providers are offended by this action as they believe it shows a lack of respect for the medical capability of providers in Colville and do not believe it is in the best interest of the child. This has resulted in distrust of DCFS by a significant sector of the medical community in Colville. Moreover, DCFS supervisors reported to OFCO that Stevens County has x-ray equipment available for purposes of conducting a skeletal survey to diagnose suspected physical abuse of a child, but does not have a bone scan machine. OFCO found this to be inaccurate after OFCO interviewed medical providers. Both x-ray machines and bone scan machines are available at the Colville Medical Center and both are used for purposes of diagnosing suspected physical abuse of children when medical professionals believe it is medically indicated. DCFS appears to use the purported lack of a bone scan machine in Colville as justification for seeking outside medical attention for children. Some CPS workers in the Colville area inappropriately substitute their judgment for that of medical professionals making medical decisions.

OFCO Recommends:

- Use an **outside professional mediation service** that is mutually agreed upon by DCFS, the CASA program, and the medical community to help rebuild trust, encourage dialogue, and address specific issues needing repair.

- **Require Colville DCFS to use local community resources** unless a mutually agreed upon provider agrees in writing that there is a compelling reason for use of resources outside the local community. If local resources are consistently found not to be sufficient, efforts should be made to identify funding sources to augment local resources so they can be developed sufficiently over time to meet the capacity and needs of the community.

- Judiciary should enforce the requirement under the law that parties select a **"mutually agreed upon provider"** and if a provider cannot be agreed upon, the judge selects the provider so that parties in a dependency action have a level field. This will encourage parents to comply with services and help neutralize allegations that DCFS is "shopping" for providers who are supportive of their objectives.

Allegation 9: Failure of CPS to adequately investigate referrals of child abuse or neglect

Law: When a referral regarding child abuse or neglect is screened in for investigation, a DCFS/CPS social worker investigates if a parent or guardian abused or neglected the child; a DLR/CPS social worker conducts the investigation if the allegation arises in a licensed facility or foster home. RCW 26.44.030; WAC 388-15-017, 388-15-021. Law and policy direct social workers to determine whether or not the alleged abuse or neglect occurred by interviewing and observing the child, caregivers, alleged subject, other collateral sources, and the person who made the referral. Completing the investigation often involves collecting and reviewing other relevant documentation and information. At the end of the investigation, the allegation is either "founded," meaning that more likely than not the alleged abuse or neglect did occur, or "unfounded," meaning that more likely than not the alleged abuse or neglect did not occur or there is insufficient evidence to make a determination. WAC 388-15-005.

DLR also investigates alleged licensing violations -- such as lack of nurture/care, lack of supervision, health/sanitation concerns, and other violations of the rules governing minimum licensing requirements -- that do not rise to the level of child abuse or neglect. A licensing

violation is determined to be either "valid" or "invalid." See Methods and Procedures Practice Guide for Foster Family Home Licensing.

Policy: Practices and Procedures Guide, Section 2331; Division of Licensed Resources' Child Abuse and Neglect Section Practice Guide - Investigating Abuse and Neglect in State-Regulated Care.

> *Of 62 complaints received, 8 alleged that CPS failed to adequately investigate referrals of abuse or neglect. Four of these involved investigations by DCFS/CPS and four involved DLR/CPS.*

Finding: OFCO did not find evidence to support allegations that DCFS/CPS failed to adequately investigate abuse or neglect. However, OFCO did find evidence in three cases that DLR/CPS failed to adequately investigate abuse or neglect in foster homes. Those cases are summarized below:

> OFCO found that DLR/CPS failed to establish an adequate basis for several findings of child abuse/neglect regarding a foster parent. This resulted in removal of several children from a long-term foster home. The Ombudsman intervened to request that the agency review the basis for several of the CA/N findings against the foster parent. The review resulted in two of the findings being overturned, while two were upheld. The Ombudsman requested further review by the Acting Assistant Secretary of the Children's Administration, who agreed to review the decision-making regarding the problematic findings against the foster parent. The outcome of the agency's review is still pending.

> DLR failed to fully investigate previous allegations of abuse and neglect of foster children by a foster parent, by failing to interview the referent who could have provided additional details that would have yielded stronger evidence of maltreatment. By the time the Ombudsman received the complaint, there had been a subsequent investigation resulting in founded findings of maltreatment. The foster home had been closed by DLR. The children identified in the complaint had been placed in safe alternative placements.

DLR failed to adequately monitor and correct poor hygienic conditions and lack of nurturing in a foster home over several years. Concerns had been reported by several people, including agency social workers, about the persistent smell of pet urine and pet hair in the home, as well as a harmful emotional environment in the home. Some children placed in the home complained that the foster parent yelled at them and called them names, and favored the biological children. Others reported feeling belittled and disrespected by the foster parent. DLR discussed these concerns with the foster parent on several occasions, and although the foster parent made verbal commitments to change this behavior, DLR did not establish a corrective action plan, nor did it monitor for changes in the foster home environment.

OFCO Recommends:

- CA continue its review of policy and practice for conducting DLR/CPS investigations to improve practice in this area.

Allegation 10: Alleged retaliation against parent, relatives, and foster parent for advocating for children or expressing practice concerns to DCFS

One complaint out of 62 alleged retaliation. However, although other complaints did not specifically allege retaliation, in the course of being interviewed by the Ombudsman, complainants sometimes described actions that could be construed as possible retaliation by the agency.

Law: Current law provides that a foster parent who believes that a department employee has retaliated against the foster parent or in any other manner discriminated against the foster parent may file a complaint with the Office of the Family and Children's Ombudsman. The law directs OFCO to identify trends to improve relations between the department and foster parents and to make recommendations. RCW 74.13.332; 74.13.333; 74.13.334. Engrossed Substitute Senate Bill 5811, a bill amending these sections to require OFCO to put any findings of retaliation in writing to DCFS, and requiring DCFS to respond in writing within 30 days outlining any personnel action taken with regard to the employee, is pending signature by the Governor.

The right to be free from discrimination and retaliation does not only apply to foster parents. OFCO also receives, investigates, and reports on complaints from other stakeholders, including parents, alleging agency retaliation.

Finding: OFCO could not find clear evidence of retaliation in its investigations of complaints as part of this report. However, as noted above, OFCO does find that if the agency perceives a care provider is not cooperating with the agency, advocating too strongly for the child (especially if this runs counter to the agency's plan), or initiating complaints (by contacting other high profile entities—the legislature, the media) it appears more likely that this will result in abrupt removal of the child.

III. ALLEGED LACK OF ACCOUNTABILITY BY DCFS

"It is imperative that government is held accountable to ensure appropriate, balanced and well-considered steps are taken in these matters that fully comply with the law, otherwise the lives, futures and well-being of children, parents and families are at risk." Few people would take issue with this statement by Representative Kertz in his original letter requesting an investigation of the Colville DCFS office and it reflects the sentiment of the Colville community.

In our interviews of community members, they identified accountability as an essential ingredient to a child welfare system that ensures the best interest of the child. But, what is accountability and to whom should the child welfare system be accountable? People support accountability, but do different stakeholders and parties define it in the same way?

When OFCO asked a department employee if they believed there was a problem with accountability, they responded: "*If by accountability you mean you can follow through on their word and trust what they say—I think there is a lack of it."* When asked, to whom they were referring, they responded *"upper [DCFS] management."* Although some stakeholders differed in their response about whom the system should be accountable to, by all accounts they agree that it means taking responsibility for your actions, staying true to your word, being responsive to others, applying a fair and consistent set of standards, being able to trust in the accuracy of the information provided, and having rational outcomes that naturally flow from the chain of events. They also expressed how important it is that there be consequences for failure to follow through.

We believe there are several necessary elements to creating a child welfare system that is more accountable:

- Focusing child welfare practice on specific goals and assessment measures;
- Clarifying roles, rights, and responsibilities of parties and stakeholders;
- Promoting a culture of respect and accountability by de-personalizing differences of opinion and establishing mutually agreed upon standards of behavior;
- Providing internal and external oversight over DCFS decisions;[78]

[78] OFCO provides external oversight of DCFS action or inaction. Internally, DCFS policy provides for a system of accountability and quality assurance. Section 6000 of the DSHS CA Operations Manual sets forth the agency's system of accountability between different levels of organization within CA to ensure that "services are provided to the clients of CA in compliance with policy and statute." Section 6221 of the DSHS CA Operations Manual sets forth the oversight of Regional Administrators. Section 6222 sets forth the areas of responsibility of DCFS area managers, including the requirement of reviewing one case per unit supervised per month and meeting with each supervisor on a monthly basis to review casework supervision and practice.
.

- Using court sanctions to enforce compliance with court orders and other willful violations of law, policy, and procedure.

Most members of the Colville community agree that accountability does not just rest with DCFS. However, as the petitioner in dependency/termination cases and the largest state agency, DSHS is recognized as a powerhouse that must take primary responsibility for being accountable. It must lead by example and help the parents it serves to recognize why their children are in care and to engage in services.

Confidentiality can undermine accountability by creating an unnecessary air of secrecy. Accountability will be difficult to achieve without greater transparency in agency decision-making:

> *"Child Protective Services has not been accountable mainly because we do not know what they are doing or why they are doing it. Secrecy is not compatible with accountability. Therefore, without a lifting of the secrecy, it would be difficult to document and to prove that the agency is being accountable."* [medical professional]

An important aspect of accountability is the ability of citizens to have recourse (a mechanism for review of agency decisions) if they do not agree with the agency's decisions.

> *"[W]e must have an accountability system whereby those working in CPS have a clear chain of command to which health care providers or other individuals can appeal if a problem arises. In other words, we need to know who their bosses are so that we can bring issues of concern and expect that something will be dealt with, that we will receive feedback in a timely manner, and we can have the opportunity to review the process, the procedures, and the policies of CPS so that there is an understanding of what is happening."* [medical professional]

> *"I believe in order to improve how the system operates, we must have an accountability system whereby those working in CPS have a clear chain of command to which health care providers or other individuals can appeal if a problem arises."* [medical professional]

> *"We need to have a system in place that oversees CPS. It is ridiculous, in my opinion, to have our local judge make a pronouncement against CPS that they need to follow the law. If any of the rest of us broke the law and were brought in before the judge, it is unlikely that the judge would simply tell us, 'You need to obey the law.' There should be punishments in place for breaking the law and it should not come out of the taxpayer's dollars."* [medical professional]

> *"I really think that the problem [in accountability] is fairly one-sided. As you know, physicians and counselors have to be accountable. If we don't, we are subject to the legal system and therefore we are accountable for exactly what it is that we are doing,*

as well as the communication that we have with patients, the decision-making that we do, and the reasons that we use in our decision-making." [medical professional]

OFCO believes the child welfare system has the best chance at success when key participants can agree on common elements in their mission, and understand the role and responsibilities of themselves and how these intersect with those of other participants. **Accountability is also more likely if parties have an accurate understanding of respective rights and responsibilities and show respect for these differing roles.**

DCFS & CASA Relationship as Key Players in the System

As discussed throughout this report, two of the key parties in Title 13 dependency actions are DCFS and the CASA. In Stevens, Ferry, and Pend Oreille counties, CASAs serve in a volunteer capacity to represent the best interests of a child. OFCO identified a high level of discord between the Stevens CASA program and the DCFS Colville office. In our interview of each of these participants, they expressed frustration about the other making unreasonable demands, having unrealistic expectations, or exercising authority beyond established laws and procedures. In contrast, Ferry County and Pend Oreille participants did not report this same level of tension in the relationship between DCFS and CASA in their respective counties and described a relationship of mutual support. One participant who is not with either the CASA program or DCFS noted that when the CASA program director from Ferry county came on board, "she extended an olive branch to DSHS" and the participant believes this made a significant difference in setting a tone of cooperation and collaboration. Moreover, in Ferry County, the CASA program and DCFS have office space in the same building. This was described as a factor that facilitated easy communication. Participants noted that it is not uncommon for DCFS staff to wander downstairs where the CASA office is located to informally check in with the CASA program manager on particular cases or to more generally gauge how things are going or whether there are any issues that need to be addressed.

The appointment of CASA/GALs is governed by state law. RCW 13.34.100 provides that "The court shall appoint a guardian ad litem for a child who is the subject of an action under this chapter, unless a court for good cause finds the appointment unnecessary." The CASA/GAL must meet certain criteria to be eligible for appointment. This includes completing an approved training program, providing background information to the court, and meeting any other eligibility requirements set by local court rule or policy.

CASAs are trained and supervised by the local CASA program with support from the State CASA program. Each superior court maintains a registry of individuals who are qualified to serve as CASA/GALs. According to the Program Manager of the Stevens County CASA program, their program has a pool of approximately 20 volunteer CASA/GALs, with varying degrees of involvement. She states that there is "always a shortage of volunteers" and that the program also has two part-time paid volunteers and a volunteer coordinator.

Specific responsibilities of the CASA are governed by statute, state and local court rules, and the order of appointment. The CASA-DSHS MUA sets forth core responsibilities of each of these parties.[79] Under the direction of the court, a GAL performs an investigation and prepares a report for the court of the GAL's findings and recommendations.

Each superior court has established a process for handling complaints against a CASA/GAL.[80] The local GAL grievance rules for Ferry, Pend Oreille, and Stevens counties provide that within 10 days of receiving a written complaint, the court administrator shall convene the complaint review committee.[81] The complaint review committee is made up of a judge, the court administrator or Clerk, and a representative of the county bar association.[82]

The Administrative Office of the Courts (AOC) "has authority over funding distribution, formula development, policy standards for local programs, and other elements included in contracts between AOC and local CASA programs."[83]

Some participants OFCO interviewed expressed concerns about the potential conflict of interest in having the court supervise CASAs on cases over which the court is making decisions. OFCO finds this concern has been raised in jurisdictions across the state. With direction from the judiciary, Stevens County recently drafted revised policies to create a modified chain of command structure so that issues related to budget and personnel go to the court administrator first, rather than to the Judge. This buffer intended to alleviate the perception of a conflict of interest.

Statewide Agreement of Mutual Understanding

On May 1, 2006, the Washington State CASA and the DSHS Children's Administration entered into a Statewide Agreement of Mutual Understanding, which provides "a framework in which to begin or enhance best practice and open dialogue on issues that affect [both entities]."[84] This agreement was developed jointly and its stated purpose is to:

- Foster safety, health and permanency for Washington's children,
- Promote greater understanding of each other's role in serving children, and
- Provide local communities and Tribal Governments a model for working together on behalf of dependent children and their families.

It is helpful to take note of each entities' mission and set of values as jointly agreed upon and articulated in their Statewide Agreement of Mutual Understanding.[86] This serves as a helpful

---

[79] Core Responsibilities of DCFS and CASA are in Appendix A

[80] Rules for Superior Court Guardian ad Litem Rules (GALR) 1 - 7
http://www.courts.wa.gov/court_rules/?fa=court_rules.rulesPDF&groupName=sup&setName=GALR&pdf=1

[81] Local Guardian Ad Litem Grievance Rules (LRGAL) 3 for Ferry, Pend Oreille, and Stevens Counties.

[82] LRGAL 1 for Ferry, Pend Oreille, and Stevens Counties.

[83] Memorandum of Understanding between the Washington Courts—Administrative Office of the Courts (AOC) and the Washington State Court Appointed Special Advocates (CASA). This MOU became effective July 1, 2007 and remains in effect until June 30, 2009.

[84] May 1, 2006 Statewide Agreement of Mutual Understanding between Washington State CASA and DSHS Children's Administration ("CASA-DSHS MUA"), p. 2.

[86] The Mission Statements of CASA and DSHS, from the CASA-DSHS MUA is attached in Appendix B.

reminder about parties' respective roles and responsibilities. It may also provide a useful framework for further discussions to clarify roles and agree on the scope of the CASA's investigative power.

Role of Judiciary in Accountability

One aspect of "accountability" OFCO has explored has been the role of the of the courts in dependency matters. We have heard from several sources that the court is unwilling, or perhaps unable, to impose sanctions against the DCFS or other parties for contempt of court. **The judiciary needs to reassure the community that it expects a culture of accountability and that there are reasonable consequences for intentional noncompliance of a court order by the agency or other parties by using its power to impose sanctions.**

Court commissioners do have the statutory authority to impose sanctions on any party to a dependency action for contempt of court under RCW 7.21.010 et seq., and RCW 13.24.165. The statute defines contempt as intentional disorderly behavior toward the court, disobedience of any lawful court judgment, order, or process, or refusal of a party to participate in the court process. RCW 7.21.010(1). In general, sanctions can be either remedial (civil contempt) or punitive (criminal contempt). Most applicable to the dependency process are "remedial sanctions," which "means a sanction imposed for the purpose of coercing performance when the contempt consists of the omission or refusal to perform an act that is yet in the person's power to perform," RCW 7.21.010(3). These statutes authorize the court, on its own motion or on a motion by a party, to find DCFS in contempt for failure to follow court orders an to impose remedial sanctions including further orders designed to ensure compliance or monetary penalties accruing every day the contempt continues. RCW 7.21.030.

Although contempt proceedings and the imposition of sanctions are not legal remedies to be sought lightly, the availability of sanctions through the court may be a useful tool for improving accountability.

Finding: The judiciary can play a role in enforcing accountability and promoting a culture of compliance.

OFCO Recommends:

- **Recognize accountability is a shared responsibility.**

- The judiciary is respected by all parties. **Encourage the judiciary to take a leadership role in addressing accountability** and information sharing by creating a culture of compliance, encouraging a dialogue about mutual accountability as a shared responsibility, and spearheading training on conflict of interest considerations among parties. Provide specific training to judiciary on availability of sanctions under the law to enforce court orders and compliance with other law, policy, and procedure.

- Encourage judiciary to conduct monthly operations meetings between significant stakeholders to encourage regular communication and help set a tone of civility and respect among stakeholders.

- Create a diverse **community advisory board** including members who are not connected to the child welfare community to provide advice to DCFS.

DISCUSSION

History Influences Current Child Welfare Practice

The history of child welfare practice within a particular community influences current practice, especially those cases which sit in the collective conscience as reminders of where the system failed. These are the ghosts of children past--children who died or were significantly injured while under the care and supervision of the child welfare agency charged with protecting them. Or, dependency cases which may not have resulted in physical harm to a child, but in significant trauma to professionals providing services on the case and the families affected.

In the Colville community, there are three tragedies in recent history that inform child welfare practice: the death of 7 year old foster child Tyler DeLeon in 2005,[89] the death of 15 year old dependent youth Robley Carr in 2006, and the 2005 machete attack on a Ferry County social worker by an angry father during a child welfare check.[90] The father was shot and killed by a sheriff's deputy who had accompanied the DCFS social worker to the property.

Foster parent Carol DeLeon was charged with homicide by child abuse after investigators determined that Tyler DeLeon died from dehydration as a result of her depriving him of adequate food and drink. This was only part of a long list of other forms of abuse that this child suffered at the hands of DeLeon over the course of the seven years he lived with her. Several other foster children placed by the agency in her home were also starved and beaten, but they survived their ordeal and were removed from the DeLeon home. Instead of going to trial, DeLeon entered an Alford[91] plea to lesser charges of one count of criminal mistreatment in the first degree for Tyler and an Alford plea to criminal mistreatment in the second degree for her care of another foster child in her care who prosecutors alleged was severely malnourished by DeLeon. DeLeon is currently serving a six year prison term.

Washington CPS began receiving referrals regarding Robley Carr's care in his mother's home as early as 1992. Dependency was established in 1996, and Robley bounced between numerous placements with relatives, in foster care, and with his mother. In 2000, Robley and his siblings were removed from a relative placement after suffering significant physical abuse. A court awarded the siblings $5 million as compensation for this abuse. In 2001, Robley was placed with new foster parents who eventually became his guardians. From 2001 until Robley's death in December 2006, DCFS received five referrals alleging licensing violations in the Horton foster home. Concerns were raised regarding the condition of the home, family financial problems, supervision issues, concerns about nurture/care, and concerns about the foster parent's mental health. All investigations were determined to be "not valid." Robley died from an accidental overdose of his guardian's methadone.

---

[89]The dependency case of Tyler DeLeon was based in Spokane. However Tyler and his siblings resided in Stevens County. See http://seattletimes.nwsource.com/html/localnews/2003765789_abuse28m.html

[90] http://www.seattlepi.com/local/212589_machete18.html

[91] An Alford plea is a plea in criminal court where a defendant does not admit to the act or crime, but admits that the prosecution could likely convince a judge or jury to find the defendant guilty based on the evidence. Once an Alford plea is entered, the court may then find the defendant guilty and impose a sentence.

These cases, in part, drive social work practice today in the tri-county area. Sometimes this is intentional and can be a good thing. One community professional interviewed by OFCO frequently referenced the Tyler Deleon case and acknowledged that it has an impact on the delivery of services: *Tyler was in our school district, and the school was at odds with the professionals who were involved who were saying nothing was wrong in the foster home. High profile cases always tend to be the elephant in the room when the CPT is deliberating on other cases."*

Tyler and Robley's deaths and the injuries to the social worker have perhaps led to greater vigilance on the part of both DCFS and law enforcement, greater sensitivity about the stress to social workers of doing one of the most difficult social service jobs imaginable, and recognition of the need for more team work. The tragic death of Tyler has also led to practice reform that improves safety for children, including the requirement put into effect after 2005 by the Governor that high risk abuse investigations begin within 24 hours.

On the other hand, tragedies can result in a hardening of perspectives across a broad spectrum of the community: citizens lose confidence in the agency to adequately protect children or its own workers; professionals believe the agency does not take into account their expertise and opinions and if they did, such tragedies could be avoided; families' fear intervention by CPS and law enforcement; workers' concerns that they do not have enough support are validated based on what happened to one of their colleagues out in the field. It is hard to undo such lack of confidence and trust within the community and within the child welfare system, and it will take work from the outside to help restore confidence. These tragedies do not tell the whole story in Colville, but they should not be ignored in considering the range of complaints and results of investigative interviews conducted by OFCO.

Overview of Child Welfare Related Resources

Stevens, Pend Oreille, and Ferry counties are collectively referred to as the tri-county area. As the following county-by-county description shows, there is certain overlap among the counties in professionals that service the area, such as the same two superior court judges who preside over most of the dependency and termination fact-findings for all three counties and the same Children's Administration Area Administrator (AA) who supervises child welfare cases in this area. Other roles are distinct to each county. For example, each county has a different CASA/GAL program manager.

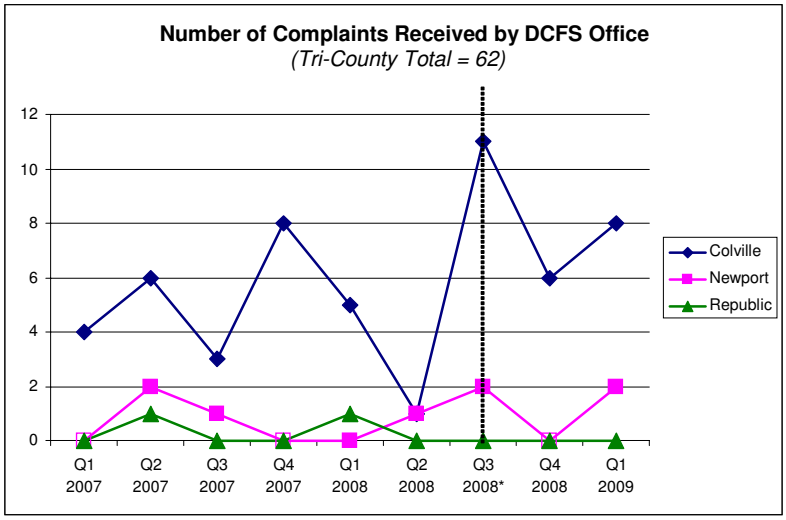
Select Tri County Child Welfare Resources			
	Stevens	**Ferry**	**Pend Oreille**
CA Staffs	Colville	Republic	Newport
Area Administrator	1[93] →		
Supervisors	3 →	1 (out of Colville)	1
Social Workers	15	2 (1 is out of Colville)	6
Foster Care Licensor	1	-	-
FTDM Specialist	1	-	-
Home Support Specialist	1	1	1
Clerical Staff	2	1 (Part-time)	1
Judiciary			
Superior Judges	2[94] →		
Court Commissioner	1[95] →		
District Court Judges	-	1[96]	1[97]
Legal Representation			
AAG assigned to dependency/termination cases	1	-	1
County Prosecutor	-	1[98]	-
Office of the Public Defense	Provides 3 to 4 contracted attorneys	provides contracted attorneys	provides contracted attorneys
CASA			
Program Manager	1	1	1
Active CASA Volunteers (as of 2007)	21	8	7

[93] The AA is scheduled to be in the Colville Office one day a week.
[94] The tri-county area shares two superior court judges, Allen C. Nielson and Rebecca M. Baker, and a court commissioner, Patrick A. Monasmith.
[95] In Stevens county, the court commissioner hears most of the juvenile court cases, including juvenile offender cases, Child in Need of Services (CHINs) petitions, at risk youth (ARY) petitions, BECCA proceedings, and truancy matters. The judges typically hear the fact finding dependency and termination of parental rights trials.
[96] Ferry County district court judge, Lynda Eaton, presides over juvenile dependency cases.
[97] In Pend Oreille County a district court judge, Phillip Van de Deer hears dependency matters.
[98] Republic DCFS is represented by the Ferry County Prosecutor, Mike Sandona. The Prosecutor's office has a deputy prosecutor as well but that individual does not currently carry a dependency/termination caseload.

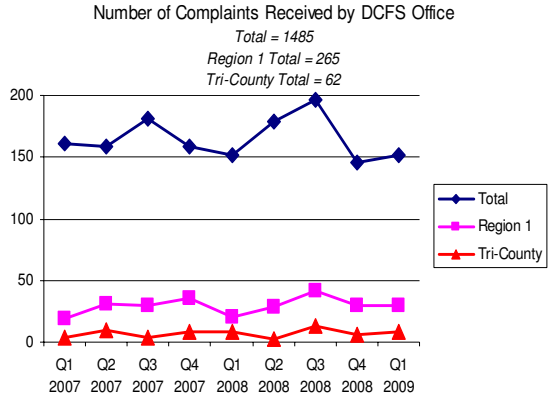
Summary of Complaint Investigation Results

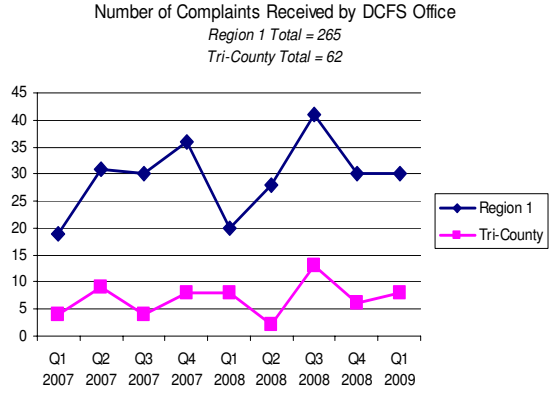
Complaints Received

OFCO received 62[101] complaints regarding the Colville, Republic and Newport offices between January 1, 2007 and March 31, 2009.[102]



Data reported by quarter
*OFCO asked to investigate during Q3 2008 and OFCO Director visited area

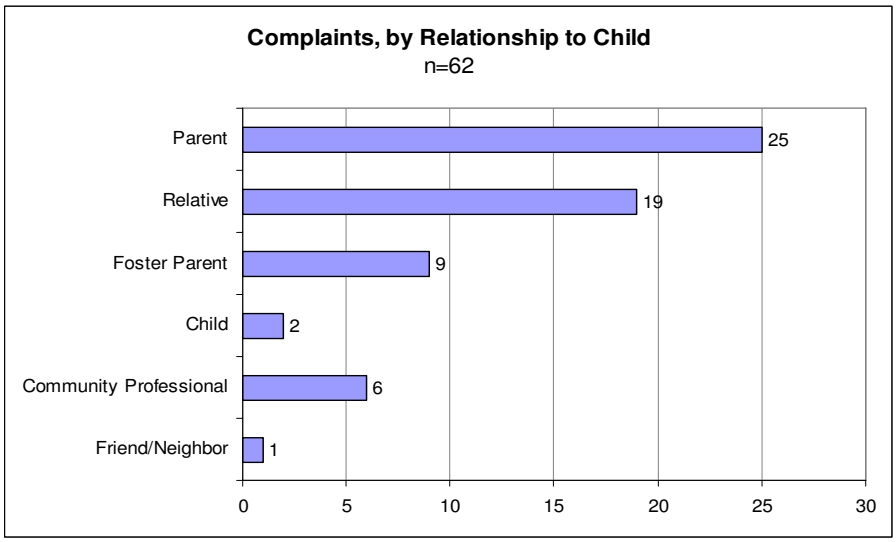




[101] Of the 62 complaints received, 46 were requests for non-emergent intervention, 14 were requests for emergent-intervention, and 2 were requests for systemic investigation. For detailed information about OFCO's complaint investigation process, please refer to our Annual Reports, available online at www.governor.wa.gov/ofco/reports.
[102] Two of the 62 complaints received were regarding organizations outside of the Ombudsman's investigative authority. OFCO reviewed the issues regarding the "non-OFCO" subjects, and initiated investigations to examine the agency's role in the issues being raised.

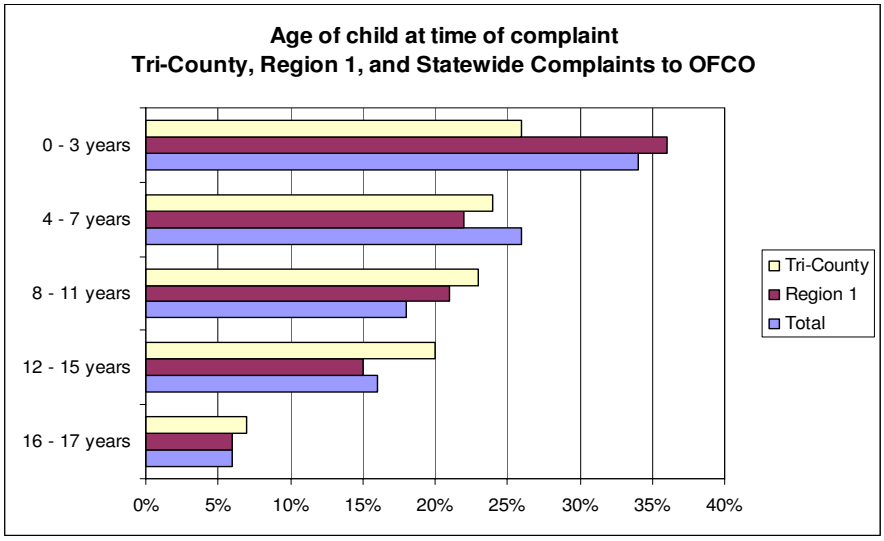
Relationship of Person Who Complained

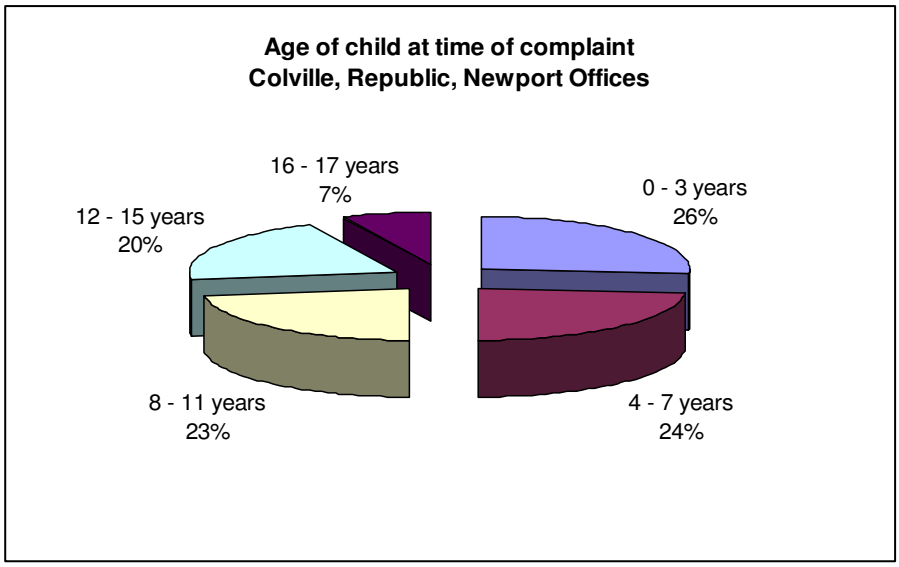
Consistent with statewide complaints, parents, grandparents and other relatives of the child whose family is involved with DSHS filed the majority of complaints to the Ombudsman. The third largest source of complaints came from foster parents; the fourth from community professionals. Only two complaints came from children (defined as age 17 or younger), and only one from a neighbor or friend.



Age of Children Identified in Complaints

Children identified in complaints related to the Colville investigation are more evenly distributed across age groups than children indentified in complaints regarding Region 1 or complaints statewide.





Issues Identified in Complaints to OFCO

Between January 1, 2007 and March 31, 2009

Complainants can identify more than one issue

Issues include closed and open investigations

Family Separation and Reunification	**31**
Inappropriate Removal from Parents/Legal Guardian	**6**
Non-Dependent Child	5
Dependent Child	1
Inappropriate Removal from Relative Caregiver (Non-Foster Care)	**4**
Inappropriate Placement of Dependent Child	**10**
Too Distant From Family	2
Not Placed With Relative	6
Parental Wishes Not Followed	2
Failure to Provide Appropriate Contact Between Family and Child	**6**
Failure to Reunify Despite Compliance with Services	**3**
Relinquishment/Termination	**1**
Other: Contact between siblings	**1**
Dependent Child's Safety, Well-Being & Permanency	**22**
Safety	**10**
Caregiver Abuse/Neglect	8
Child Returning Home	1
Other: Moving child to treatment facility with parent without sufficient planning for transition	1
Health and Well-Being	**2**
Medical, Dental	2
Service Plan	**2**
Unnecessary Change of Foster Placement	**6**
From Non-Relative Foster Placement	6
Permanency	**1**
Permanency Plan/Adoption	1
Other: Failure to inform youth of options for ongoing services and placement after turning 18	**1**
Non-Dependent Child In Need of Protection	**6**
Suspected Child Abuse	**4**
Physical	1
Emotional	1
Sexual	2
Suspected Child Neglect	**1**
Basic Needs	1
Other: Agency failed to assist parent with ARY petition	**1**
CPS Issues	**4**
Unreasonable Findings	**1**
Other:	**3**
Unreasonable expectations/failure to close case	1
Unreasonable CPS investigation based on unreliable source.	1

CPS made inaccurate report to police	1
Other:	**4**
Failure by DCFS CWS to live up to agreement made at time of relinquishment	1
Failure to do adequate relative search (on maternal side of family)	1
Inappropriate release of non-redacted case file to LE	1
Foster home licensor conduct.	1
Non-OFCO	**4**
Colville CASA	2
Colville Business Council	1
Inappropriate use of DCFS database by DCFS employee	1
Children in Institutions and Facilities	**1**
Health and Well-Being	**1**
Other: Failure to provide personal care items (soap, shampoo, clothing, etc.)	1
Foster Parent Retaliation	**1**
	1

Demographic Data

Select Characteristics	Stevens	Ferry	Pend Oreille	*Spokane*	*Washington State*
POPULATION[103]				**Added for comparison.*	
Population	43,000	7,550	12,600	451,200	5,894,143
Land Area in sq. mi.	2,478	2,203.98	1,400.27	1,763.64	66,544.10
Population Density (persons per sq. mi.)	17.4	3.4	9	255.8	88.57
HOUSEHOLDS/FAMILIES[104]					
Total households	15,017	2,823	4,639	163,611	2,271,398
Family households	73.40%	70.40%	70.30%	64.80%	66.00%
Female family household	33.60%	10.20%	8.40%	11.00%	9.90%
Average household size	2.64	2.49	2.51	2.46	2.53
Average family size	3.08	2.95	2.98	3.02	3.07
SOCIO-ECONOMIC					
Median family income 1999 (in dollars)[105]	40,250	35,691	36,977	46,463	53,760
Families below poverty level in 1999[106]	11.50%	13.30%	13.60%	8.30%	7.30%
TANF, Child Recipients in 2007 (Rate per 1,000)[107]	82.28	85.12	115.45	103.15	90.6
Unemployed Persons in 2007 (Rate per 100)[108]	7.12	7.77	7.02	4.75	4.54
DSHS Client Use Rates (7/06-6/07)[109]	38.40%	41.60%	40.08%	36.10%	33.10%
PROBLEM OUTCOMES: CHILD/FAMILY HEALTH[110]					
Victims of Child Abuse and Neglect in Accepted Referrals (Rate per 1,000)	38.56	61.56	63.63	42.67	34.56
Injury or Accident Hospitalizations for Children (Percent of total child hospitalizations)	6.47	3.45	6.22	5.78	3.86

[103] Washington State Office of Financial Management. *2007 Databook.* Available online at: http://www.ofm.wa.gov/databook/
[104] U.S. Census Bureau. Profile of General Demographic Characteristics: 2000.
[105] U.S. Census Bureau. Profile of General Selected Economic Characteristics: 2000.
[106] U.S. Census Bureau. Profile of General Economic Characteristics: 2000.
[107] Washington State Department of Social and Health Services. Research and Data Analysis Division. *Risk and Protection Profile for Substance Abuse Preventions for Washington State and its Counties.* December, 2008. Available online at: http://www.dshs.wa.gov/rda/research/risk.shtm
[108] Washington State Department of Social and Health Services. Research and Data Analysis Division. *Risk and Protection Profile for Substance Abuse Preventions for Washington State and its Counties.* December, 2008. Available online at: http://www.dshs.wa.gov/rda/research/risk.shtm
[109] Washington State Department of Social and Health Services. Research and Data Analysis Division. *DSHS Client Counts and Service Costs.* Available online at: http://clientdata.rda.dshs.wa.gov/
[110] Washington State Department of Social and Health Services. Research and Data Analysis Division. *Risk and Protection Profile for Substance Abuse Preventions for Washington State and its Counties.* December, 2008. Available online at: http://www.dshs.wa.gov/rda/research/risk.shtm

CONCLUSION

It will take leadership from within the Colville community and impartial advice and consultation from the outside to restore trust in the child welfare system in Stevens County. Judicial leadership can assist by creating a culture of compliance and accountability for which all parties have collective responsibility. Transparency and clarity can be brought to the process if stakeholders understand their roles, rights, and responsibilities and DCFS is honest.

Stakeholders have a point of agreement from which to launch these improvements. There is consensus that the current system is flawed and needs fixing, and relationships must be restored so that Colville can return to a culture of professionalism and cooperation. Lack of trust among professionals diverts critical time to micromanaging cases and takes attention away from **families and children who must be the priority**.

It is time to rebuild confidence in the system. OFCO finds that the will to do so exists within the community. It is now up to parties and key stakeholders to agree on how they can make a difference. We hope our recommendations will contribute to that process.

APPENDIX A: CORE RESPONSIBILITIES OF DCFS AND CASA

The following is a chart developed by DSHS and CASA setting forth core responsibilities. OFCO is incorporating it into this report as it is an accurate and useful summary of the differences and similarities in each entities' respective duties:

CORE RESPONSIBILITIES[111]

Social Worker	CASA
Agency Representative who is responsible for evaluating and reviewing information about each child and the child's family for purpose of investigation of allegations of child abuse and neglect, provision of remedial services, and permanency planning for the child. Professional who is able to provide expert opinion and assessment in court proceedings when required to do so.	Trained community volunteer who reviews and evaluates information in order to represent the best interests of the child in juvenile court dependency, termination of parental rights and adoption proceedings. Legal party who is appointed by the court to represent the best interests of the child until the case is dismissed by the court.
Gathers and assesses information and makes decisions regarding placement, service delivery and the case plan per Children's Administration manual, ICW manual, or court order. CA makes active efforts in ICW cases to honor the spirit and intent of the ICW act.	Gathers information from all persons significant to the case and makes independent recommendations to the court based on a review of all information obtained and first hand review of the child's situation.
Works to provide reasonable efforts and to reunify the child with his/her family whenever appropriate and consistent with the child's paramount right to health, welfare and safety.	Advocates for a child's best interests at all times.
Normally, petitioning party of the action; carries burden of proof and must present sufficient evidence to support allegations of abuse or neglect; makes recommendations regarding disposition of the case; required by law to develop a permanent plan of care for the child which may consider family reunification as the preferred permanency option.	Appointed by the court and serves as the child's guardian ad litem in the dependency action; presents factual information regarding the child/family situation, and makes recommendations regarding disposition of the case.
Responsibilities include, but are not limited to, supporting children residing in their own homes, providing out-of-home placements, arranging visits, transporting	Responsibilities defined by statute and include gathering information on the child's situation, and reporting it to the court (RCW 13.34.105). Not responsible

[111] CASA-DSHS MUA, p. 5.

children, communicating with foster parents, and ensuring a culturally relevant permanent plan for each child in the Department's care.	for other activities (e.g., supervising visits, selecting foster homes, transporting children), but may make recommendations on these issues.
Provides ongoing professional assessment of family and child needs; makes specific referrals to address parental deficiencies and needs of child. Monitors parents' progress in services plans	Monitors court orders for compliance and progress and brings to the court's attention any change in circumstance that requires modification of those orders. RCW 13.34.105 (c).

PROCESS RESPONSIBILITIES[112]

Social Worker	CASA
Shares all information with the CASA as set forth in RCW 13.34.105, with the exception of records specified in 13.50.100(7).	Shares information with all parties in accordance with RCW 13.50.100.
Informs the CASA a minimum of 24 hrs. in advance of any movement of the child unless in case of an emergency. If a child is moved in an emergency, inform the CASA on the next business day after the move.	Tracks placement history of the child and reports that history to the court.
Visits the child in accordance with Children's Administration policy.	Has regular in person contact with the child sufficient to have in depth knowledge of the case, the child's progress, well being and appropriateness of placement and to make fact based recommendations to the court unless the child is placed out of the jurisdiction
Provides referrals and/or provides services to the child and family directly or through contracted service agencies within available resources. Monitors compliance with services and reports to court.	Recommends appropriate services for the child and family but does not provide services.
Prepares Individual Service and Safety Plan (ISSP) for each child and provides the ISSP to all parties prior to court hearings in accordance with local court rules.	Prepares CASA court report and recommendations, and provides to all parties prior to court hearings in accordance with local court rules.
Represents DSHS in providing services to child and family and implementing duties and policies of the agency as set forth in statute, regulation, Children's	Represents each child's best interests, which may not be the child's specific wishes; not bound by public policy, but by a common sense approach to timeliness

[112] CASA-DSHS MUA, pp. 6-7.

Administration Manuals and ICW Manual.	and needs of the child.
Participates in Shared Planning meetings/multidisciplinary meetings that pertain to the child, and provides CASA and CASA program staff the opportunity and timely notification to participate in these meetings as well.	Participates in meetings that pertain to the assigned child, including but not limited to Shared Planning meetings, multidisciplinary teams, administrative reviews, case staffings, Child Protection Team (CPTs), Local Indian Child Welfare Advisory Committees (LICWAC and Individual Education Plan meetings (IEPs)
Mandated reporter.	Not a mandated reporter (RCW 26.44.030) unless otherwise mandated by their professional status. CASAs must report any suspected abuse of a child or vulnerable adult per local program policy.
Notifies the child's Tribe of placement and court actions, per the Indian Child Welfare Act and Tribal/State Agreement; if the Tribe does not take jurisdiction, involves the Tribe in case planning and decision-making and staffs tribal cases with LICWAC teams when required by agency policy; and reports to the court information on the child's enrollment or membership information and the Department's compliance with the Indian Child Welfare Act; DCFS follows the Indian Child Welfare Manual.	Reports to the court information on the potential status of a child's membership in any Indian Tribe or band (RCW 13.34.105(1)(d)); provides information to a Tribe, tribal court, or Local Indian Child Welfare Advisory Committee as allowed by law. Receives training in the Indian Child Welfare Act and honors the spirit and intent of the law.
Works collaboratively with all parties.	Works collaboratively with all parties.

APPENDIX B

Washington State CASA Mission and Values

Our mission is to support member CASA/GAL programs in providing trained volunteer advocates for abused and neglected children in the court system. Our vision is to ensure that every child has a safe, supportive and permanent home.

1. We embrace diversity, and work to ensure that CASA programs have the resources needed to provide culturally appropriate advocacy for children.
2. We strive to create the best possible child-focused advocacy by promoting fresh ideas and perspectives to effectively respond to each child's individual needs.
3. We support CASA programs and CASA volunteers in providing effective advocacy in the best interest of children who have been abused, neglected or abandoned.
4. We listen to CASA volunteers, program staff, judges and court administrators in order to provide effective services and training to volunteers advocating in the best interest of children. Washington State CASA's success is predicated on the success of each local program.
5. We educate the public regarding state of abused, neglected and abandoned children and invite the community to mobilize its resources to benefit the best interest of the children.
6. We advocate and educate elected officials, child and family serving agencies and public interest organizations on behalf of CASA volunteers and CASA programs.
7. We are prudent and effective in the use of the resources entrusted to us for advocacy in the best interest of children.[113]

Washington State Department of Social and Health Services Children's Administration

MISSION
The mission of the Children's Administration is first to protect abused and neglected children, to support the efforts of families to care for and parent their own children safely, and to provide quality care and permanent families for children in partnership with parents and kin, tribes, foster parents and communities.

VISION
The Children's Administration seeks to be an organization that provides excellent services, which produce successful safety, well-being, and permanency outcomes for children and families. We strive to be innovative, results-driven, responsive to changing needs, accountable, and guided by a commitment to professionalism and excellence in the field of child welfare. We promote teamwork and embrace our partnership with parents and kin, Tribes, foster parents and communities in the design and delivery of child and family services we would be proud to offer our own families.[114]

[113] CASA-DSHS MUA p. 3.
[114] CASA-DSHS MUA, p.4.

APPENDIX C[115]

DLR/CPS and CASA

Information Sharing

- There is no specific reference regarding the sharing of information with CASAs, or practice specific to CASAs, in the current Child Abuse and Neglect Section Practice Guide Investigating Abuse in State-Regulated Care.

- Policies and procedures relied upon for DLR's interactions with CASAs are currently those outlined in CA policy and state-wide agreements.

- According to the Practice and Procedures Manual Chapter 4100 Section 4413, and effective 6/12/08: "The assigned CFWS worker will promptly notify the assigned GAL/CASA whenever CA receives a report of alleged abuse or neglect involving a dependent child. The social worker shall also notify the GAL/CASA of the disposition of the investigation. RCW 26.44.030." Notification by the CFWS worker is to be within 24 hours of receipt of the notice. This is the policy and practice relied upon by DLR in regards to notification of intakes.

- CASAs may have contact with DLR/CPS investigators due to on-going investigations involving one of the children on a CASA's caseload. DLR/CPS complies with the Washington State CASA Statewide Agreement of Mutual Understanding between Washington State CASA and DSHS Children's Administration (MOU) and provides information specific to that child which does not jeopardize an on-going investigation. However, as defined in the CA policy update from 06/12/08 contact is typically between the CFWS social worker and the CASA as that worker "has a working relationship with the GAL/CASA."

- DLR/CPS acts in accordance with the MOU. As in the agreement, CASAs are invited to shared planning meetings, such as Child Protection Team meetings, when involving a DLR/CPS case.

- DLR/CPS follows the roles and responsibilities outlined in the MOU in regards to investigations. The DLR/CPS social worker is responsible for the investigation of allegations of child abuse and neglect, and providing evidence to support allegations of abuse and neglect.

- Information specific to concern about a child's placement is communicated to the DCFS social worker assigned to the case. This is outlined in the current Child Abuse and Neglect Section Practice Guide Investigating Abuse in State-Regulated Care.

[115] Hancock, Darcey (Administrator, Licensed Resources). "DLR-CPS and Info Sharing with CASA." Email Attachment to Mary Meinig. 29 April 2009.

APPENDIX D: THE OFCO REVIEW PROCESS

The investigative team included the Director of OFCO, Mary Meinig, and attorney Ombudsman Linda Mason Wilgis, and additional support from OFCO staff. During the ten-month full-scale review (June-April 2009) the investigative team has:

Reviewed:

- DCFS confidential family and child case files
- The Division of Licensed Resources (DLR) foster parent licensing files
- CAMIS, GUI and FAMLINK record entries[116]
- Children's Administration internal reports
- Court orders and other pleadings
- 2006 Washington State CASA Statewide Agreement of Mutual Understanding between Washington State CASA and DSHS Children's Administration
- Draft Stevens County CASA Program Policies and Procedural Guidelines & Draft Stevens county CASA Organizational Chart
- Police reports
- Transcripts and/or recordings of court proceedings of hearings
- Children's Administration policies and procedures
- Newspaper articles
- Materials received from individuals interviewed
- Professional literature on pertinent topics

Reviewed legal authority:

- Applicable RCWs & WACs pertaining to DCFS duties, CPS investigations and dependency and termination proceedings
- Chapter 43.06A RCW – Authorizing statute of OFCO
- RCW 13.34.100 – Appointment of Guardian ad Litem; Rights; Appointment of counsel for child
- RCW 13.34.105 Access to Information
- RCW 13.50.100 -- Keeping and Release of Records by Juvenile Justice or Care Agencies
- Ferry, Pend Oreille & Stevens Counties Local Juvenile Court Rules

Conducted interviews of:

- Parents
- DSHS/CA social workers from Child Protective Services (CPS) and Child Welfare Services (CWS)
- DSHS/CA managers and administrators at the local, regional and state-wide (Headquarters) level
- CASA/GAL Program
- Relatives
- Foster parents

[116] CAMIS and GUI were the prior state-wide automated case management system of DSHS/CA; FAMLINK is the new automated system that became operational in January 2009.

- Court administrators
- Office of the Attorney General; county prosecutors and defense attorneys
- Law enforcement
- Medical professionals
- Other service providers including Children's Advocacy Center staff and school personnel
- Community members and community groups

Met and/or spoke with:

- Elected officials including Governor Christine Gregoire, Attorney General Rob McKenna, Representative Kretz, and Senators Stevens and Morton

APPENDIX E: INTERVIEW PROCESS

The investigative team, in initial contacts, had very open ended conversations with individuals working in or connected to the child welfare system in the Colville area. In the course of OFCO's initial interviews, recurrent themes emerged from a diversity of subjects interviewed (DCFS social workers, CASA/GALs, foster and relative care providers, service providers, court personnel, attorneys). Participants identified poor communication, lack of collaboration and cooperation, and lack of civility between participants as significant factors affecting child welfare practice. They acknowledged that this has eroded trust throughout the community. Lack of accountability was also frequently raised as an issue. In contrast, participants in Pend Oreille and Ferry Counties seldom raised these as issues in their cases. They expressed a mutual appreciation for the role other participants serve, and commented on the respect the judiciary has for the DCFS workers.

After developing preliminary findings based on initial interviews, OFCO then proceeded to the second stage of our interviewing process—keying off of the themes that had emerged. In this stage, OFCO used a more consistent and structured questioning format to elicit responses from individuals (this included new subjects and some individuals with whom OFCO had already spoken) that were more specifically directed at issues that were identified in our preliminary conversations. Participants were asked:

1. Title/ Occupation
2. What are your key responsibilities?
3. How long have you held this position/worked in this capacity?
4. What is your highest priority for the child welfare system?
5. What is the # 1 issue that needs to be addressed to improve the child welfare system in this community?
6. What needs to happen to improve the way the system operates?
7. What is the biggest barrier to improvement? How can you use your role to overcome barriers?
8. **Lack of trust** has been uniformly identified by parties and other stakeholders as a problem. What do you think this stems from?
   What can be done to rebuild trust?
9. **Poor communication** has been identified as a problem. What can other parties do to improve communication; what can you do?
10. **Lack of cooperation** has been identified as a shortcoming in the system. What can parties, including yourself, do to improve this? Have you participated in cross-training and if so, was this useful?
11. **Lack of accountability** has been identified as a problem. How can parties and participants become more accountable in their work and to each other?

APPENDIX F: RELATED CORRESPONDENCE

Attachments pending.