JOINT TASK FORCE ON CHILD SAFETY FOR CHILDREN IN CHILD PROTECTIVE SERVICES OR CHILD WELFARE SERVICES CUSTODY
FINAL REPORT

January 2007

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I. EXECUTIVE SUMMARY

The Joint Task Force on Child Safety for Children in Child Protective Services or Child Welfare Services Custody was created in 2005 by SHB 2156**.** The legislation required the Task Force to review several issues relating to improving the health, safety, and welfare of Washington children in Child Protective Services or Child Welfare Services custody and to make recommendations to the Legislature and the Governor regarding those issues.

The Task Force met four times during the 2005 Legislative Interim. During these meetings, the full Task Force heard information regarding federal and state laws pertaining to child welfare, the child welfare system, fatality reviews from both the Office of the Family and Children's Ombudsman (OFCO) and the Department of Social and Health Services (DSHS), and a summary of recommendations from previous task forces, work groups, and studies relating to child welfare reform in Washington. The result of the Task Force work in 2005 was to create several subcommittees assigned to review the following specific areas of interest focusing on the Department of Social and Health Services: intake and investigation; review, oversight and accountability; services; and caseworker and supervisor training, workload, and support.

The Task Force did not meet during the 2006 Legislative Session. In May 2006, the full Task Force resumed its meetings. Following the May meeting, each of the four subcommittees met two times and created a list of recommendations for consideration by the full task force. At the final meeting of the full task force in October, the subcommittees presented their lists of recommendation in order of priority. This report contains the recommendations agreed upon by the full Task Force, as well as the recommendations that were discussed, but not agreed upon by the full Task Force. Each recommendation is preceded by a description of the issue to which the recommendation relates in order to provide context for the recommendation. Finally, the report appendices contains the full subcommittee recommendations and the Task Force Preliminary Report issued in 2005.

II. BACKGROUND

A. Introduction

The legislative members of the task force would like to extend their gratitude to all of the members of the task force who devoted a significant amount of time and energy to the work of this group. The members of the task force spent two years working to produce the recommendations contained in this report and their dedication permitted the task force to look at a broad range of issues relating to the safety and welfare of children in Child Protective Services (CPS) or Child Welfare Services (CWS) custody. The recommendations in this report are the embodiment of the work of this group; however, they are far from the end of the process. Rather, these issues, and potentially others raised in the meetings but not contained in this report, will become a part of the legislative process in which they will be further discussed and developed. It should also be acknowledged that while task force participants brought tremendous expertise and careful thought to the development of these final recommendations, there are others with expertise in child welfare who did not participate in the task force who may bring forward ideas to the legislature. The legislature will consider all of the ideas and recommendations in its efforts to improve the safety of all children in CPS or CWS custody.

B. Legislation

The legislation required the Task Force to look at the following issues in preparing its recommendations:

(a) State and federal statutes regarding child safety, placement, removal from the home, termination of parental rights, and reunification with parents;
(b) Current and ongoing department of social and health services work groups or work plans regarding child safety, placement, removal from the home, termination of parental rights, and reunification with parents;
(c) The purpose and value of child protection teams and determine whether any changes should be made;
(d) Best practices regarding children removed from parents at birth and placed in out-of-home care, transition services for families with children in out-of-home placement for an extended period of time, and standards for return to home placement when a child has been placed out-of-home including situations where a child has been placed out-of-home and returned to home multiple times;
(e) The training that is offered to social workers regarding child development and determine

whether any changes should be made;

(f) Best practices regarding sharing of accurate, complete, and relevant medical, mental health, and substance abuse information between case workers, supervisors, the courts, child protection teams, counsel, guardians, parents, and other relevant participants in child placement decisions;

(g) Best practices for assessing and addressing chemical dependency issues of parents;

(h) The effectiveness of current home-based service providers currently used and determine whether any changes should be made;

(i) Best practices addressing family cultural and tribal issues and the role, if any, of social worker training or bias in safety assessment and placement decisions; and

(j) Other issues deemed relevant to improving child safety outcomes.

The Task Force wass required to report its preliminary findings and recommendations to the Legislature by December 31, 2005, and provide a final report on its findings and recommendations by September 1, 2006.

C. Task Force Membership

The Task Force includes the following members:

Senator Dale Brandland
Senator Jim Hargrove
Representative Bill Hinkle
Representative Ruth Kagi
Melissa Allen, Department of Health, Maternal and Child Health
Robin Arnold-Williams, Dept. of Social and Health Services
Danielle Baxter, Foster Parent Association of Washington State
Charlotte Booth, Institute for Family Development
Rick Byalock, Cascade Recovery
Linda Collins, Child Welfare Services
Yolanda Duralde. M.D., Mary Bridge Childhood Abuse Intervention
Steve Hassett, Office the Attorney General
Hon. Margie Hutchinson, Colville Business Council
Linda Katz, CASA Program
Amy Kernkamp, Child Protective Services, DSHS
Shelly Lacy, Tulalip Tribe
Laurie Lippold, Children's Home Society of Washington
Gary Malkasian, Foster Parent
Byron Manering, Brigid Collins
Mary Meinig, Office of the Family & Children's Ombudsman
Joanne Moore, Office of Public Defense
Michael Petcu, Birth Parent
Joan Sharp, Washington Council for Prevention of Child Abuse and Neglect

Chief Colleen Wilson, Washington Association of Sheriffs and Police Chiefs
Judge Diane M. Woolard, Superior Court

The task force created an Executive Committee which consisted of the following members:

Senator Dale Brandland
Senator Jim Hargrove
Representative Bill Hinkle
Representative Ruth Kagi

D. Task Force Staff

Legislative staff assigned to the task force:

Sonja Hallum, Staff Counsel, Office of Program Research, Children and Family Services Committee
Edith Rice, Staff Counsel, Senate Committee Services, Human Services and Corrections Committee (2005)
Kiki Keizer, Staff Counsel, Senate Committee Services, Human Services and Corrections Committee (2006)

E. Task Force Meetings

1. 2005

The Task Force began its work on August 23, 2005. Members received overviews of federal and state law, the child welfare system, fatality reviews from both the Office of the Family and Children's Ombudsman (OFCO) and the Department of Social and Health Services (DSHS), and a summary of recommendations from previous task forces, work groups, and studies relating to child welfare reform in Washington.

The Task Force met four times from August through November 2005. Meetings were held in Olympia.

The Task Force found that a significant amount of work had been conducted by other groups in the past and more efforts were currently underway. Additionally, the Task Force recognized that the DSHS had made efforts to address many problem areas within the Children's Administration (CA) and the child welfare system; however, much remained to be done to improve the quality and consistency of system.

The Task Force recommended that the Task Force continue its work in 2006 by forming subcommittees to review specific topic areas in greater detail and create recommendations that they would then share with the full Task Force. The Subcommittees were to be formed to review

the following areas:

1. Intake and Investigation;
2. Caseworker and supervisor workload;
3. Services, including on-going services after a child is returned home;
4. Internal and external review, including oversight and accountability; and
5. Caseworker and supervisor training and support.

2. 2006

Prior to the first subcommittee meetings, the caseworker and supervisor workload and caseworker and supervisor training and support subcommittees were combined because their issues were related and the same members would be serving on both subcommittees. The result was that four subcommittees met throughout the 2006 interim. Each subcommittee met twice and created recommendations for the full Task Force. In October 2006, the subcommittees met and prioritized their recommendations which they then presented to the full Task Force.

III. RECOMMENDATIONS

The following is the final list of recommendations from the task force in order of priority from each subcommittee. Each set of recommendations is preceded by an issue statement which the recommendations are intended to address. The issue statements reflect the views of the stakeholders in attendance at the task force meetings and are not intended to be a statement of the legislature or individual legislators who served on the task force. They are intended solely for guidance in understanding the problem, as seen by the members of the task force, which they were attempting to address through their recommendations.

A. Intake and Investigation Subcommittee

1. **Issue:** In some cases, a child who has been removed from the home due to abuse or neglect may be returned home and subsequently removed several times over the course of years in attempts to reunify the parent and child. In these situations, the child remains in foster care for years without establishing permanency.

   Recommendation: If a child is removed from home due to allegations of abuse or neglect, returned home, and subsequently removed and placed in out-of-home care, the court shall hold a hearing no later than 30 days from the date of the removal to determine the appropriate action, including a change in the permanency plan or the filing of a termination petition. The best interests of the child must be the primary consideration.

2. **Issue:** Child fatality reviews have identified problems in the investigations conducted

prior to placing a child into a home, particularly when a child is being placed into the home of a parent after the child had been removed from a parent. The fatality reviews identified situations in which sufficient background information was not obtained on the child's primary caregiver or other adults living in the home. Additionally, the reports identified a reluctance to require other adults in the home, who may be primary care givers, to engage in services when they are not the parent who is a party to the dependency.

Recommendation: The Children's Administration must identify all persons who will act as a caregiver for the child and determine whether the caregiver is in need of any services in order to ensure the safety of the child, regardless of whether the caregiver is a party to the dependency. If the caregiver fails to engage in the recommended services, then the child welfare worker must promptly notify the court. Additionally, the Children's Administration must determine all others residing in the home and conduct background checks on those persons. The parent in the home to which the child is being returned must be notified that he or she has an on-going duty to notify the Children's Administration of any persons who are residing in the home or acting as a caregiver for the child.

3. **Issue**: When a referral is made to CPS, a CPS intake worker reviews the referral and determines the appropriate action that should be taken. The referral may be documented for information only and not accepted for investigation, accepted for investigation, and/or referred to a third party such as law enforcement. If the referral is accepted it will be assigned a risk tag. If the risk tag is low, the only action that might be taken is that a letter is sent to the family giving them information on services that are available. If the risk tag is low, or moderately low, it may be sent to Alternative Response Services (ARS). Once the referral is made to ARS, there is not a standard procedure for following up to determine the outcome of the referral, particularly whether the family was contacted and whether the family engaged in services.

   Recommendation. There must be more consistency in how low risk referrals are handled and face-to-face contacts must be made in all cases where a referral has been accepted. The contact should be made by a the Children's Administration or by the agency with whom the Department has contracted to provide Alternative Response Services. If, after a contact by Children's Administration or by an Alternative Response Services provider, it is determined that a family has failed to engage in services, then the case must be re-evaluated to determine whether another form of intervention is appropriate. The planned development of Children's Administration's practice model and the design of Washington's statewide automated child welfare system (SACWIS) should include these requirements for contact and follow-up, as well as the ability of the SACWIS system to track the referrals and outcomes.

B. Caseworker and Supervisor Training, Workload, and Support Subcommittee

1. **Issue:** The ability of social workers to adequately staff cases to ensure child safety and permanency is greatly impacted by the workload of the social worker. Currently, caseloads are high, there is little support to assist with work that does not require a caseworker's knowledge and experience, and there is too great a delay in filling vacant positions which leads to even greater caseloads for the remaining caseworkers. Several child fatality reports found that caseworkers in the case were ill, on vacation, or that their supervisors were carrying caseloads which impacted their ability to actively supervise the caseworkers.

   Recommendation: The Children's Administration should be encouraged to establish an overhire pool of previously trained workers who would be available to fill temporary vacancies and to carry cases when caseloads in a particular office exceed maximum workload standards. The overhire pool would be funded with both existing and new resources. The Children's Administration will require more flexibility with respect to spending authority, as well as managing staffing levels, staffing functions, and priorities in order to address the workload issues.

   Recommendation: Adequate administrative support is necessary and should be provided so that social workers may focus on the priority work of conducting social work in the field. Non-case carrying workers should be hired to provide support to social workers. Support for workers should be in three areas:

   a. Case aid: provides in-office support that does not require the level of education and training held by a caseworker such as providing transportation, gathering documents, delivering information, and other administrative functions.

   b. Discovery Disclosure Expert: a person with training in records and public disclosure to assist with court discovery requests and public disclosure requests.

   c. Home Support Services: provides concrete in-home services to families to teach basic skills in order to better care for their children..

2. **Issue**: There is a lack of communication between law enforcement and the Children's Administration. The Children's Administration may have information that is not communicated to law enforcement that may aid in the law enforcement investigation. Conversely, law enforcement may have contact with a child, such as through a welfare check of a home, and not report the contact to Children's Administration. There may also be information in the possession of law enforcement of which Children's Administration is not aware prior to placing a child in a home. This was the situation in the Sirita Sotelo case. According to the Department of Social and Health Services (DSHS) fatality report,

the Regional Drug Task Force had information on the family that Children's Administration did not have, and which may have made a difference in placing Sirita in her father's home.

Recommendation: Children's Administration and law enforcement should work together to develop protocols about contact and communication between agencies in physical abuse cases, similar to those protocols that have been developed to handle sex abuse cases.

Recommendation: All law enforcement officers should receive training on child abuse and neglect issues. The training should be consistent, thorough and required for all law enforcement officers. Additionally, social workers and law enforcement officials should cross-train to gain perspective on the roles and responsibilities of the various agencies involved in investigations of child abuse and neglect. Such training could encompass protocols that are developed for inter-agency communication, as well as investigative best practices.

C. Services Subcommittee:

1. **Issue:** Parents who are involved in the Child Protective Services (CPS) or Child Welfare Services (CWS) systems are frequently required to engage in services. However, there appears to be a lack of a basic array of services, or inconsistency of services, that are available to parents across the state. Additionally, many parents have difficulty accessing services in a timely manner for a variety of reasons. Particular areas of concern include the lack of transportation available to parents to enable them reach services, the availability of culturally appropriate services, the financial accessibility of the services, the availability of services only during work hours which conflict with the efforts of the parents to maintain employment, and the availability of timely and appropriate services.

   Recommendation: The state should inventory services parents are required to engage in by the court pursuant to a dependency action and determine what services are currently available in each county, assess the service gaps or unmet needs, and examine alternatives for delivery and payment of services. The inventory of service should extend beyond those offered through Children's Administration to include all services that may be court ordered in a dependency. The examination of alternatives for the delivery of services should include options for improving the access to services in rural areas, providing culturally appropriate services, and services that are financially accessible to parents.

   Recommendation: The Legislature should require that parents in dependency proceedings should be statutorily granted priority for court ordered service, including mental health services, domestic violence treatment, parent-child therapy, and parenting classes. This priority would extend through the pendency of a court-ordered transition

plan. Additionally, the court-ordered services should be provided to parents at the expense of the state if the parent is unable to pay for the services.

2. **Issue:** It is a traumatic experience for a child to be removed from his or her home and the integration into a parent's home also brings trauma or emotional upheaval in the child's life. It is important to recognize that this period of transition is a difficult and stressful one for both the child and the parent. It is important to utilize all resources available to the family to assist in helping the child make a successful transition into the home. An important resource can be the child's foster parent. The foster parent should be used as a resource to help the child move from the foster home into the home of the parent. The foster parent can offer emotional support and continuity while helping the child to integrate into the new family. The foster parent can also act as a mentor to the parent to provide assistance during the transition period. The mentoring programs in Clark and Thurston Counties are models of programs in which foster parents are successfully mentoring the biological parents.

   Recommendation: Foster parents should be used as a resource when a child is transitioned to the home of the parent if such contact with the foster parent is appropriate and the court determines it is in the best interests of the child. If appropriate, foster parents should be involved in family team decision meetings to offer insight into the case.

   Recommendation: Barriers to programs designed to provide mentors to parents involved in dependency proceedings should be reduced. For example, finding a way to provide insurance coverage to persons willing to serve as mentors, or to exempt mentors and the state from civil liability should an accident occur in the course of mentorship, could facilitate the expansion of programs intended to support children and families.

D. Review and Oversight Subcommittee:

1. **Issue:** Supervisors play a critical role in the safety of children in Child Protective Services (CPS) or Child Welfare Services (CWS) custody. Supervisors mentor new staff, provide guidance and oversight in caseworker decision-making, monitor compliance with policy and procedure, and intervene to administer disciplinary measures when necessary. However, supervisors are often promoted as caseworkers and must act as supervisors to people with whom they were formerly co-workers. This can create a situation in which it is difficult to manage personnel effectively. Additionally, the workload of supervisors is such that it is unrealistic to expect that supervisors will have the time available that is required to perform the oversight and management functions effectively.

   Recommendation: The Legislature should mandate a supervisor ratio of no greater than 1 supervisor to 6 caseworkers. Additionally, the Legislature should statutorily mandate

limits on workload standards in accordance with accreditation standards and legal obligations, taking weighted caseloads into consideration.

2. **Issue:** In many cases, children remain in foster care far too long before permanency is established for the child. A greater emphasis must be placed on establishing permanency in the lives of children in foster care. If a child must remain in foster care for an extended period of time, the child's case should be reviewed frequently to ensure that everything possible is being done to move towards permanency.

   Recommendation: The Legislature should pass a statute modeled after Utah which holds all entities jointly accountable for cases that are in the child welfare system for lengthy periods of time by requiring an annual report to the legislature of all child welfare cases that fall outside of statutory time limits. The report should be required of the DSHS, the Attorney General's Office, and the Courts and should identify the cases not in compliance with the statutory time limits regarding the following: pretrial and adjudication hearings; dispositional hearings and reunification services; permanency hearings and petitions for termination; and the reasons for the noncompliance. The Legislature may choose to create a Legislative Oversight Panel to receive the reports, monitor compliance with state and federal laws, and make recommendations to the Legislature.

   Recommendation: The Legislature should request that the Foster Care Commission to consider whether the following changes should be made to current law:

   a. Whether the Legislature should pass a statute which requires that when the final plan for a child is to proceed toward termination of parental rights, a petition for termination of parental rights shall be filed against a parent who has failed to have contact with the child or indicate a willingness to care for the child. The hearing on the termination petition must be held within 90 calendar days after the permanency hearing.; and

   b. Whether the Legislature should pass a statute which requires that the decision on the petition for termination of parental rights shall be made within 18 months from the date of the child's removal from the home when a parent who has failed to have contact with the child or indicate a willingness to care for the child.

3. **Issue:** Courts provide an important oversight function in the child welfare system. However, judges are unable to provide necessary oversight of child safety decisions when they are not provided with full and accurate information. This is often the case when the judge is presented with agreed orders and no testimony or information is provided to the court or if the court is provided with only summaries of information from the parties.

   Recommendation: The Legislature should require a judicial hearing on every dependency case at least one time per year in which the court hears testimony and

inquiries into issues in the case such as the safety planning for the child.

Recommendation: The Legislature should pass a statute requiring that courts be provided with original documents and expert reports including, but not limited to, psychological evaluations, services, visitation reports, foster parent reports, medical reports, and other reports *relevant to that particular court hearing* and not summaries of the reports.

Recommendation: Best practices should be reviewed regarding changes of placement for a child, or extended visitation, without a judicial hearing or judicial approval.

4. **Issue 1**: Under the Collective Bargaining Agreement entered into between the State of Washington and the Washington Federation of State Employees, social workers are considered "for cause" employees which means that they may only be disciplined" for cause." The process to discipline or terminate a "for cause" employee can be lengthy and cumbersome. However, when the Department of Social and Health Services (DSHS) hires a new social worker, the social worker is placed on probation for a period of 12 months. During the probationary period, the social worker is an "at-will" employee rather than a "for cause" employee which means the standard to discipline or terminate a new employee is lower. A supervisor should be utilizing this probationary period to work with new social workers and to determine whether they are appropriate for the position. Currently, the probationary period is not being fully utilized to remove case workers who are not meeting performance standards.

   Recommendation 1: Supervisors are required to conduct evaluations of new case workers during the first 12 months of employment. The Practice Model should encourage Supervisors to utilize this 12 month period to conduct reviews and determine whether the caseworker's employment should continue.

5. **Issue:** Child Protection Teams (CPTs) play an important role in oversight of child placement decisions and are a key piece of the child safety team. CPTs are not implemented consistently and are often not utilized to their greatest potential. CPTs must be implemented more effectively to enhance child safety in placement decisions. CPT facilitators play an important role in the effectiveness of CPTs.

   Recommendation: The Legislature should fund CPT facilitator positions.

   Recommendation: The DSHS should implement the revised CPT policy it is currently developing as soon as possible.

Appendix A

History of the Bill

Sirita Sotelo was a dependent of the State of Washington since her birth in 2000. She had been placed with her mother four times and removed from her care after each placement. Since her birth, Sirita had resided in seven different foster care placements. During this time, Sirita's father had little or no involvement in planning or care of Sirita.

In May 2003, the Department of Social and Health Services filed a petition for termination of parental rights for both of Sirita's biological parents. The father then requested that Sirita be placed with his family. The father was living with his wife and three children at the time. In November 2003, Sirita was placed in her father's home. The dependency was dismissed in November 2004. On January 21, 2005, Sirita Sotelo died as a result of severe injuries inflicted by her stepmother.

During the 2005 Legislative Session, HB 2156 was introduced and referred to as "Sirita's Law." The bill established increasingly strict standards for a parent to meet in order to have a child returned to his or her care after each time the child is removed from the care of the parent due to abuse or neglect. Additionally, the bill required the Department of Social and Health Services to file a petition to terminate parental rights after the child had been removed from the parent's care after three times.

The bill was amended and became SHB 2156 which created the Joint Task Force on Child Safety for Children in Child Protective Services or Child Welfare Services Custody to review issues related to safety of children in the care of the Department of Social and Health Services.

The assignment of the task force was to review and make recommendations to the Legislature and the Governor on improving the health, safety, and welfare of Washington children in child protective services or child welfare services custody.

Appendix B

Intake and Investigation Subcommittee
Recommendations
August 1, 2006

Recommendations of full subcommittee

I. **Issue 1**: When a referral is made to CPS, a CPS intake worker reviews the referral and determines the appropriate action that should be taken. The referral may be documented for information only and not accepted for investigation, accepted for investigation, and/or referred to a third party such as law enforcement. If the referral is accepted it will be assigned a risk tag. If the risk tag is low, the only action that might be taken is that a letter is sent to the family giving them information on services that are available. If the risk tag is low, or moderately low, it may be sent to Alternative Response Services (ARS). Once the referral is made to ARS, there is not a standard procedure for following up to determine the outcome of the referral, particularly whether the family was contacted and whether the family engaged in services.

Recommendation 1: The DSHS should re-examine how referrals are currently accepted at intake to determine whether referrals are being appropriately accepted and whether the risk level that is being assigned is accurate for the referral. The CA has indicated that they currently have plans to consider this issue in the development of the Practice Model.

Recommendation 2: If a referral is accepted, a face-to-face contact must be made with the child by either a Child Protective Services (CPS) caseworker or a community provider. If the face-to-face contacts cannot be accomplished within existing resources, the Legislature should appropriate sufficient funds to ensure that a face-to-face contact occurs in every accepted referral.

Recommendation 3: If a family is referred to Alternative Response Services, the CA must follow-up on the case to determine and document the outcome. If the family fails to complete the recommended services, the CA should review the case to determine if further action is appropriate.

Recommendation 4: CPS should meet with local area service providers on a regular basis to discuss the status and follow through of pending cases that were referred to the service providers for ARS and other voluntary services.

Recommendation 5: The new SACWIS computer system design should include the ability of the CA to document the status and outcomes of cases referred to ARS to enable CA to track the interventions.

II. **Issue 2:** Child fatality reviews have identified problems in the investigations conducted prior to placing a child into a home, particularly when a child is being placed into the home of a parent after the child had been removed from a parent. Problems have been identified in the practice of failing to obtain sufficient background information on adults living in the home or who will be primary care givers. Additionally, there has been a reluctance to require other adults in the home, who may be primary care givers, to engage in services when they are not the parent who is a party to the dependency.

Recommendation 6: When a child is placed into a home, the CA should identify all persons who will act as primary care givers to the child and engage them in any services which may be needed to ensure the safety of the child, regardless of whether or not they are a party to the dependency. If the caseworker has concerns regarding the ability of the primary care giver to care for the child, the caseworker may recommend additional services that may be needed to correct any care giving issues. If the primary care giver refuses to engage in services, the caseworker shall promptly notify the court to enable the court to make any decisions necessary to ensure the safety of the child.

Recommendation 7: The CA should provide the court with all criminal history information pertaining to adults in the home in which the child is to be placed that is available to the DSHS. The courts should not rely on the summary or conclusions made by the DSHS regarding the criminal history of adults in the home.

Recommendation 8: The courts should utilize all information sources available to them to determine criminal history of adults in the home in which a child may be placed and are encouraged not to rely solely on the conclusions of the DSHS as to the appropriateness of the background of any adults living in the home.

Recommendation 9: All law enforcement jurisdictions should be required to send conviction information to the Washington State Patrol to be placed into the criminal history database.

III. **Issue 3**: A problem area identified in several child fatality reviews relates to caseworker bias that affects the decisions made by the caseworkers and, ultimately, places the child at greater risk. An area in which this can occur is during the investigation of a referral in an open dependency or in which there have been multiple screened in referrals.

Recommendation 10: As a part of the CPS/CWS redesign, the CA should review ways to address investigator bias when there is a subsequent investigation of an abuse or neglect referral in a case in which there is an open dependency and in cases in which there are several referrals accepted for investigation, but no action has been taken.

IV. **Issue 4:** Voluntary Placement Agreements (VPAs) are short term agreements entered into by the CA and a parent in which a parent agrees to a placement arrangement for the child

and the CA offers services to the family. The use of VPAs within the state varies by region. However, very little information is available regarding the use of VPAs including how and when they are used and what impact they may be having.

Recommendation 11: The CA should look at how VPAs are used within the regions, whether there is consistency in their use, whether they are being used appropriately for the safety of children, and whether VPAs place parents at a disadvantage. The CA has indicated that they currently have plans to consider this issue in the development of the Practice Model.

Recommendation 12: Assistance of a fully knowledgeable parent's advocate should be made available to a parent entering into a VPA.

V. **Issue 5:** In some cases, a child who has been removed from the home due to abuse or neglect may be returned home and subsequently removed several times over the course of years in attempts to reunify the parent and child. In these situations, the child remains in foster care for years without establishing permanency.

Recommendation 13: If a child is removed from the home due to allegations of abuse or neglect, returned home, subsequently removed and again placed in out-of-home care**,** the court shall hold a hearing within seven days of the removal to determine what action should be taken, including a change in permanency plan or the filing of a termination petition.

Recommendations of individual members of the subcommittee, but no agreement reached:

Subcommittee recommendations were adopted by the full task force that address the goals expressed in the following recommendations, including recommendations requiring a court review to determine appropriate action within 30 days for a child removed twice for allegations of abuse or neglect and utilizing foster parents as a resource when a child is transitioned back to the home of a parent.

VI. **Issue 6:** Children who have been removed from a parent due to abuse or neglect need to have permanency established in their lives. Though parents must be given the opportunity to correct the issues that lead to the removal of the child and to be a parent to the child, this opportunity is not endless. If a parent repeatedly demonstrates that he or she is unable or unwilling to do what is necessary to parent the child, the court must review the case to determine if termination of parental rights is the more appropriate alternative for the child.

Recommendation 14: The Legislature should create a rebuttable presumption that a parent may not be considered a placement option for the child if the parent fails to identify himself or herself as a placement option within the first 15 months after a child is

removed from the home, so long as the parent received notice of the removal and was a part of the proceeding.

Recommendation 15: The Legislature should require that a petition for termination of parental rights be filed if a child has been removed from his or her parent's care due to abuse or neglect and there have been two subsequent placements of the child with the parent which have resulted in the child being removed from the care of the parent due to parental deficiencies which place the child at risk.

Appendix C

Caseworker and Supervisor Training, Workload and Support Sub-Committee Recommendations
July 19, 2006

I. **Issue 1:** There is a lack of communication between law enforcement and the Children's Administration (CA). Law enforcement may have contact with a child, such as through a welfare check of a home, and not report the contact to CA. Additionally, there may be information in the possession of law enforcement of which CA is not aware prior to placing a child in a home. This was the situation in the Sirita Sotelo case. According to the Department of Social and Health Services (DSHS) fatality report, the regional drug task force had information on the family that CA did not have, and which may have made a difference in placing Sirita in her father's home.

Recommendation 1: The Legislature should fund collaboration between agencies to develop child abuse and neglect protocols and best practices for use at the local level using existing models of collaboration such as the Governor's Methamphetamine Task Force. The protocols and best practices should include law enforcement obtaining information on an open CA case before going to the home on a call and when law enforcement is to share information with the CA. Agencies who are encouraged to collaborate in the development of the protocols and best practices include, but are not limited to, representatives of law enforcement, courts, the DSHS, prosecutors, defense attorneys, and the Attorney General's Office.

Recommendation 2: The Legislature should require law enforcement to notify CA whenever a child welfare check is conducted. Law enforcement should provide information about the report and allegations that were made to law enforcement, what the officer found when he or she investigated, and the outcome of the investigation.

II. **Issue 2:** Law enforcement officers and social service providers are trained, and approach situations, differently. When they are involved in investigations, they do not always clearly communicate to one another. The fatality reviews point to specific instances where collaboration failed and/or where our perspectives were not honored or understood. Child safety would be improved if both roles are understood and valued and these two perspectives are encouraged to work together.

Training for both law enforcement and social service providers on each other's roles and perspectives would be valuable. Currently, there are some multi-disciplinary training efforts underway; however, these specialized trainings reach only a small number of the 10,000 law enforcement officers in Washington.

Recommendation 3: All law enforcement officers should receive training on child abuse and neglect issues, particularly child safety. The training should be consistent, thorough, and required for all law enforcement officers.

Recommendation 4: The DSHS and the Office of the Family and Children's Ombudsman should collaborate with the Washington State Criminal Justice Training Commission to develop child abuse and neglect training to be provided to all law enforcement officers at the Basic Law Enforcement Academy.

Recommendation 5: CA, law enforcement, and other relevant stakeholders should collaborate to provide multi-disciplinary child abuse and neglect trainings.

III. **Issue 3**: Several problems related to the courts were identified that may potentially lead to placing a child at greater risk, causing a delay in permanency, or increasing the workload of caseworkers. The following are some of the problems identified: 1) continuances and delays in court hearings and termination of parental rights appeals leading to delays in establishing permanency and cases being left on caseloads beyond what is necessary; and 2) the potential for insufficient judicial oversight that may result from frequent judicial rotations, the entry of agreed orders without the court being involved in the decision-making, and insufficient judicial training in child safety.

Recommendation 6: The Courts are encouraged to consider the recommendations of the Court Improvement Project and the Foster Care Commission in order to address delays and inefficiencies in the current system. Particular consideration should be given recommendations that relate to child safety and reducing the time to establish permanency, including expediting appeals of termination of parental rights to decrease the delay in establishing permanency.

IV. **Issue 4:** The ability of social workers to adequately staff cases to ensure child safety and permanency is greatly impacted by the workload of the social worker. Currently, caseloads are high, there is little support to assist with work that does not require a caseworker's knowledge and experience, and there is too great a delay in filling vacant positions which leads to even greater caseloads for the remaining caseworkers.

Recommendation 7: The CA should create a hiring waiting list. There should be a list of applicants who have been prescreened, interviewed using a standardized interview process, and are ready to be hired and begin training.

Recommendation 8: The CA should create an overhire pool that consists of trained workers who are available to fill temporary vacancies and to manage caseloads by assisting when caseloads exceed the maximum caseload standards. The overhire pool should be funded using the funds not utilized when a social worker position is vacant.

Recommendation 9: Non-case carrying workers should be hired to provide support to social workers. Support for workers should be in three areas:

1. Case aid: provides in-office support that does not require the level of education and training held by a caseworker such as providing transportation, gathering documents, and delivering information.

2. Discovery Disclosure Expert: a person with training in records and public disclosure to assist with court discovery requests and public disclosure requests.

3. Home Support Services: provides concrete in-home services to families to teach basic skills in order to enable the family to support and care for the child.

Appendix D

Services Subcommittee
Recommendations
August 4, 2006

I. **Issue 1:** Parents who are involved in the Child Protective Services (CPS) or Child Welfare Services (CWS) systems are frequently required to engage in services. However, there appears to be a lack of a basic array of services, or inconsistency of services, that are available to parents across the state. Additionally, many parents have difficulty accessing services in a timely manner for a variety of reasons. Particular areas of concern include the lack of transportation available to parents to enable them reach services, the availability of culturally appropriate services, the financial accessibility of the services, the availability of services only during work hours which conflict with the efforts of the parents to maintain employment, and the availability of timely and appropriate services.

Recommendation 1: The state should inventory existing services in each county, assess the service gaps or unmet needs, and examine alternatives for delivery and payment of services. The examination of alternatives for the delivery of services should include options for improving the access to services in rural areas, providing culturally appropriate services, and services that are financially accessible to parents.

Recommendation 2: After reviewing the information obtained in the assessment of services within the state, the Legislature should develop a statewide plan to provide the federally mandated basic services to families across the state and should ensure that there are adequate resources to fund the services.

Recommendation 3: The Legislature shall require that services be available after hours and on weekends to enable working parents to engage in services.

Recommendation 4: Parents should not be prevented from accessing any services that are listed in the service plan or court order due to inability to pay.

Recommendation 5: The Department of Social and Health Services (DSHS) is encouraged to continue its efforts to move toward more effective services and better matching parents and children to the appropriate services. Services provided to the parent should address any emotional or behavioral issues of the child and assist the parent to address the child's issues.

II. **Issue 2:** It is a traumatic experience for a child to be removed from his or her home and the integration into a parent's home also brings trauma or emotional upheaval in the

child's life. It is important to recognize that this period of transition is a difficult and stressful one for both the child and the parent. It is important to utilize all resources available to the family to assist in helping the child make a successful transition into the home. An important resource can be the child's foster parent. The foster parent should be used as a resource to help the child move from the foster home into the home of the parent. The foster parent can offer emotional support and continuity while helping the child to integrate into the new family. The foster parent can also act as a mentor to the parent to provide assistance during the transition period. The mentoring programs in Clark and Thurston Counties are models of programs in which foster parents are successfully mentoring the biological parents.

It is important that the family be provided with appropriate transition services to enable the successful transition of the child into the parent's home. The DSHS is working to develop an assessment tool to help more accurately identify the needs of the family during this period, as well as the training necessary to implement the tool.

Recommendation 6: During the post placement supervision period after a child has been in out of home care in a foster home or relative placement, the person(s) who was (were) in loco parentis, if willing, shall be a transition resource and allowed visitation with the child, when approved by a judge as in the best interest of the child. The purposes of visitation are: 1) to assist the child with detachment issues and the grieving process, 2) to assist the child's integration into the new family, and when appropriate, provide mentoring to the child's parents, and 3) to provide extra oversight to ensure the safety of the child, from resource that likely knows this child better than any other external source. Visitations shall have the following conditions: 1) the persons included in the visitation shall be limited to those for whom the child is grieving, such as the parental figures and foster/step/virtual siblings. Extended family members should only be included if they were significant persons in the home and the child is specifically grieving for them. 2) The adults allowed visitation shall receive a guidance on the above mentioned purposes of visitation and what behaviors are appropriate, for example, "I love you and miss you" is appropriate, but "I miss you and wish you could come home with us" would not be appropriate or helpful. 3) A social worker shall be present at the first visitation to assist in what may be an emotional first moment. 4) Visitations shall take place preferably in the new environment, or when necessary, in a neutral environment. Visitations should not take place in the old environment, but this condition does not prevent the child from returning to the previous placement if the child returns to out of home care or requires respite care.

Recommendation 7: Mentoring programs such as the Clark and Thurston County programs should be supported and increased by the DSHS and the Legislature. There should also be evaluations conducted of the programs to ensure that there continue to be positive outcomes.

Recommendation 8: The DSHS and the Legislature should ensure that parents have access to services during the transition period, including the Homebuilders Program.

Appendix E

Review , Oversight and Accountability Sub-Committee Recommendations July 21, 2006

I. **Issue 1:** Under the Collective Bargaining Agreement entered into between the State of Washington and the Washington Federation of State Employees, social workers are considered "for cause" employees which means that they may only be disciplined" for cause." The process to discipline or terminate a "for cause" employee can be lengthy and cumbersome. However, when the Department of Social and Health Services (DSHS) hires a new social worker, the social worker is placed on probation for a period of 12 months. During the probationary period, the social worker is an "at-will" employee rather than a "for cause" employee which means the standard to discipline or terminate a new employee is lower. A supervisor should be utilizing this probationary period to work with new social workers and to determine whether they are appropriate for the position. Currently, the probationary period is not being fully utilized to remove case workers who are not meeting performance standards.

Recommendation 1: Supervisors are required to conduct evaluations of new case workers during the first 12 months of employment. Reviews shall occur at three months and six months and should include review of goals and performance measures. At nine months an additional review and evaluation shall be conducted with the supervisor and supervisor's superior, or the superior's designee, to determine whether the social worker's employment should continue. The DSHS shall generate automatic notification that the review is due and hold area managers accountable.

II. **Issue 2:** Supervisors play a critical role in the safety of children in Child Protective Services (CPS) or Child Welfare Services (CWS) custody. Supervisors mentor new staff, provide guidance and oversight in caseworker decision-making, monitor compliance with policy and procedure, and intervene to administer disciplinary measures when necessary. However, supervisors are often promoted as caseworkers and must act as supervisors to people with whom they were formerly co-workers. This can create a situation in which it is difficult to manage personnel effectively. Additionally, the workload of supervisors is such that it is unrealistic to expect that supervisors will have the time available that is required to perform the oversight and management functions effectively.

Recommendation 3: The DSHS should require training for supervisors regarding how to manage new employees, as well as personnel and discipline issues.

Recommendation 4: The Legislature should mandate a supervisor ratio of no greater than 1 to 6.

III. **Issue 3:** Increasing child safety requires maintenance a qualified CPS and CWS workforce, reduction in turnover rates, and enabling caseworkers and supervisors to carry caseloads that permit adequate handling of cases. High caseworker caseloads have been specifically cited as an issue in several high profile child fatalities in Washington. The Legislature has made an effort to reduce the high caseloads in 2005 by appropriating a significant amount to fund additional caseworkers.

Recommendation 5: The Legislature should statutorily establish maximum caseload standards in accordance with accreditation standards and legal obligations and provide funding to reduce caseloads when caseloads exceed the standards.

Recommendation 6: The Legislature and the DSHS must invest in the CA workforce to recruit, retain and build a skilled workforce. The DSHS should incentivize skill building in areas of expertise needed in child welfare.

IV. **Issue 4:** Child Protection Teams (CPTs) play an important role in oversight of child placement decisions and are a key piece of the child safety team. CPTs are not implemented consistently and are often not utilized to their greatest potential. CPTs must be implemented more effectively to enhance child safety in placement decisions. CPT facilitators play an important role in the effectiveness of CPTs.

Recommendation 7: The Legislature should fund CPT facilitator positions.

Recommendation 8: The DSHS should implement the revised CPT policy it is currently developing as soon as possible.

V. **Issue 5:** In the area of child welfare, research is not currently available to establish what is a reasonable in-home safety plan. There is a pressing need to have more information on what is effective for in-home safety planning.

Recommendation 9: The DSHS should conduct a study to evaluate current practice in the use of safety plans when a child in the custody of CPS or CWS is residing in-home and determine what plans are best to protect a child in high risk environments. The DSHS should coordinate with other agencies in conducting the study.

VI. **Issue 6:** Courts provide an important oversight function in the child welfare system. However, judges are unable to provide necessary oversight of child safety decisions when they are not provided with full and accurate information. This is often the case when the judge is presented with agreed orders and no testimony or information is provided to the court or if the court is provided with only summaries of information from the parties.

Recommendation 10: The Legislature should require a judicial hearing on every

dependency case at least one time per year in which the court hears testimony and inquiries into issues in the case such as the safety planning for the child.

Recommendation 11: The Legislature should pass a statute requiring that courts be provided with original documents and expert reports including, but not limited to, psychological evaluations, services, visitation reports, foster parent reports, medical reports, and other reports relevant to the court hearing.

Recommendation 12: The Legislature should pass a statute prohibiting a change of placement for a child, or extended visitation, without a judicial hearing held for the purpose of providing information to the court on the status of the case and obtaining court approval for the change.

VII. **Issue 7:** In many cases, children remain in foster care far too long before permanency is established for the child. A greater emphasis must be placed on establishing permanency in the lives of children in foster care. If a child must remain in foster care for an extended period of time, the child's case should be reviewed frequently to ensure that everything possible is being done to move towards permanency.

Recommendation 13: The Legislature should pass a statute modeled after Utah which requires an annual report to the legislature of all child welfare cases that fall outside of statutory time limits. The report should be required of the DSHS, the Attorney General's Office, and the Courts and should identify the cases not in compliance with the statutory time limits regarding the following: pretrial and adjudication hearings; dispositional hearings and reunification services; permanency hearings and petitions for termination; and the reasons for the noncompliance. The Legislature may choose to create a Legislative Oversight Panel to receive the reports, monitor compliance with state and federal laws, and make recommendations to the Legislature.

Recommendation 14: The Legislature should pass a statute which requires that when the final plan for a child is to proceed toward termination of parental rights, a petition for termination of parental rights shall be filed against a parent who has failed to have contact with the child or indicate a willingness to care for the child. The hearing on the termination petition must be held within 90 calendar days after the permanency hearing.

Recommendation 15: The Legislature should pass a statute which requires that the decision on the petition for termination of parental rights shall be made within 18 months from the date of the child's removal from the home when a parent who has failed to have contact with the child or indicate a willingness to care for the child.

Appendix F

PRELIMINARY RECOMMENDATIONS FROM THE JOINT TASK FORCE ON CHILD SAFETY FOR CHILDREN IN CHILD PROTECTIVE SERVICES OR CHILD WELFARE SERVICES CUSTODY

December 2005

JOINT TASK FORCE ON CHILD SAFETY FOR CHILDREN IN CHILD PROTECTIVE SERVICES OR CHILD WELFARE SERVICES

Preliminary Findings and Recommendations
December 2005

Background

In 2005, SHB 2156 created the Joint Task Force on Child Safety for Children in Child Protective Services or Child Welfare Services Custody to review issues related to safety of children in the care of the Department of Social and Health Services.

The assignment of the task force was to review and make recommendations to the legislature and the governor on improving the health, safety, and welfare of Washington children in child protective services or child welfare services custody.

The legislation required the task force to look at the following issues in preparing its recommendations:

(a) State and federal statutes regarding child safety, placement, removal from the home, termination of parental rights, and reunification with parents;
(b) Current and ongoing department of social and health services work groups or work plans regarding child safety, placement, removal from the home, termination of parental rights, and reunification with parents;
(c) The purpose and value of child protection teams and determine whether any changes should be made;
(d) Best practices regarding children removed from parents at birth and placed in out-of-home care, transition services for families with children in out-of-home placement for an extended period of time, and standards for return to home placement when a child has been placed out-of-home including situations where a child has been placed out-of-home and returned to home multiple times;
(e) The training that is offered to social workers regarding child development and determine whether any changes should be made;
(f) Best practices regarding sharing of accurate, complete, and relevant medical, mental health, and substance abuse information between case workers, supervisors, the courts, child protection teams, counsel, guardians, parents, and other relevant participants in child placement decisions;
(g) Best practices for assessing and addressing chemical dependency issues of parents;
(h) The effectiveness of current home-based service providers currently used and determine whether any changes should be made;
(i) Best practices addressing family cultural and tribal issues and the role, if any, of social worker training or bias in safety assessment and placement decisions; and
(j) Other issues deemed relevant to improving child safety outcomes.

The task force is required to report its preliminary findings and recommendations to the Legislature by December 31, 2005, and provide a final report on its findings and recommendations by September 1, 2006.

Membership

The task force includes the following members:

Senator Jim Hargrove
Representative Bill Hinkle
Representative Ruth Kagi
Senator Dale Brandland
Melissa Allen, Department of Health, Maternal and Child Health
Robin Arnold-Williams, Dept. of Social and Health Services
Danielle Baxter, Foster Parent Association of Washington State
Charlotte Booth, Institute for Family Development
Rick Byalock, Cascade Recovery
Linda Collins, Child Welfare Services
Yolanda Duralde. M.D., Mary Bridge Childhood Abuse Intervention
Steve Hassett, Office the Attorney General
Hon. Margie Hutchinson, Colville Business Council
Linda Katz, CASA Program
Amy Kernkamp, Child Protective Services, DSHS
Shelly Lacy, Tulalip Tribe
Laurie Lippold, Children's Home Society of Washington
Gary Malkasian, Foster Parent
Byron Manering, Brigid Collins
Mary Meinig, Office of the Family & Children's Ombudsman
Joanne Moore, Office of Public Defense
Michael Petcu, Birth Parent
Joan Sharp, Washington Council for Prevention of Child Abuse and Neglect
Chief Colleen Wilson, Washington Association of Sheriffs and Police Chiefs
Judge Diane M. Woolard, Superior Court

The task force created an Executive Committee which consisted of the following members:

Senator Jim Hargrove
Representative Bill Hinkle
Representative Ruth Kagi
Senator Dale Brandland

Legislative staff assigned to the task force:

Sonja Hallum, Counsel, Office of Program Research, Children and Family Services Committee
Edith Rice, Counsel, Senate Committee Services, Human Services and Corrections Committee

Meetings

The task force began its work on August 23, 2005. Members received overviews of federal and state law, the child welfare system, fatality reviews from both the Office of the Family and Children's Ombudsman (OFCO) and the Department of Social and Health Services (DSHS), and a summary of recommendations from previous task forces, work groups, and studies relating to child welfare reform in Washington.

The task force met four times from August through November 2005. Meetings were held in Olympia.

Findings

1. Numerous studies and reports have been prepared over the years discussing the child welfare system and system reforms in Washington.

2. Several efforts are currently underway to review specific issues in the child welfare system including the Braam Oversight Panel, the Commission on Children in Foster Care, and the Task Force on the Administrative Organization, Structure, and Delivery of Services to Children and Families.

3. The child fatality reports conducted by the DSHS and the OFCO highlight many areas of concern regarding the current child welfare system.

4. The DSHS has made efforts to address many problem areas within the Children's Administration (CA) and the child welfare system; however, much remains to be done to improve the quality and consistency of system.

5. The task force will utilize work previously completed relating to child welfare reform, and not duplicate efforts to review specific areas that are being conducted by other work groups, such as placement issues being reviewed by the Braam Oversight Panel.

Recommendations

1. The Task Force shall continue its work in 2006 by forming subcommittees to review specific topic areas in greater detail. The subcommittees will report to the full committee with findings and recommendations no later than July 1, 2006.

2. Subcommittees will be formed to review the following areas:
   a. Intake and Investigation;
   b. Caseworker and supervisor workload;
   c. Services, including on-going services after a child is returned home;
   d. Internal and external review, including oversight and accountability; and
   e. Caseworker and supervisor training and support.

3. No later than April 15, 2006, the subcommittees shall submit a work plan to the Executive Committee that lists the issues upon which the subcommittee will focus during its meetings. The Executive Committee will review and approve the work plan.

4. The goal of the Task Force, and each subcommittee, shall be to develop recommendations designed to maintain the safety and well-being of children and improve child welfare practice. The focus shall be a greater emphasis on training, better consistency of practice and service delivery, early identification of familial child welfare issues, early family engagement in appropriate services, and the prevention of unnecessary placements of children in the foster care system.