Joint Task Force on Child Safety

The Office of the Family and Children's Ombudsman
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Origin of OFCO

Established in 1996 after the death of 3 year old Louria Grace and in response to abuse at the OK Boys Ranch.

Role of OFCO

- To provide citizens an **independent and impartial review** of DSHS decisions
- To **identify problems** in child welfare law, policy or practice
- To **recommend necessary changes** to improve the child welfare system

I. OFCO Role in Child Fatality Review

A. Monitor Child Fatalities

B. Facilitate Investigation by Fatality Review Teams

C. Conduct Independent OFCO Child Fatality Review

A. Monitor

Since its inception, OFCO has monitored child fatalities.

OFCO Monitoring Process

- Receive a notifier of child fatality
- Review case status & CA/N history
- Determine DCFS/CPS failures or violations
- Notify CA Headquarters to ensure appropriate review

B. Facilitate Investigation by Child Fatality Review Team

- Identify issues that warrant further investigation
- Provide case chronology to executive review team

C. Conduct Independent OFCO Child Fatality Review

OFCO independently determines that review is necessary.

II. OFCO Concerns Re: Review Process

- Lack of clarity about what triggers Executive Fatality Reviews
- Recommendations lack implementation
- Apparent lack of auditing/reporting on implementation
- Lack of state level child fatality review process

Today, all states "except Idaho and Washington have child death review programs in place at the state and/or local levels."

-National Conference of State Legislatures
www.ncsl.org/programs/cyf/childfatal.htm

III. Recommendations Re: Review Process

A. Executive Child Fatality Reviews should not be triggered solely at the discretion of the CA Assistant Secretary.

B. CA should be required to provide a written response to recommendations in each independent child fatality review conducted by OFCO.

Recommendations (cont.)

C. CA shall report on implementation of fatality review recommendations to OFCO.

D. CA shall provide OFCO with a copy of its determination to waive a fatality review and the basis for that decision.

IV. Common Factors identified in Fatality Reviews

A. Common Practice Deficits

- High caseloads
- Caseworker bias
- Lack of CW follow through to monitor compliance with services & to promote accountability
- Failure to provide support services to ease transition of child into home
- Minimization and/or failure to investigate reports of child abuse and neglect
- Multiple changes of caseworker

B. Common Recommendations Generated by Reviews

- Reduce Caseloads
- Consistently use evidence based assessment of parents
- Improve monitoring and verification of compliance with court-ordered services
- Improve team staffing
- Improve training of caseworkers & mandatory reporters
- Improve supervisory review of CPS investigation
- Modify statutory definition of CA/N
- Better screening decisions by CPS
- More strategic use of CPTs

C. Common Family Dynamics

- Lack of attachment
- Children identified by caregiver as having difficulty adjusting to being in their home
- Discrepancy between behavior reported by parents and foster parents
- History of substance abuse and/or mental health problems

Importance of Joint Task Force

- Every child death teaches us something.
- Fatalities underscore greatest failures of the system.
- Fatalities are the springboard for discussing failures and necessary improvements to the child welfare system.