COMPILATION OF RECOMMENDATIONS FROM PREVIOUS REPORTS RELATING TO WASHINGTON'S CHILD WELFARE SYSTEM

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For Use By

The Joint Task Force on Child Safety for Children in Child Protective Services or Child Welfare Services
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INTERNAL AND EXTERNAL REVIEW/INVOLVEMENT RECOMMENDATIONS

Child Protection Teams

1. Child Protective Teams (CPTs) should be mandatory in all dependency cases established due to abuse and or neglect. This CPT should occur 30 to 60 days prior to court hearings where the recommended plan is return home. *Fatality Review at 3 (Nobles Review).*

2. If individuals such as mental health counselors, drug and alcohol counselors, domestic violence treatment professionals and others involved with the family cannot be present at Child Protection Team meetings (CPTs) or Prognostic staffings, their written reports should be submitted at the meetings or staffings. The CPT or Prognostic team should not rely on the social worker's summary of these reports. *Fatality Review at 3 (Nobles Review).*

3. If the service providers involved with the family are not able to present their reports regarding the family directly to the CPT, their reports should be made available to the team as opposed to the interpretation of these reports by the presenting social worker. *Fatality Review at 3 (Nobles Review).*

4. When a review or consult is requested from an outside provider, one consistent source should be used to review all information. This consultation should then be available by speaker phone in the event the information is needed for CPT and/or other staffings. *Fatality Review at 3 (Gomez Review).*

5. Social workers should provide copies of CPS referrals, evaluations and any pertinent information related to the case on hand. CPTs should be fully informed of all circumstances, services and treatment provided, with progress reports from the providers, recommendations and evaluations from department contracted and non-contracted providers. Such information should be provided to the CPT members in advance of the CPT meetings so members can have the time to absorb and digest the information on which they would base their recommendations. *Fatality Review at 3 (Gomez Review).*

6. The Department should ensure that when a child has a GAL that the GAL receives proper notice and are invited to CPTs. The team should not rely on the social worker's summary of these reports. *Fatality Review at 3 (Gomez Review).*

7. CA employees should not be members of the CPT. *Fatality Review at 3 (Gomez Review).*

Guardians Ad Litem and CASAs

8. Guardians Ad Litem or Volunteer Court Special Advocates (CASAs) must be assigned to dependent children and must have adequate time to monitor their caseload. Pierce County currently has both paid Juvenile Court GALs and a volunteer GAL/CASA Program. Best practice indicates that Pierce County should aggressively seek to expand its volunteer program, perhaps using the current paid Juvenile Court GALs as supervisors for volunteers. This would lead to significant reduction in caseload ratios. The National CASA Association recommends three cases per volunteer and 30 volunteers per supervisor in order to properly represent children. *Fatality Review at 7 (Nobles Review).*

9. While it is recognized by the Committee that the Department cannot change the judicial system, the Committee recommends that the Department support the following recommendations. Court Appointed Special Advocates (CASA)/GAL caseloads need to meet the standards set by the National CASA Association and CASA/GALs need proper administrative supervision and support as recommended by the National CASA Association. *Fatality Review at 7 (Gomez Review).*

Judicial System

10. Juvenile Dependency cases should be assigned to one specific judicial officer at the time of filing. The same judicial officer assigned at the time of filing should hear all proceedings in the case, to the extent possible. When this is not possible, subsequent judicial officers should consider all prior judicial rulings. *Fatality Review at 12 (Nobles Review).*

11. Judicial rotations should be extended to allow for the continuity of judicial oversight on dependency cases. *Fatality Review at 12 (Gomez Review).*

12. Continuances must be kept to a minimum; a limit should be set at 2 continuances that the Assistant Attorneys General can request for the termination trial. *Fatality Review at 12 (Nobles Review).*

13. Judges should be alert to a pattern of non-contested agreed orders and consider the value of having an in-court hearing so that evidence, recommendations, agreed-upon services and the status of the case can be reviewed on the record *Fatality Review at 12 (Gomez Review).*

14. Courtrooms must be made available to hear termination trials. *Fatality Review at 12 (Nobles Review)*

Staffings by DCFS

15. Cases must receive a team review including involved service providers from outside "the agency". Supervisors and managers must be responsible for assuring that needed reviews are conducted, and that outcomes are clearly documented and implemented. *Fatality Review at 17 (Grace Review).*

16. A team of DSHS staff and other involved professionals (herein referred to as the case management team) should be developed around a case within the first 60 days that the child is in placement. As much as possible this team should manage the case throughout the time that the children are in care. *Fatality Review at 17 (Nobles Review).*

17. The Department should reassess the need for Prognostic Staffings in light of the above recommendation. *Fatality Review at 17 (Nobles Review).*

18. Appoint an independent, outside panel separate from the CPT to review the death of a child in complex cases. Cases in which it becomes apparent that agency management of policy may have had a role in a death will be best handled by an outside panel. *Fatality Review at 18 (Grace Review).*

19. The case management team should be developed around the child within 60 days of out of home placement. As much as possible, this team should manage the case throughout the time that the children are in care. *Fatality Review at 18 (Nobles Review).*

20. Cases in which a Dependency is established, or 90 days after the pick-up order is issued, which ever comes first, should be viewed by the Department as high risk cases with regards to returning the child home. The team managing the case should be required to document why the risk is no longer viewed as high prior to the children being returned. *Fatality Review at 18 (Nobles Review).*

21. Family Group Conferences should occur frequently in dependency cases to assure family and community members share responsibility for the care and protection of dependent children. *Fatality Review at 18 (Nobles Review).*

Bibliography

1. "Recommendations of Respective CA Fatality Review Committees by Issue" Office of Family and Children's Ombudsman (*Fatality Review)*, August 3, 2005.

2. "OFCO Issues and Recommendations" Office of Family and Children's Ombudsman (*OFCO)*, September 12, 2005.