



## Budget Tidbits... just the facts

Senate Republican Caucus

### Budget Brief #6: (6/30/08)

#### **Children's Administration: The Costs of Compromising Children's Safety**

*This reviews a state audit expressing concern about DSHS' investigation of child abuse referrals, cites other authorities with grave concerns, looks at DSHS' dubious use of data, and examines the number of unexpected child deaths and potential state liability.*

*Simply put, the risks to the state budget of sizable lawsuit judgments are significant if practice is not changed.*

#### **I. State Audit: Expressed concern over 60% of child abuse referrals reviewed**

As part of a recent investigation into a whistleblower claim, the state auditor's office reviewed a sampling of 20 child abuse and neglect referrals to DSHS' child protective services. The auditor expressed concern over the handling and investigation of 12 of the 20 cases (60%).<sup>1</sup> Case examples from the auditor's work papers:

- Case #2.<sup>2</sup> Allegation of physical abuse by father. Three prior referrals, including previous physical abuse finding. Father stated in prior referral he can discipline his children how he wants. CPS file states that father "does not appear to recognize the problems as he has continued to escalate in behavior."<sup>3</sup> File notes father has an alcohol problem. Case closed with "inconclusive" finding, noting family not willing to work with agency. Less than eight months later, father shot and killed one of his other children.
- Case #3.<sup>4</sup> Long history of referrals concerning physical and emotional abuse by parents. None ever founded for abuse and seven prior screened out as "information only", including multiple referrals by school. Child wrote note to teacher that he hates his parents so much and they are "horrible people" who he wishes "were dead." Child engages in self-abuse and school staff reported home discipline is extreme and emotionally damaging to boy. School referral is screened out as "information only" and not investigated.
- Case #6 (screened in, then out).<sup>5</sup> Sixteen year old child indicated being punched and kicked by father that night, stated he wanted to be removed from his home, that his "mother doesn't like him" and "there's no meaning in life."<sup>6</sup> Screened in for investigation, but reviewed by supervisor consensus team and area administrator and changed to "information only" as "there is no specific allegation of abuse or neglect that was independently validated by law enforcement on the scene."<sup>7</sup> Thirty eight prior referrals of physical abuse and chronic neglect of all children in family. Auditor found "documentation shows that the children were suicidal because of abuse they have endured" and child cried to school personnel to "not call CPS because all they do is come out and talk to the parents."<sup>8</sup>

- *Case #8 (screened in, then out).*<sup>9</sup> Fourteen year old child disclosed that one month earlier mom had beaten him with miniature baseball bat, spatula, closed fist, kicked and choked him. Case screened in for investigation, yet then reviewed by “consensus committee” and screened out. The prior month CPS received allegation of physical abuse against five year old child by mother. This was deemed “information only” and not investigated. In that allegation, referrant stated that five year old is anxious when asked about injuries and begged referrer “can you tell my mommy I have been really good, tell her I’ve been really good.”<sup>10</sup> Referrant frustrated that children are returned home despite past abuse.

DSHS workers in region raised concern about how case was handled. Family reconciliation services worker sent email to boss expressing concern about handling of case, saying “**Kids are not being protected** and Tacoma is operating outside of State policy. . . . **Intake is assessing the risk as a 3 or higher and accepting it for investigation. The ‘consensus’ committee is downgrading accepted referrals . . . and that it happens so frequently it is very obvious they are controlling their workload[.]**”<sup>11</sup>

- *Case #10 (screened in, then out).*<sup>12</sup> Fourteen year old child disclosed he gets hit by parents on daily basis. Held at Secure Crisis Residential Center. Screened in as risk level 5. The next day the referral was reviewed at a consensus meeting with CPS supervisors and the acting area administrator. Report changed to low risk and “information only”. Fourth referral concerning child’s safety in two months. Auditor noted pattern of abuse, referrals by other parties beside child, that child had physical marks, and had told law enforcement he was afraid to go home.<sup>13</sup>

## II. Serious concerns voiced about Children’s practice by others

### 1. *Children’s Ombudsman: Children’s Administration is compromising child safety*

The Office of the Family and Children’s Ombudsman is the office statutorily charged with oversight and monitoring DSHS’ provision of family and children services.

A February 21, 2008 memo from the office reported concerns about the placement, supervision, and treatment of children in state care, stating:

**“CA practice lacks common sense, is compromising child safety, and delaying permanence for dependent children placed out of the home; . . . the agency culture is alienating upper management from field workers, and discouraging internal communication, constructive criticism, and accountability.”**<sup>14</sup>

The memo says, “Workload continues to be high, in excess of COA standards, morale is low, staff retention is low, and cases are left unassigned for weeks on end.” OFCO said based on input from within the agency and the broader child welfare community, there is “a lack of openness driven by the management style of agency leadership” and a “culture of fear” which discourages employees from disagreeing with or questioning certain directives”.<sup>15</sup>

### 2. *2004 comprehensive federal review: Failed all seven child outcome measures*

The federal government periodically reviews each state’s child welfare system, evaluating based on seven outcome measures dealing with children’s safety, permanence, and well-being. Washington’s review was completed in 2004.<sup>16</sup> The state failed all outcome measures.<sup>17</sup>

### 3. *Braam Lawsuit: Returned to Court, Citing Crisis in Foster Care*

A class action lawsuit brought on behalf of foster care children throughout the state, commonly referred to as the Braam lawsuit, was settled in 2004. An independent panel was set up to monitor DSHS' progress in reforming the foster care system and measure compliance with the settlement.

Plaintiffs' attorneys have recently returned to court, alleging DSHS' non-compliance with the terms of the settlement. They claim DSHS has fallen short with regard to monthly visits, caseload standards, sibling contact, and mental health assessments for foster children:

“We have attempted to resolve all issues through the Braam Panel process, as well as informally. We no longer have faith that the Department will comply on its own volition, even with the recent funding provided by the Legislature, unless the court orders it to do so,” noted Casey Trupin of Columbia Legal Services, one of Plaintiffs' attorneys. “We are saddened by the Department's decision to ignore the very real harms that foster children are facing.”<sup>18</sup>

Plaintiffs question the veracity of DSHS' public claims:

- “Monthly visits – While the Department has now promised to implement a policy to provide monthly visits to all children in foster care in September, the Department has also released a report showing it expects the policy to be ignored for years to come for thousands of children. The Department and Governor's Office also continue to publicly claim that more children are receiving monthly visits than actually are by using data that they know does not reflect Department policy.
- Caseloads – The Department has failed to commit to a plan to reduce caseloads of foster care workers to adhere to accepted professional standards. The Department has not provided reliable data as to how many caseworkers' caseloads are above the 18:1 standard (8:1 for children with special needs). The Department insists it is getting close to meeting the standard, relying on misleading data that reflects the statewide average (as opposed to individual caseloads).”<sup>19</sup>

Plaintiffs' counsel concludes, “The Department continues to break promises, confuse the public with misleading data, and deny the crisis that exists in foster care.”<sup>20</sup>

### **III. Concerns whether DSHS is knowingly distributing misleading data**

#### **1. Caseload Figures: Include Non-Case Carrying Workers**

DSHS claims it has reduced the average caseworker's load from 26 to 21.<sup>21</sup> In addition to the concerns noted by Braam counsel, there is one other point worth making about this assertion:

- The calculations include non-case carrying workers. Most notably, intake social workers – who screen in referrals, yet don't carry or investigate cases. According to the most recent data, there are 130 such staff, or nearly 8% of the staff DSHS is using in its calculation.<sup>22</sup> These staff perform a vital service, but it paints a misleading picture to publicly claim that the average caseworker's load is 21 when non-case carrying staff are included in the calculation.

#### **2. Monthly Visits: Count as a monthly visit, even if no visit occurs that month**

The Braam settlement and DSHS policy require monthly caseworker visits for children in foster care. Braam data indicates more than 60% of children do NOT receive regular monthly visits and one-quarter

received no visit for an entire year.<sup>23</sup> The Governor’s most recent GMAP session on vulnerable children reported a much higher compliance rate.<sup>24</sup>

Braam attorneys issued a four page memorandum last week claiming DSHS is knowingly distributing and citing misleading data. In short, even though the Department’s policy is to require a visit every 30 days, the reported GMAP data counts a monthly visit if one occurs within a 40-day look back from the end of a month. Thus, if a visit occurs on January 23<sup>rd</sup>, the GMAP data counts it as a visit in February, even though no visit occurred. Braam attorneys note this may inflate compliance rates by 25% or more, meaning the Department would be inaccurately reporting monthly visits for thousands of children.<sup>25</sup>

Notably, GMAP data had been based on a 30-day monthly visit criteria previously. Only after March 2007 did DSHS switch to the 40-day monthly visit policy for its GMAP reports.<sup>26</sup>

What is equally distressing is how DSHS has used this data. Plaintiffs’ counsel notes the department has sent out two press releases in the last year touting improved monthly visit performance. What DSHS completely fails to tell the press is that the data points for the measurement include a starting point where compliance was based on a 30-day standard and the ending rate is based on a more relaxed 40-day period.<sup>27</sup> This apple-to-oranges comparison is grossly misleading.

Braam attorneys state there are only two explanations for the use of this GMAP data:

“One, that the Department and the Governor’s office misunderstood their own policy or, two, that both understood the policy and still chose to use an inaccurate data measurement. Given that the Department has consistently refused to admit that there was any misunderstanding about its own policy, it is not clear why the Department and the Governor’s office used – and still refuse to withdraw – misleading data.”<sup>28</sup>

Braam counsel says they asked the GMAP report be withdrawn and run with measurements that reflect DSHS policy, yet “[t]he Department refused to do so.”<sup>29</sup> They conclude:

“Given that GMAP principles specifically call for ‘accurate performance data’, ‘candor’, and ‘clear accountability’, the Governor and Department must pull this report and admit to its inaccuracy. In failing to do so, the GMAP process does not serve its purpose of ensuring that ‘every agency, every program, and every employee [are] accountable to citizens every day.’”<sup>30</sup>

### 3. 24/72 hour response policy: Downscreen cases to avoid triggering policy?

In 2005, Governor Gregoire directed DSHS to make initial face-to-face contact with alleged child abuse victims within 24 hours for emergent and 72 hours for non-emergent referrals.

DSHS claims emergent referrals are responded within 24 hours 94% of the time, up from 75% prior to the policy. And non-emergent referrals receive a 72-hour response in 93% of cases, up from 40%.<sup>31</sup>

What needs to be known about the policy is that it applies only if a case is a risk level 3 or higher. From a sampling of 20 cases, the state auditor found five cases screened risk level 3 or higher that were subsequently screened down and not investigated.<sup>32</sup> That is, in 25% of the cases reviewed, referrals which originally would have triggered a 24- or 72-hour response were “downscreened” such that the policy did not apply.

As noted in one case review, a DSHS worker complained to his supervisor that the downgrading of referrals “happens so frequently” it is “very obvious they [CPS] are controlling their workload[.]”<sup>33</sup>

Given the auditor's findings, and the anecdotal evidence from the DSHS worker, there is a very real question whether regions have achieved the higher compliance figures in part by screening out cases that had initially been screened in or, alternatively, would have been investigated in the past.

#### **IV. Physical & Fiscal Toll for State**

The practices of the Children's Administration are taking a toll on the state. A distressing number of children are dying, and taxpayers stand to be on the hook for the agency's errors.

##### **1. 226 unexpected child deaths**

The Office of Family and Children's Ombudsman reports that since January 1, 2005 there have been 226 unexpected deaths of children who had contact with DSHS within one year of their death.<sup>34</sup> This includes children who either had referrals closed within the past year or had an open case at the time of death. The one year standard is the statutory directive for determining when a fatality review should take place.<sup>35</sup>

##### **2. Lawsuit exposure in the hundreds of millions**

The Risk Management Division of the governor's budget office keeps tabs on critical incidents and outstanding legal claims against state agencies.

Open claims and pending suits concerning Children's Administration are significant, both in numbers and size. Among the claims:

- \$45 million lawsuit for sexual abuse of three children by foster father over a period of several years. Attorneys contend state ignored more than two dozen warnings. Police detective called the case "the most horrific example of bureaucratic disregard for the health and safety of young children I have ever seen."<sup>36</sup>
- \$55 million lawsuit on behalf of five foster care children who resided together, including Tyler DeLeon who died on his 7<sup>th</sup> birthday weighing 28 lbs. Sixteen prior referrals, including repeated school referrals. The attorney says even if the state pays tens of millions of dollars, she's reluctant to say it will have a substantial impact on how cases are handled. "The state keeps saying they're going to change their policies every time a child dies," she said. "It doesn't appear that happens."<sup>37</sup>
- \$22 million lawsuit on behalf of Shayne Abegg, a four year old who weighed just 22 lbs and suffered from malnutrition so severe he was unable to sit up.<sup>38</sup>
- \$15 million claim on behalf of Summer Phelps, a four year old girl who died from parental abuse. There had been half a dozen prior complaints. Police records showed she was severely beaten, bruised, bitten, tortured with a dog's shock collar and smothered in urine-soaked clothing before she died March 10, 2007. Law enforcement personnel said her injuries were "among the worst examples of abuse they've encountered."<sup>39</sup>

#### **Bottom Line**

Where is the accountability for the agency's performance and dubious public use of data, and how much will it cost Washington taxpayers and families?

1. See Whistleblower Investigation, No. 06-033 (Dec. 11, 2007) (allegation region administrator instructed intake workers to screen out child abuse referrals in order to control caseworkers' load; audit concludes "no reasonable cause" to believe regional administrator gave such instruction.) But the audit concluded, "We noted, however, some documentation issues regarding risk assignment we communicated to the Department of Social and Health Services." That communication was a letter from the state auditor to the DSHS secretary saying, "We reviewed 20 case files. In 12 of the cases, we did not find documentation that showed why the action was taken." Auditor's work papers, p. 117. The assigned auditor's detailed summary of concerns about the handling of each of the twelve cases is contained in the work papers. Some excerpts of her concerns are noted throughout the tidbit.
2. Auditor's work papers, pp. 601-19.
3. Id., p. 608.
4. Id., pp. 619-45.
5. Id., pp. 878-939.
6. Id., p. 884.
7. Id., p. 917.
8. Id., p. 879.
9. Id., pp. 1011-32.
10. Id., p. 1021.
11. Id., p. 1029.
12. Id., p. 1076-92.
13. Id., p. 1078.
14. Memorandum re: Summary of presentation to Legislative Children's Oversight Committee regarding child safety concerns, p. 1.
15. Id., p.3.
16. Child and Family Services Review, February 2004. U.S. Dept. of Health and Human Services. Washington's next comprehensive review is scheduled for 2010.
17. The Department touts the fact it met its performance improvement plan in 2006, and while it is true Washington reached its improvement goals, it is important to note that in many instances these "improvement" targets were set well-below federal measures. For instance, on repeat maltreatment, the national standard is 6.1%. Washington had repeat maltreatment in 10.8% of cases in the 2004 review. The performance improvement plan set a target improvement of 9.9%. Achieving improvement goals should not be equated to, or confused with, passing federal outcome measures, which the state has not done.
18. Press Release: "Court to Consider DSHS' Non-compliance with Braam Settlement Agreement" (June 25, 2008)
19. Id.
20. Id.
21. "Legislator rebukes children's agency", Vancouver Columbian (6/24/08).
22. DSHS email to legislative staff, "Case carrying calculations thru May 2008" (6/27/08). Also included in DSHS' calculation are case support social workers of whom there are 117 by the latest monthly count.
23. Columbia Legal Services memorandum, Using Data to Paint a Misleading Picture of the Monthly Visit Performance (6/25/08), p. 1
24. DSHS GMAP presentation (4/9/08).
25. Columbia Legal Services memorandum, Using Data to Paint a Misleading Picture of the Monthly Visit Performance (6/25/08), p. 2.
26. Id., pp. 2-3.
27. Id., p. 3. (See "DSHS calls Braam Plaintiffs' Court Action Unnecessary," 1/17/08)
28. Id., p. 3.
29. Id., p. 4.
30. Id.
31. See GMAP 4/19/08 and 1/18/06 presentations.
32. See auditor's work papers for cases #6, #8, #10, #11, and #12.
33. Auditor's work papers, p. 1029.
34. OFCO email to legislative staff (6/10/08).
35. RCW 74.13.640.
36. "Foster dad gets 4 years for sexual exploitation," Seattle P-I (8/13/07)
37. "\$55 million lawsuit filed against DSHS," Spokesman-Review (6/27/07)
38. "Father of 4 year old boy charged with maltreatment," Seattle Times (3/14/07)
39. "Review delayed in Summer's death," Spokesman-Review (5/16/07)