

# Final Report

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## Independent Review of ■ Case

Benjamin de Haan, Ph.D.

9/15/2009

### Introduction

On July 29, 2009, the Independent Review Committee (IRC) and Independent Consultant, Benjamin de Haan (IC), released a Preliminary Report regarding the case of ■■■, a four-year-old foster child, who remained in foster care for most of her young life<sup>1</sup>.

While initial findings focused exclusively on the factors that led to ■■■'s unusually long stay in foster care, the committee identified a number of other issues critical to better understanding the ■■■ case. This report addresses the additional areas of concern, which includes new information gathered since the release of the preliminary report, and it expands the initial set of recommendations.

Like the Preliminary Report, this Final Report does not provide specific, prospective recommendations in ■■■'s case since the matter is still before the court - the appropriate venue for discussions about ■■■'s future. Instead, the IRCs' activities have focused on what ■■■'s case can tell us more generally about child welfare practices in Washington State.

In the three weeks since the release of the Preliminary Report, additional clarification has been offered either verbally or in writing by the Office of the Attorney General (AGO), Children's Administration (CA) personnel, the foster parents Mr. and Mrs. Langley and their legal counsel, the biological parents Mr. and Mrs. ■■■■ and their legal counsel, and the Office of the Families and Children's Ombudsman. There is general agreement about the statement of facts and the preliminary recommendations. However, there are two topics requiring additional clarification:

#### Attorney General (AGO) referral process

The Preliminary Report raised the question of why three referrals by CA to terminate parental rights were not accepted by the Everett AGO. A fourth referral by CA was finally accepted by the AGO. The AGO expressed concern that the readers of the preliminary report may draw incorrect conclusions about the Everett AGO's handling of the case<sup>2</sup>.

It was not the IRC's intention to judge the quality of the AGO's legal advice, but to point out that the process of referring the case four times was one of many factors contributing to ■■■ staying in foster care. The records show there were four referrals - three of which were not accepted over a period of two years. According to very experienced staff from both the CA Division of Child and Family Services (DCFS) and the AGO, this number of referrals is very rare, if not unprecedented. The AGO provided a detailed assessment of the factors that were taken into account in deciding if each referral was legally sufficient using the following definition:

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<sup>1</sup> Preliminary Report: Independent Review of the ■■■ Case, June, 29, 2009

<sup>2</sup> July 15<sup>th</sup> correspondence between the Office of the Attorney General and B. de Haan

A legally sufficient referral is one in which a good faith argument that there is sufficient evidence to meet the clear, cogent convincing standard of proof on the six elements in RCW 13.34.130.

In lay terms, four of the six elements are procedural and/or easily defined: (1) the child is dependent; (2) the court has entered a dispositional order; (3) the child has been removed from the parents' custody for at least six months; and (4) services have been offered that have some reasonable chance of correcting parental deficiencies. The fifth and sixth elements require more judgment: (5) will the parents improve enough to warrant reuniting with their child in the near future, and (6) will the continuation of the parental relationship be detrimental to the child's chances of being placed in a permanent home.

To answer the last two questions social workers and attorneys in Snohomish County consider not only the facts of the case but they also take into account a wide variety of contextual issues such as:

- staff workload
- case preparation by the social workers
- the probability of success in court
- a judge's expectations
- recent appellate decisions
- the credentials/credibility of available witnesses
- the requirements of their respective organizations

The Everett AGO and the Everett DCFS office both report excellent communications and collaboration in making these judgments in most cases. Nonetheless, the DCFS staff report philosophical differences with the AGO, which in their view, have slowed children's progress towards permanence. On the other hand, requirements of both state and federal law exert pressure on DCFS staff to refer cases for termination based upon "time in care" regardless of whether they meet the definition of legal sufficiency. This failure to sort out the "wheat from the chaff" exacerbates the workload of an already very busy Everett AGO.

It is impossible to determine the individual influences of these factors, particularly when viewing events through the lens of a single case; however, there is evidence, which suggests differences in the way that Snohomish County moves cases towards permanence compared to other counties:

Snohomish County has by far, the longest time to reunification (expressed in median days to reunification, 1998-2008 data) of any county in the state of Washington<sup>3</sup>. The statewide range is 29 days in Okanogan County to 508 in Snohomish County. By comparison, Pierce County, another county with a blend of urban and rural areas has a median time of 49 days. In addition, the time to reunification in Snohomish County has more than tripled within the last 10 years. (Refer to the Preliminary Report for a discussion of statewide trends in children's length of stay

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<sup>3</sup>Family Reunification for Children Entering Out-of-Home Care in Region 3 : Partners for Our Children

in foster care). At the same time, the Everett AGO, which serves Snohomish County, has the highest caseload in the state<sup>4</sup>, significantly higher than the county with the lowest caseload. There is a persistent belief among CA staff, at the state and local level, that there are regional differences among Assistant Attorneys General (AAG) in accepting termination referrals. Reasons cited for these differences include a high Everett AGO workload and a previous decision by the Court of Appeals, which reversed a termination decision in Snohomish County. In addition, there is a documented history of efforts by the Everett DCFS staff to speed up the referral process, and the record reflects that the ■ case was one of those cases identified in these efforts.<sup>5</sup> However, information compiled by the AGO reveals no significant differences between individual AGO offices regarding termination filing rates<sup>6</sup>.

The Preliminary Report offers two recommendations pertaining to this issue:

1. Thoroughly assess any differences among offices in termination filing practices.
2. Establish a clearly articulated statewide protocol for resolving differences between DCFS and each AGO office when there is a disagreement accepting a termination referral.

These recommendations remain in this Final Report and will be addressed in more detail in the recommendations section of this report.

### **The foster parents' alleged use of intimidation**

On page six of the Preliminary Report there is a discussion about how changing social workers and supervisors affected the ■ case. The report addressed one social worker and supervisor change by stating, "Sandra Kinney, the Area Administrator in the Everett DCFS office, made the decision to change the social worker and the supervisor due to "escalating personal and verbal attacks." The report concluded that this change was "well reasoned and justified." In a subsequent interview with the Langleys<sup>7</sup> they denied intimidating agency personnel, and they questioned the basis for the change in staff assigned to ■'s case.

In retrospect, the term "personal attacks" did not define the allegations with enough precision. More specifically, DCFS staff was concerned about the Langley's threatened lawsuits, and the threats that Amy Langley posted on the internet. In addition, DCFS was concerned that the Langleys had conducted unauthorized criminal background checks in an attempt to embarrass selected CA staff. A written record of Amy Langley's threatening comments on the internet was reviewed by the Independent Consultant and has also been made a part of the official court record. She also stipulated to the use of criminal background checks of DCFS staff under oath during a deposition conducted by Mr. ■'s attorney. It is not clear under what authority

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<sup>4</sup> OAG Caseload Management System

<sup>5</sup> See the "Ruby Slipper Project" summary, Everett DCFS document, July 2009

<sup>6</sup> Information presented to the Independent Review Committee, by S. Hassett, July 20, 2009

<sup>7</sup> Telephone interview between the Langley's and B. de Haan July 21, 2009

these background checks were conducted. Nevertheless, given the deteriorating nature of the relationship between the parties and the emotional tenor of the discussions, changing the social worker and the worker's direct supervisor was a reasonable strategy for de-escalating the conflict and maintaining professional neutrality.

***Additional areas of interest to the Independent Review Committee***

Three of the issues identified by the Independent Review Committee were directly related to ■'s foster parents, Richard and Amy Langley:

1. What was the justification for CA's Division of Licensed Resources' (DLR) attempt to revoke the Langley foster parent's license?
2. What was the justification for removing ■ from the Langley foster home?
3. Is there evidence that ■'s foster parents have further jeopardized ■'s welfare?

**1. Attempted foster parent license revocation and ■'s removal from the Langley home**

The Langleys were originally licensed as foster parents by New Hope Child Placing Agency in June 2001. Since that time, DLR received 24 referrals alleging a variety of licensing violations including neglect/maltreatment, lack of supervision, and breach of confidentiality<sup>8</sup>. In October of 2008, the Langleys were notified of DLR's intent to revoke their foster care license based upon a founded referral for the negligent treatment of their ■. In January of 2009, the revocation was denied at an administrative hearing and the founded referral was reversed. Nonetheless, this founded referral, along with a later referral for breach of confidentiality was the basis for the later decision to remove ■ from the Langley home.

The justification for the revocation attempt has been discussed extensively in the written record<sup>9</sup>, along with a number of weaknesses in the investigative procedures, timelines, and communication between DLR and the Everett DCFS staff. However, the more important issue is that the licensing violations/founded referral provided an expedient, though indirect, justification for removing ■ from the Langley home (in August of 2008) without dealing with the more fundamental issue of foster parents who were becoming increasingly aggressive in their attempts to undermine the agency's court-approved planning process. ■ was removed from the Langley home for one day in August and removed again following the court hearing in January of 09. The DCFS declaration to the court pursuant to this hearing still emphasized the founded referral rather than the Langley's inappropriate behavior. This declaration preceded the ALJ's ruling reversing the founded referral. When the ruling was released in April of 09, the agency's justification for recommending removal from the Langley home was seriously undermined and the Langley's inappropriate behavior had continued to escalate. By this time,

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<sup>8</sup> DLR Licensing Chronology, 8/7/09

<sup>9</sup> See ALJ Decision, 4/27/09;10/27/08 DLR Notice of Intent;6/15/09 correspondence between CA and OFCO



understandably and necessarily become attached to the children in their care. The foster parent representative on the Committee was particularly concerned about the lack of training and preparation for foster parents who must be prepared to adopt a child or return them permanently to their parent---a very difficult task for anyone who has had a child in their care for almost four years.

## **2. The Langleys' impact on** [REDACTED]

Foster parents have every right to advocate strenuously for the children in their care, up to and including contacting legislators, the media, asserting their rights in court and otherwise attempting to mobilize opinion about public agency practices. However, there is ample evidence indicating that the Langleys escalated far beyond what was appropriate by discussing the details of [REDACTED]'s case with people unrelated to the case<sup>13</sup>. The Langleys also posted damaging and erroneous information about [REDACTED] on the internet. They allowed a television crew to enter the Langley house for the express purpose of filming [REDACTED] during a difficult transition. In another incident they strip-searched [REDACTED] in view of a neighbor in order to document alleged maltreatment [REDACTED]. The last two examples are particularly egregious when one considers that [REDACTED] has been described as a child who is [REDACTED].

Since leaving the Langley home, [REDACTED]'s [REDACTED] have improved dramatically. She no longer requires [REDACTED]. There is no evidence of [REDACTED] described while she was living with the Langleys. She [REDACTED]. The new foster parents report that [REDACTED].

There are a number of explanations for the decrease in [REDACTED] exhibited by [REDACTED]. For example, the services offered have had a positive effect, the new foster home may be better equipped to meet [REDACTED]'s needs, [REDACTED] may be at a developmental stage that supports better [REDACTED], or finally, [REDACTED]'s earlier [REDACTED] may have been exaggerated by the Langleys in order to reduce the probability that she would be returned to her biological parents. Because much of the earlier record regarding [REDACTED] relies upon reports from the Langleys, it is impossible to make a judgment about which of these explanations is the most plausible.

## **3. Services offered to the biological family**

A review of the Department of Social and Health Services (DSHS) case records reveal an extensive history of services dating back to when [REDACTED]. In addition to the services [REDACTED].

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<sup>13</sup> Other foster parents who distributed letters with detailed case information

provided by CA, which will be addressed later, various family members were involved with service episodes provided by the following DSHS agencies<sup>14</sup> :

[REDACTED]

[REDACTED]

[REDACTED]

Records show that CA and their contractors, alone, provided separate services to the family in addition to the standard case management activities. The services included

[REDACTED]

[REDACTED]. In addition, [REDACTED] received a number of services and evaluations as part of her [REDACTED]. The records also indicate that largely the parents participated in these services and were compliant, for the most part, with services ordered by the court.

It is clear that the poor outcomes in this case are not attributable to the lack of available services. However, the quantity or type of services reveals very little about effectiveness or appropriateness of the services provided which is a question that goes beyond the scope of this review. In the IRC's view, it is fair to conclude that the services offered compared favorably – and in some instances surpassed services offered to other public child welfare clients.

From [REDACTED]'s perspective, many of the services were redundant because new workers wanted to make sure they had "all the bases" covered. This was particularly true for court ordered services like [REDACTED]. [REDACTED] points out that she did not [REDACTED] for more than five years yet she was required participate in [REDACTED].<sup>15</sup>

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<sup>14</sup> Consolidated Service History, DSHS Research and Data Analysis, 7/15/09

<sup>15</sup> Telephone interview with B. de Haan and [REDACTED], 8/5/09

**4. Were [redacted]'s [redacted] needs adequately addressed?**

[redacted]'s case record and supplemental documents provided by CA staff reflect a very thorough examination of her [redacted] needs<sup>16</sup>. [redacted] was assessed by [redacted], and home visits were conducted by a number of social workers. However, some of professionals relied heavily on uncorroborated information from the foster parents in drawing their conclusions, including the DCFS social workers. Some of the professionals involved with [redacted]'s case also became actively engaged in the debate about whether [redacted]. At least one professional allegedly shared medical information with the media during a television interview.

**5. Consistency with federal law, state statute, and commonly accepted social work practice**

The Independent Review Committee reviewed three documents that made a number of claims and counter-claims about the CA's compliance with state and federal laws and conformance with established child welfare practices.<sup>17</sup> The questions raised that are particularly relevant to this review are:

*a) Did the agency violate the Adoptions and Safe Family Act of 1997 (ASFA) in the [redacted] case?*

Briefly stated, the federal law requires child welfare agencies to pursue termination when a child has been in foster care for 15 of the last 22 months. The federal statute also allows for compelling circumstances that must be documented when those timeframes are exceeded. CA's first three referrals to the Everett AGO, their subsequent assessment of legal insufficiency and the later ruling by the Snohomish County court satisfies these requirements. The larger point, one which has been discussed earlier in this report and in the Preliminary Report, is that the agency can comply with AFSA and the Washington State Statute<sup>18</sup> and still allow a child to drift in foster care. From a technical point of view, the agency met ASFA and state statute in this case.

*b) The foster home investigation conducted by DLR was flawed.*

CA maintains a separate and autonomous child protective services (CPS) investigative function within DLR for cases involving licensed facilities. The rationale for this separation is that DCFS has a conflict of interest if they investigate licensed facilities where DCFS placed children. In this instance, the investigation involved the Langleys' [redacted], not their foster children. However, as mentioned above, the founded CPS referral was the basis for later removing [redacted] from the Langleys' home. The record clearly reflects that the investigation involving [redacted] was flawed and it did not meet DLR's policy requirements. The larger issue is whether a separate

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<sup>16</sup> Medical and Developmental History of [redacted] prepared by DCFS staff, 7/09

<sup>17</sup> Correspondence between OCFO and Randy Hart

<sup>18</sup> RCW 13.34.145

CPS investigative function – in this case, not well coordinated with DCFS – is necessary. While the focus of the investigation was the supervision of ■■■, no one addressed the question of how ■■■, as described by the Langleys, represented a potential risk to ■■■ placed with ■■■ in the Langley's home.

A question not raised in the documents relates to ■■■ siblings, who at different times, were also placed in foster care and why none were ever placed together. One of the basic tenets of child welfare practice is, whenever possible, siblings should live together. One possible explanation is that a single foster home would be overwhelmed by ■■■ needs and they would not be able to handle an additional child who also would require ■■■. Later discussions with DCFS staff confirmed that placing ■■■ together was not an option due to concerns about ■■■'s ■■■ needs and the deteriorating relationship with the Langleys.

## Recommendations

### 1. Improve foster parent engagement

The review of the ■■■ case raises concerns regarding the role of foster parents in case planning and the extent to which they are trained and supported in the “concurrent planning” process. Many foster parents come to the program with the expectation that they will eventually become adoptive parents. Naturally, they form strong emotional bonds with the children in their care. Frequently, they are required to go through the emotionally difficult process of letting go of these children, even if reunification with their biological parents offers an uncertain future. Without very clear communication from agency staff coupled with in depth training and strong support, open conflict over case goals can be expected. These conflicts and the decisions that follow are often viewed by foster parents as retaliation for pointing out agency deficiencies and/or advocating for the children in their care.

The ■■■ case offers a clear example. But in this case, the situation was made far more difficult by her very long stay in foster care, a case plan that vacillated frequently between reunification and termination, foster parents who were allowed to go beyond their normal role in case planning, and sensational media coverage.

From the larger systems perspective, we actually know very little about the status of CA's relationships with foster parents across the state other than the input from the foster parent representative on the IRC, the foster parents involved in this case, and a number of foster parents who have responded to the Preliminary Report. This small group of foster parents have cited the need for better training; a more defined and constructive role in case planning; a more effective venue for resolving disputes and more active engagement in the discussion of statewide foster care policy affecting them and the children in their care. It should also be noted that the State of Washington was the first state in the nation in which foster parents sought union affiliation in order to advocate for their interests.

The child welfare research literature tells us that foster parents resign most often because of inadequate agency support, not because of the difficulties presented by the children in their homes. Foster care in Washington is on the rise, and if the trend continues, the number of foster parents needed, will continue to grow. The number of children adopted in 2007 declined slightly from 2006 and the number of children freed for adoption within 24 months fell by 3.5% during the same time period (note: the number of children adopted in 2008 rose significantly. The median number of days in care for all children rose from 505 to 536 and the number of children in care for more than two years also rose slightly (one percent)).

The publicity surrounding the [REDACTED] case will no doubt have a chilling effect on foster care recruitment and retention. Given the increased demand for foster parents a concerted effort to learn more about foster parents' needs is recommended. Currently, there is no systematic, statewide method for soliciting foster parent feedback other than the annual, retrospective telephone surveys<sup>19</sup> and meetings required by statute.

The IRC recommends conducting a series of focus groups across the state with foster parents to:

- Assess their most pressing training needs
- Learn how they can better meet the needs of the children in their care
- Generate ideas for improving communication
- Gather feedback about better ways to resolve disputes
- Evaluate the effectiveness of current foster care policies

## 2. Finalize the cross agency mental health/DDD guidelines

In her June 30<sup>th</sup> 2009 letter to Randy Hart, interim Assistant Secretary of Children's Administration, Mary Meinig, Director Ombudsman, of the Office of the Family and Children's Ombudsman underscores the importance of providing services to assist adoptive families with special needs children. In the [REDACTED] case this issue was highlighted by the failed adoption [REDACTED]. Whether additional services for [REDACTED] would have made a difference in this case is debatable ([REDACTED]), but in many cases, these services are critical for the survival of the adoptive placement. According to Ms. Meinig, DSHS convened a cross agency work group to develop protocols between Developmental Disabilities Division (DDD) and CA. Department staff report that a similar effort is also underway with Health and Recovery Services Division (HRSA).

The IRC recommends that the draft guidelines which simplify access to mental health and DD services for children who can no longer be managed at home, be finalized immediately.

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<sup>19</sup> Required under the Braam settlement

### 3. Improve coordination between DLR and DCFS

In 1996, an Executive Order created an independent child protection investigative function within the Children's Administration. The Division of Licensed Resources came about after ongoing failed investigations of a licensed residential facility for boys<sup>20</sup>. The thinking at the time was that social workers who place children are more likely to dismiss or minimize child safety concerns due to the difficulty of finding new placements. On the other hand, investigators who bear no case planning responsibility for children in placement may be more willing to disrupt those placements rather than to look for other ways of resolving child safety concerns. The current dual structure adds complexity, increases the need for communication, and it may ultimately produce divergent standards for child safety. Further, it is difficult to see how objectivity is increased by this parallel process, since DLR is a division within CA ultimately reporting to the same Assistant Secretary as the other employees in the DCFS field offices.

In the ■ case, there was a lack of communication about the events leading up to ■'s removal and the investigation went far beyond acceptable timeframes. Also, the subsequent attempt to revoke the Langley's foster care license did not consider the overall impact on the other children in the Langley home.

It should be noted that members of the IRC were more concerned about the quality of the investigations, the communications between DLR and DCFS, and the management of the dual investigative functions, rather than the structure itself.

The IRC recommends convening an agency/community work group to assess how frequently investigations of licensed facilities exceed the time -frames specified in both policy and state statute. If necessary, the work group should identify strategies for accelerating investigations and for improving decision-making between DLR and DCFS when conducting investigations of licensed facilities.

### 4. Greater emphasis on timely, child-centered permanency

Data reviewed above and discussed in the preliminary report suggest that foster care in Washington is increasing, children are staying longer, and there are significant regional differences in the time necessary to achieve a permanent home for children. The preliminary report included recommendations that are a part of the larger issue of permanency:

#### **A. Immediately review a stratified sample (by age group) of children from each region who have been in care the longest to develop enhanced permanency strategies**

CA periodically reviews children in foster care to overcome barriers to permanency. Since the evidence points to regional variation in practice, in time to reunification, and in length of

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<sup>20</sup> Governor Lowry's Executive Order 96-03, January, 1996

stay, the review should be conducted by a single review team using standardized criteria. Some child welfare jurisdictions refer to these reviews as “permanency roundtables” since the emphasis is on taking actions rather than auditing case files.

### **B. Organize and Integrate Measures of Permanency**

CA reports permanency measures in a number of venues including the Braam settlement and the Program Improvement Plan related to federal Child and Family Service Reviews. At the time of this writing it is unclear how these strategies relate to one another. The department should develop a single, focused action plan with concrete and specific regional goals related to reducing time to permanency for all children in care. These measures should be a part of the dashboard of critical indicators reviewed by agency leaders on a regular basis.

### **C. Create a “Red Flag” System**

CA is required by state statute to gather performance data in four general areas, one of which is permanency. This information is reported in the aggregate, on an annual basis, using data drawn primarily from the old Case and Management Information System (CAMIS). As CA refines the implementation of the new FamLink data system, producing useful, accessible information about children’s “real time” status in the system should be a high priority. Each region should get a monthly red flag report listing children who are not making sufficient progress towards a permanent home. Ensuring that CA staff understands how to access and use these reports will be one of the greatest challenges.

### **D. Immediately assess regional differences in accepting TPR referrals**

A great deal has been written in this report and in the Preliminary Report about the need to understand regional differences in the speed with which children are legally free for adoption or reunited with their parents. Recent data from Snohomish County indicate distinct differences in comparison with other counties or when looking at Snohomish County over time. As previously indicated, there is a prevailing belief among DCFS staff that AGO workload and differences in philosophy have hampered attempts to speed up the termination process. The IRC strongly urges the leadership in the AGO office to continue the discussion, and to further consider the effects of the AGO workload in the Everett office.

## **5. Implement a consistent ICW policy in the regions**

The federal Indian Child Welfare Act of 1978 requires public child welfare agencies to make “active efforts” to facilitate family rehabilitation of Indian families. In practice, this means that social workers are required to determine if a child has Indian heritage, so the child’s tribe has an opportunity to intervene as a full party in the case. Some CA regions automatically transfer cases to specialized Indian Child Welfare social workers and if Indian heritage and/or tribal affiliation is not confirmed the case is transferred back. Others don’t transfer until Indian heritage is confirmed and still others have no specialized caseloads. In ■■■’s case, the transfer

took place [REDACTED] but this cost time, and unnecessary case transfers. It is unclear if this is a problem with policy, training, or the lack of sufficient resources for specialized caseloads.

## **6. Assure greater consistency in shared decision-making**

CA, like most child welfare agencies, has adopted a practice model that emphasizes working with families, both formally and informally, across service systems to enhance their capacity to care for and protect their own children. These approaches take many forms, Family Group Conferencing, Family Team Decision-Making, Family Unity meetings and Family Mediation, just to name a few. While the names and approaches vary, all of them attempt to focus on the needs and welfare of children within the context of their families and communities. Many jurisdictions, including Washington State, also require multi-disciplinary teams (MDTs) or child protection teams (CPTs) to expand the number of disciplines and participants in local case planning. If implemented well, these practices can improve decisions, identify family strengths, and give the family members a stronger voice.

In the [REDACTED] case FTDMs and the CPTs were both used frequently with mixed results. Agency staff identified a number of inconsistencies in approaches between CPTs and FTDMs and some participants reported confusion, redundancies, and even breaches of confidentiality. DCFS staff outside of Snohomish County has also identified the need for clearer expectations, more training and better quality assurance in the use of these participatory models.

## **7. Create a framework to better support external reviews**

The Revised Code of Washington allows the DSHS Secretary (or designee) to share information under certain conditions specified in RCW74.13.500. The statute clearly authorizes the release of information, in cases of fatal or near fatal maltreatment; but, the Secretary's authority to release information in support of an external review in non-fatal cases is unclear. As a result, the Department has neither the policy framework nor the history to guide external reviews in non-fatal cases. The agency response to requests for information under the auspices of the IRC can only be described as tentative and confused. This hesitancy does not reflect any individual unwillingness to cooperate; department staff simply don't know how to share information without violating the confidentiality rules. These concerns are particularly acute in the [REDACTED] case since one of the most important issues has been inappropriate release of information. Curiously, similar concerns arose related to sharing program information across DSHS agencies.

Without question, external entities already participate in case planning activities – the Guardians Ad Litem (GAL), Court Appointed Special Advocate (CASA), AAGs, and the courts to name a few. Each of these entities has a particular vantage point and an institutional relationship with the other agencies or participants. To be of maximum value, an external review process requires the ability to gather perspectives from individuals selected for their specific expertise in a given case, not only individuals representing an institutionalized policy or agency perspective.

Creating a well defined avenue to increase external participation in sensitive cases will, no doubt, result in more external reviews and more time and energy to support them. The DSHS Secretary will need to decide if that is the course she wants to pursue. If so, there are two obvious pathways. The first involves legislative action to provide statutory authority. An example of this approach is found in our neighboring state of Oregon. Two sessions ago the Oregon legislature created Oregon Revised Statute 409.225(3) (b) which authorizes the Director of the Department of Human Services to convene a Sensitive Review Committee. In the Oregon statute, the Director of the Department of Human Services is authorized to release information at his/her discretion to:

A person designated as a member of a sensitive review committee convened by the Director of Human Services when the purpose of the committee is to determine whether the department acted appropriately and to make recommendations to the department regarding policy and practice.

The second option is to make broader use of the statute authorizing the activities of the (Washington State) Office of the Children and Families Ombudsman. To do so would require a very different approach to reviewing cases, one which would include convening outside experts on a time limited basis, depending on the issues at hand.

### Summary

In the Preliminary Report, the IRC concluded that:

It is impossible to identify a single cause for ■'s long stay in foster care. Clearly, many factors combined to slow down ■'s progress towards a permanent home. Social worker turnover, supervisor turnover, inadequate tracking, workload at the AAG's office, the fog of claims and counter claims and the complexities of the family situation all played a role.

In this final report, the IRC has been asked to consider what the ■ case tells us about child welfare policies and practices on a systems level. All of those who participated in the review process, including the committee members, agency staff and other parties, have cautioned against making too many assumptions based upon a single case. With that in mind, the committee still concludes that many of the factors that led to ■'s long foster care stay are, in many respects, reflections of larger systems issues. Better coordination between the AGO and CA, expanded training and preparation of foster parents for the rigors of concurrent planning; improved management of the DLR/DCFS investigative process; increased emphasis on child-centered permanency; better quality control regarding shared decision making models, and improved information about children in foster care, we believe, are all important steps towards achieving better outcomes for children in Washington's child welfare system.

## Appendix A

### Independent Review Committee Members

Dr. Benjamin de Haan, Independent Consultant

Justice Bobbe Bridge (retired), Washington Supreme Court

Judge David Foscue (retired), Grays Harbor Superior Court

Ryan Murrey, Program Services Manager, Washington Association of Court Appointed Special Advocates (CASAs)

Patrick Dowd, Washington State Office of Public Defense

Bruce Clausen, former Assistant Attorney General (AAG)

Beth Canfield, Foster Parent's Association of Washington

Vicki Wallen, former Director, State of Washington Office of the Family and Children's Ombudsman

Bonnie Peterson, Public Health Nurse, Thurston County Public Health Services

#### **Resource people in attendance:**

Stephen Hassett, AAG

Sandra Kinney, Area Administrator for CA, Everett office,

Deborah Purce, CA Executive Staff Director